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APTA National Physical Therapy Month webpage www.apta.org/nptm/

### #ChoosePT

Theme of first National Physical Therapy Month.

APTA National Physical Therapy Month History webpage www.apta.org/NPTM/History/

### Back in Action

Theme of first National Physical Therapy Month for 2017, referencing APTA’s award-winning campaign to address the opioid epidemic.

APTA National Physical Therapy Month webpage www.apta.org/nptm/

### 264 million

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Nielsen Media Research

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Global PT Day of Service website www.ptdayofservice.com/
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**The Boys in the Boat**

A friend of mine, knowing I enjoy reading about World War II history, recommended that I read author Daniel James Brown’s *The Boys in the Boat*. Assuming that “boat” meant submarine or destroyer, I eagerly downloaded this book onto my e-reader ... and discovered the world of crew—a rowing sport about which I knew very little!

Until now.

I quickly became engrossed in this true story about a special group of athletes—the 8-oar crew team from the University of Washington, their devoted coaches, a highly-skilled boat builder, and the team’s collective heart and soul. Brown artfully weaves into their story the effects of the Great Depression, the natural disasters of that period, and the man-made disaster of Hitler’s Nazi Germany—all leading up to the 1936 Olympics in Berlin.

Why am I telling you this in “Viewpoints”? Because when I received the June issue of *PT in Motion* and discovered the article “Fluid Motions” by Keith Loria, I was at once excited, delighted, and anxious to share *The Boys in the Boat* with you!

As I was reading about the symptoms and injuries typical of crew athletes with whom physical therapists (PTs) work, I also was reading about the building of a “shell” (a crew boat), the smell of cedar and varnish, and members of a crew team decades ago that placed their utmost trust in one another—suddenly finding their “swing” and slicing elegantly through the water in a craft that looks more like a needle than a boat.

Because we are PTs, we can look at this account of the sport and its participants from a unique perspective. Throughout the book, words related to our craft appear: strength and grace, stress and strain, massage tables and steam rooms, “muscles ... scream[ing] in agony,” mental toughness, power and endurance, and so forth.

Brown did his research. Chapter Three touches on the enormous amount of oxygen consumption demanded, and the aerobic and anaerobic use of muscles required, in competitive rowing. Reading about this was mind-boggling to me! Imagine what reaction the crew of 1936 would have had if they’d read the 21st-century research that the author presents in his book.

The “Fluid Motions” article gives us an up-close look at PTs’ work with competitive crew athletes and describes what those therapists are up against. *The Boys in the Boat* reveals the very essence of crew: cooperation, trust, and the resilience of the human spirit.

Cooperation, trust, resilience. Whether we are treating an elite athlete, an aging person, or the smallest infant, PTs tap into each of these qualities every time we greet our next patient or client.

For those of you who will read *The Boys in the Boat*, I believe you will be both enlightened and enriched.

Celia Rosenberg, PT, BS

**REFERENCES**
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The Shift Toward Value-Based Payment
For PTs, now is the time to prepare.

US health care is in the midst of a paradigm shift—away from the fee-for-service payment structure, in which providers are rewarded solely by the volume of services provided, and toward a structure that holds providers accountable for patient outcomes and costs.

This move to value-based care is intended to advance the goals of health care’s “triple aim”—improving the patient experience of care (including quality and satisfaction), bettering the health of populations, and reducing the per-capita cost of health care. Physical therapists (PTs) must quickly identify opportunities to become engaged in value-based payment models. Otherwise, they will be left behind, with lasting ill effects on their practices.

Value-based payment models often are referred to as alternative payment models (APMs). An APM is a payment approach that offers incentives to providers to collaborate to provide high-quality and cost-efficient care. APMs can apply to a specific clinical condition, a care episode, or a population.

**Shared savings/shared losses.** Groups of providers are paid for their services at the traditional contracted fee-for-service rate. At year end, total fee-for-service expenditures attributed to the provider network are compared against a pre-determined budget target.

Risk may be 1- or 2-sided. In either case, if expenditures are below the target and certain quality metrics have been satisfied, providers are eligible to receive a portion of the shared savings. Under the 2-sided risk model, if total fee-for-service expenditures exceed the cost target, providers repay a portion of the shared losses. The potential reward is larger in a 2-sided model, given the added risk of absorbing losses.

**Types of APMs**

The growing array of APM models includes shared-savings/shared-losses (accountable care organizations), bundled payment, global capitation, partial or blended capitation, pay-for-performance or enhanced fee-for-service, and medical home.

Kara Gainer, JD, is director of regulatory affairs at APTA.

Heather Smith, PT, MPH, is the director of quality at APTA.
quality. They can be penalized, however, if they are unable to manage their costs. Also, the more severe the patient’s condition, the higher the risk of failing to meet cost targets. This could discourage providers from taking on such patients.

Example: Medicare Shared-Savings Program accountable care organization tracks 1-3.

Bundled payment. The payer—Medicare, for example—establishes a fixed price for all services, across multiple providers and care settings, covering a specific episode of care. Bundles may cross providers, allowing hospitals, physicians, and other providers to partner with different types of facilities, including physical therapy clinics, skilled nursing facilities, and home health agencies. As with shared-savings/shared-losses models, participating providers are paid at the traditional contracted fee-for-service rate for their services. At year end, actual spending for the episode of care is compared with the established target.

Depending on quality of care and spending performance, participating providers either may receive an additional payment from the payer or be required to repay the payer for a portion of the episode spending that exceeded the target. Providers exceeding the prearranged amount for the episode bear financial responsibility for overages. The goal is to encourage providers to make efficient and effective care decisions. It may be difficult, however, to manage costs for a patient’s treatment that may be out of the provider’s control. Also, again, the more severe the patient’s condition, the higher the risk of not meeting cost targets. This might discourage providers from taking on those patients.

Example: Medicare Comprehensive Care for Joint Replacement (CJR) model.

Global capitation. The payer makes a single comprehensive payment to cover an individual over the course of a defined time period. Capitation is a fixed amount of money per patient per unit of time, paid to the clinician in advance for the delivery of health care services. Providers are incentivized to increase efficiency and reduce costs. Again, this can create an incentive for the provider to avoid the most costly patients.

Example: Medicare Comprehensive Care for Joint Replacement (CJR) model.

Partial or blended capitation. Certain types or categories of services are paid on a capitated basis, while other services are paid on a fee-for-service basis.

Example: New York’s managed long-term care program, which covers only institutional and community-based long-term services and supports. (Medicaid-covered primary and acute care is offered on a fee-for-service basis.)

Pay-for-performance and enhanced fee-for-service. Providers receive financial incentives for meeting performance measures related to cost savings, achieving favorable outcomes, and following evidence-based guidelines.

Example: The former Physician Quality Reporting System (now rolled into the Merit-Based Incentive Program System as the “quality” portion of the program).

Medical home. The primary care physician coordinates all patient care and referrals.
This model sometimes is combined with shared savings and/or value-based quality incentives.

Example: Medicare medical home model (expanded under the Centers for Medicare and Medicaid Services’ Innovation Center).

The transition to value-based care is a priority of both the private sector and the federal government. Many commercial payers have adopted APMs. Medicare also is committed to shifting Medicare payments from volume to value, having set a goal in 2015 of tying 50% of Medicare fee-for-service payments to quality or value through APMs by 2018.

Pressure on providers to reduce costs and improve quality and outcomes will continue to grow. Determining which value-based model is the right one for a particular PT or practice will require PTs to understand how the various models work—including their requirements, incentives, risks, and potential financial impacts. Hospitals and health systems, among other providers, are looking for partners and suppliers that can offer lower prices, reduce spending, and contribute to better quality scores and outcome measures. PTs who can demonstrate these things will be preferred over other potential partners.

Managing Patients In a Value-Based Payment World

To navigate value-based payment, providers will need data. PTs need to understand the value they bring to the health care system and to the models in which they participate. Value in health care typically is expressed as quality (outcomes of care and patient experiences) divided by cost (direct and indirect). PTs need to know their outcome and cost data at the individual and practice level, as well as for the APM in which they participate, in order to determine how their and the group’s performance may affect payment.

Because the goal for APMs is the highest possible health care value, these models incorporate measures to ensure that patient outcome quality is not compromised when controlling for cost. The quality measures for an APM are specific to the target patient population.

In APMs, the population may be focused on a clinical condition, a care episode, or a geographic population. A clinical condition could be oncology care or end-stage renal disease. The previously referenced CJR model is an example of a care episode (see further explanation on this page under “The CJR Example”). An example of a geographically based population is an accountable care organization that covers patients within a specific metropolitan area.

The need for real-time data will require PTs to incorporate technology into their practice that enables them to be agile in a value-based payment environment. Currently, PTs collect data in every interaction with their patients, but that data typically remains isolated within the individual patient record. Participation in APMs will require PTs to manage beyond the individual patient to the population level, requiring that population data be aggregated. PTs may find it challenging to develop skill sets to understand population data, but incorporating such knowledge and technology into practice can strengthen their ability to manage at the population level.

The CJR Example

As an example, let’s look more closely at CJR. This Medicare model began in 2016 in 67 selected metropolitan areas for patients undergoing total knee and total hip replacement. Participating hospitals are given target case rates for these episodes that include the costs of the inpatient stay and all related care through 90 days postdischarge. (For more information on CJR, go to www.apta.org/Payment/
To help ensure that lower costs do not compromise care, Medicare has included quality-reporting requirements in the CJR model: (1) the hospital-level risk-standardized complication rate following elective primary THA (total hip arthroplasty) and/or TKA (total knee arthroplasty), and (2) the survey measure of the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) of patient experience.

In addition, Medicare is allowing participating facilities to submit patient-reported outcome measures. Accepted global measures of patient function are PROMIS (the Patient Reported Outcome Measurement Information System) and the Veterans Rand 12-item health survey. Accepted condition-specific patient-reported outcome measures are the Hip Disability and Osteoarthritis Outcome Score (HOOS) and the Knee Injury and Osteoarthritis Outcome Score (KOOS).

PTs who participate in this model need to understand and convey the value of their services, which requires understanding the outcomes. In this case, the value is the lower cost of physical therapy care and the positive change in function for patients with joint replacement. The first step in understanding these outcomes is identifying this patient population. This can be a challenge if PTs are relying only on the ICD-10 diagnosis codes, especially if the codes include only the rehabilitation diagnosis. Top ICD-10 codes that PTs use include those for muscle weakness, difficulty in walking, unspecified abnormalities of gait and mobility, pain in right or left hip, and pain in right or left knee.
Compliance Matters

CJR Model

Need to identify patient population (joint replacements)

Need to understand cost of care (direct and indirect)

Need to speak the same outcome language (HOOS or KOOS)

left knee, all of which may encompass the joint replacement population. (See graphic above.)

The ability to identify these patients and aggregate the data can be enhanced by technology such as a registry. Data needs to be aggregated in a way that is visual, intuitive, and actionable for the PT. The Physical Therapy Outcomes Registry has visual reports that allow providers to identify patient populations and relevant outcomes at both the practice and individual therapist levels. These visual reports allow PTs to monitor outcomes for the population and assess how changes in care redesign affect cost and outcomes.

Steps to Take

PTs need to plan for value-based payment. To prepare your practice to participate in APMs, here are some steps you can take now:

- Standardize your documentation to ensure uniformity of data collection.
- Adhere to evidence-based practice. Use clinical practice guidelines and clinical protocols to standardize care and outcome measures.
- Use technology to prepare your practice for data collection at the population level. Adopt electronic health recordkeeping, and use registries.
- Deploy your data to show the value you can bring to value-based payment models.

Resources

Under the Medicare Quality Payment Program (QPP), advanced APMs (a subset of APMs) are 1 of 2 tracks for participating in QPP (the other being the Merit-based Incentive Payment System, or MIPS). Advanced APMs let practices or clinicians earn greater rewards in exchange for taking on risk related to patient outcomes. They require, however, the use of certified electronic health record technology, taking on more than a nominal amount of risk for monetary losses, and reporting of quality measures similar to those in MIPS.

For more information on MIPS and advanced APMs, read PT in Motion’s Compliance Matters columns on the QPP. Part 1 (www.apta.org/PTinMotion/2017/4/ComplianceMatters/) is about MIPS, and Part 2 (www.apta.org/PTinMotion/2017/5/ComplianceMatters/) is about advanced APMs.

For additional resources on how to become a collaborator in an APM, visit APTA’s resource page on APMs under Medicare at www.apta.org/Payment/Medicare/AlternativeModels/.

For information on the Physical Therapy Outcomes Registry, visit www.apta.org/Registry/.

APTA continues to explore opportunities to work with members on participation in and/or development of advanced APMs. If you or your facility is interested, contact us at karagainer@apta.org or heathersmith@apta.org.

REFERENCE


Top ICD-10 Codes Used by Physical Therapists

- Muscle weakness – generalized M6281
- Other abnormalities of gait and mobility R2681
- Persons encountering health services in other specified circumstances Z7689
- Low back pain M545
- Difficulty in walking, not elsewhere classified R262
- Unspecified lack of coordination R279
- Unspecified abnormalities of gait and mobility R269
- Pain in right hip M25551
- Dizziness and giddiness R42
- Pain in right knee M25561
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A PTA has questions about a patient’s best interest and a PT’s motivation.

The physical therapist (PT) and physical therapist assistant (PTA) are teammates whose bond and respective roles are codified by state or jurisdictional law and defined in the APTA position Direction and Supervision of the Physical Therapist Assistant. (See resources box on page 15.) Consider the ethical implications of the following scenario, in which these teammates—and a patient under their care—do not see eye-to-eye.

Honesty: The Best Policy?

Mark has been a PTA for more than a decade and has worked in home care for the past 3 years. He very much enjoys this practice setting, as he can see firsthand patients’ surroundings and—within the bounds of PT direction and supervision—help them navigate challenges. He has a great working relationship with Sarah, his PT teammate, who values his skills and judgment and affords him as much autonomy as the state practice act and APTA policy allow.

Mark has been working for the past 2 weeks with Sam, who is 58, had bilateral total knee replacements, and was discharged directly from the hospital to home care. Sam’s insurance would have covered a subacute inpatient stay, but he has a business trip scheduled in 6 weeks and feels that he’ll make quicker and better progress at home. Sarah makes no promises on that score, but she tells the self-employed entrepreneur that she and Mark will do their best and see if the goal is achievable. At his initial evaluation, after having spent just 2 days in the hospital, Sam had presented with 80% range of motion and clearly was very motivated.

When Sarah returns to Sam’s house 2 weeks later, on Mark’s sixth visit, she and Mark find, however, that they have differing opinions on Sam’s readiness for discharge to outpatient therapy.

Mark, who has seen a number of patients in similar circumstances in his time in home care and is impressed with Sam’s functional level and determination, silently believes that Sam is ready...
for discharge and outpatient therapy, which should allow him to reach his travel goal.

Sarah acknowledges that Sam has made good progress, but says that she feels he isn’t quite ready for discharge and that progressing him too rapidly would be detrimental to him.

“You’re doing great, but I’m afraid you’re not quite a discharge candidate yet, and that it’s best that you postpone that trip,” Sarah tells a clearly disappointed Sam. “Better to be safe than sorry.”

While Sam is processing this setback, Mark asks Sarah if they can talk in private. They go into the kitchen, where Mark asserts that Sam can handle the increased rigor of outpatient therapy, which then would allow him to take his business trip. While emphasizing that she always values Mark’s opinion, Sarah notes that their agency’s protocol for patients with Sam’s presentation is that they be discharged after a minimum of 12 visits, which will take another 2 weeks. Mark acknowledges this, but he notes that Sarah and other agency PTs sometimes—if rarely—are successful in arguing with agency officials for exceptions to be made.

“Don’t you think there’s a strong case for an exception here?” Mark asks. “A ‘strong’ case? No. Not strong enough to mount a challenge, anyway,” Sarah responds. “And by the way, while I appreciate your advocacy for the patient, I’m not fond of the way you suggested to Sam by your timing that perhaps we’re not a united front on this decision. I think it sends a bad signal.”

Slightly stunned by the unprecedented, if mild, rebuke, Sam apologizes. They return to the room where Sam has been awaiting them.

“So,” Sarah repeats. “I’ll see you in a couple of weeks, and will leave you in Mark’s capable hands in the meantime.”

resources

At www.apta.org/Policies/Practice/

- Standards of Practice for Physical Therapy
- Direction and Supervision of the Physical Therapist Assistant

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/

- “Ethical Decision Making: Terminology and Context”
As soon as she leaves, Sam turns his attention to Mark. “Look,” he says. “I like you a lot and appreciate all the help you’ve given me, but I’ve been around the physical therapy block a few times. I feel like I’m ready for outpatient care. I want to keep this ball rolling. I need to make this trip. I’m sorely tempted to discharge myself from home care and check myself into the outpatient clinic to speed things up.”

Sarah’s words about presenting a “united front” resound in Mark’s mind as he responds, “I understand that, Sam, but you heard Sarah. It’s in your best interest to remain in home care for now.”

“I’m not sure I believe that,” Sam says. “And I’m pretty sure that you don’t believe it, either. I mean, what were you two talking about in the kitchen? Tell me that you weren’t advocating for discharge—that you agree with Sarah’s assessment of my situation—and I’ll think about staying in home care.”

Mark feels confident that Sam is ready for outpatient care, and that the patient is correct when he suggests that discharge best meets his interests. Mark respects Sam’s autonomy, and he wonders if Sarah is too hung up on the difficulty of challenging agency protocol. At the same time, Sarah is his supervisor, and she has stated publicly that keeping Sam in home care is the safest and best course of action.

**Realm.** The ethical realm is both *individual*—between Mark and Sam, and between Mark and Sarah—and *organizational*, given agency protocol that Mark believes may be inappropriately influencing the situation.

**Individual process.** For Mark, this is an issue of *moral sensitivity* in recognizing, interpreting, and framing the ethical situation—and arguably of *moral courage*, should he choose to revisit the matter with Sarah even though she had made her decision and already has chastised him for his action at Sam’s house.

**Ethical situation.** Mark faces ethical *distress* because he feels constrained by his defined role as a PTA and by agency protocol from advocating for what he believes is best for the patient. If Sarah actually believes that Mark is right about Sam but is choosing to take the path of least resistance by simply backing the protocol, she is engaging in ethical *silence*.

**Ethical principles.** The following Standards of Ethical Conduct for the Physical Therapist Assistant offer Mark guidance:

- **Standard 3A.** Physical therapist assistants shall make objective decisions in the patient’s/client’s best interest in all practice settings.
- **Standard 3C.** Physical therapist assistants shall make decisions based on their level of competence and consistent with patient/client values.

- **Standard 3E.** Physical therapist assistants shall provide physical therapy services under the direction and supervision of a physical therapist and shall communicate with the physical therapist when patient/client status requires modifications to the established plan of care.
- **Standard 7A.** Physical therapist assistants shall promote work environments that support ethical and accountable decision making.

The following principles of the Code of Ethics for the Physical Therapist offer Sarah guidance:

- **Principle 2A.** Physical therapists shall adhere to the core values of the profession and shall act in the best interests of patients/clients over the interests of the physical therapist.
- **Principle 3A.** Physical therapists shall demonstrate independent and objective professional judgment in the patient’s/client’s best interest in all practice settings.
- **Principle 3E.** Physical therapists shall provide appropriate direction of and communication with physical therapist assistants and support personnel.
- **Principle 7A.** Physical therapists shall promote practice environments that support autonomous and accountable professional judgments.
- **Principle 8C.** Physical therapists shall be responsible stewards of health care resources and shall avoid overutilization or underutilization of physical therapy services.
Mark feels stuck between a rock and a hard place. The patient is demanding honesty, and Mark wants to give it. On the other hand, he feels that expressing his honest opinion on the matter is inappropriate, given his role as a PTA under Sarah’s direction and supervision. He now wishes he hadn’t pulled Sarah aside in Sam’s presence, and he feels he should immediately apprise her of Sam’s desire to discharge himself.

“Well?” Sam asks again.

**For Reflection**

Under Direction and Supervision of the Physical Therapist Assistant, “establishment of the discharge plan” is among the responsibilities that “must be borne solely by the physical therapist” regardless of the setting in which physical therapy is provided. Consider that dictate in determining which ethical standards and principles may apply to the PTA and PT, respectively, in this scenario.

**For Followup**

I encourage you to share your thoughts about the issues raised in this scenario by emailing me at kirschna@sph.rutgers.edu or by posting a comment online.

If you are reading the print version of this column, go online to www.apta.org/PTinMotion/2017/10/EthicsinPractice/ for a selection of reader responses to the scenario and my thoughts on those responses. Scroll down to the heading “Author Afternote.”

Be aware, however, that it takes a few weeks after initial print and online publication for feedback to achieve sufficient volume to generate this online-only feature.
A well-conceived clinical space can improve the care experience for patients and staff alike.

By Chris Hayhurst
Tara Jo Manal, PT, DPT, FAPTA, has no training whatsoever in construction, architecture, or interior design. She is, however, a seasoned physical therapist (PT), and she knows from experience how a physical therapy clinic should be built.

Manal, director of clinical services and residency training in the physical therapy department at the University of Delaware, led the total overhaul in 2013 of the department’s 10,000-square-foot outpatient clinic. Initially, she recounts, the department turned to a local architectural firm to draw up a set of plans. “We told them what we wanted to accomplish, and what we needed in terms of rooms, offices, and places for equipment,” she says. “When I looked at the plans, it was clear that they’d tried to incorporate everything we’d asked for. But it also was obvious that the design was never going to work.”

The problem primarily was sight lines and distances between the spaces the practice’s clinicians would use the most. “One thing they did was put all the offices around the perimeter so they’d have windows that looked outside,” Manal recalls. “The center of the clinic would be wide open. That sounds nice, but we need to watch our patients, not look out the windows. And walls are important, because without walls to place things against, you have nowhere to put everything.”

Manal asked the architects what structurally had to stay and what could go. They told her that the building’s 4 interior columns were structural, so moving them was out of the question. Beyond that, “We could do what we wanted,” Manal says. “So I chopped what they gave us into pieces. We then rearranged the parts to make it work.”

As they did, the architects and Manal mapped out exactly where equipment would go, adding outlets and data ports as needed. They segmented the space with a series of half-walls—high enough to define treatment areas and pathways but low enough to provide PTs with clear sight lines. “Functionally, it’s perfect now,” she says. “When you’re standing at certain spots you can see across the entire clinic, but you still have the needed space and privacy to do your work.”

**DECIDING TO DESIGN**

Chances are there isn’t a PT in the country who hasn’t dreamed about ways to improve his or her clinical space. Most practices, after all, could use some sort of upgrade, whether it’s a fresh coat of paint or better flooring or lighting. And more than a few could stand to start from scratch—whether by packing up and moving to a new location or by tearing down walls for a custom rebuild. Growing practices start to burst at the seams, forcing owners to weigh the merits of expanding to meet demand. Or, there’s mounting pressure from nearby facilities: When competitors decide to invest in flashy remodels, it’s only natural to think it may be smart to do the same.

There are, of course, potential drawbacks to renovating: expense, disruption, questionable returns. And while studies conducted primarily in hospitals have shown that high-quality facility design can lead to better patient privacy, decreased risk of infections and injuries, shorter stays, and lower costs, other research...
indicates that patient satisfaction is unlikely to be swayed by aesthetics alone.1,2

“You can’t just assume that by opening up your clinic and flooding it with daylight, your patients will love it and clinical care will improve,” notes Deborah Franqui, health care market leader at the design firm Leo A. Daly and coordinator of health care design programs at the University of Miami School of Architecture.

Whether you intend to build a facility from the ground up or renovate your current clinic, it’s important, Franqui says, to base design decisions on information gathered from all stakeholders. “You have to involve all of your clinicians and, in fact, everyone in your organization, because they all use the space,” she notes. “They know what works and what doesn’t. You also should engage your patients, if you can, because their perspective may be different—and that may affect the decisions you make.”

Joe Latozas, an architect and senior associate with Designhaus Architecture in Rochester, Michigan, agrees that thoughtful collaboration can be the key to successful health care facility design. Latozas, who has several physical therapy offices in his clinical-space portfolio, says the first thing he does is sit down with clinicians and ask about their process: “What happens when a patient comes in?” “Where’s your staff, and what’s their routine?” Then he spends a half-hour or so “just observing what happens as everyone does their thing.”

As he watches, Latozas says, he considers his own experiences as a physical therapy patient and tries to put himself in the shoes of those he sees in the clinic. “Physical therapy can be a strenuous process,” he observes, “so I’m always looking for ways to make it easier on the patient—to create an environment that patients will enjoy visiting, and hopefully will want to return to.”

From there, Latozas typically will produce a rough schematic floor plan, then meet with the clinical team to get their input. “That’s where everything hopefully comes together—during that process of reviewing and revising,” he says. “You start tossing around ideas and thinking things through, and you eventually get to a design that yields the outcomes you want to achieve.”

PUTTING PATIENTS FIRST

One PT who is quite familiar with that creative process is Jeff Leatherman, PT, DPT, MS. He’s program director of the physical therapist assistant (PTA) program at South University in High Point, North Carolina. Leatherman, who also works part-time with patients at Pivot Physical Therapy in nearby Greensboro, has been involved in the design or redesign of 3 different practices, beginning in the late 1990s.

The first, he recalls, was a small satellite clinic that his then-employer built from scratch in a strip mall. A few years later, as a private practice owner himself, Leatherman led the “up-fit” development of a 2,000-square-foot clinic attached to a much larger
sports performance and fitness facility. Finally, there was his most recent project: the complete overhaul of a former automotive center to create the space that now houses Pivot.

“We’d outgrown our previous location,” he says, “and were searching for something that might fit us better. I came across this old tire-service place. It was kind of odd but also ideal.” The 9,000-square-foot facility included 3 wide-open bays, 22-foot ceilings, and a storage area in the back that Leatherman imagined as a gym. The renovation, he says, “was nasty work” but ultimately was well worth the effort.

“We knocked out a bunch of walls, built a couple others, and had a lot of fun getting it into shape,” Leatherman recounts. Much of the work was completed by Leatherman’s brother, a contractor. They didn’t use an architect because they already had a clear vision of what they wanted to do. Still, “there was a lot to consider,” Leatherman says, and it took time to get things off the ground. “We had to deal with permits, accessibility requirements, and so on. And we had to make sure that we’d thought of everything”—from office locations and treatment room placement, to lighting and storage needs, to where to put the gym equipment. “But the biggest thing all along was taking a patient-centered approach,” he says. “We wanted it to be a place where our patients felt special—where their experience was positive the second they walked in the door.”

Todd Schemper, PT, DPT, partner and chief operating officer of Kinetic Edge Physical Therapy and a board-certified orthopaedic clinical specialist, took a similar approach to recent renovation of the clinic he manages in Des Moines, Iowa. His team didn’t employ an architect but did rely on the goodwill of their artistic landlord, who financed the work and helped design the new space. “We’d been here for about 10 years, and all we’d done when we originally moved in was put carpet on the floor and paint the walls,” Schemper recalls. “We finally reached the point where we needed to spruce it up—to modernize and make it more patient-friendly.” Toward that end, Schemper says, they shifted the position of their front office and moved the patient fitness area so their clients could see outside as they
Reimagining the Clinic

Often, a clinic redesign involves tweaks and minor modifications. Done properly, that’s usually enough to improve efficiency, appearance, and the overall environment. But some designers are rethinking the primary concept and function of a clinic.

In a recent study, Parkland Hospital of Dallas, BBH Design, and KI (a furniture manufacturer) studied the impact of design on a traditional outpatient clinic operated by Parkland. That study, in turn, built on earlier findings that 3 of the 5 major predictors of patient loyalty stem from effective communication: the provider’s concern for the patient’s worries, ability to listen, and courtesy.

“This implies,” the study continued, “that ambulatory care floor plans and furniture configurations need to promote improved personal interactions, thereby enhancing the outpatient experience.” The research—which included behavioral observations, interviews and ethnographic observation, and space syntax analysis (optimal spatial configuration)—identified 4 key design opportunities:

Create a floor plan that improves communication. The study found that patients spent most of their time in the waiting and exam rooms. Physicians primarily were at their workstations. Nurses were interspersed throughout the clinic. The study suggested that clinics explore an open-concept clinic design that could lend itself to more effective personal interactions.

Heighten interactions by increasing visibility. The research found that if patients were in a more visible area of the clinic, providers were more likely to speak with them. Options to increase these interactions include the open-concept floor plan design. The report suggested 2 specific strategies: (1) reduce the height of view-impeding walls, and (2) increase transparency where walls are necessary.

Enhance communication by promoting more standing. The research found that prolonged sitting often stymied communication in the outpatient facility. This led researchers to suggest flexible sit-stand solutions, including height-adjustable tables, and fixed café-height tables and stools.

Strategize computer use to increase interpersonal engagement. The study found that “while computers and smart devices are finding their niche in the health care industry, these tools are also impacting patient communications in less positive ways.” For instance, any health care provider using a computer was 67% less likely to interact with a patient. The researchers suggested that clinics make computer use an interactive experience between the caregiver and patient. Furnishing outpatient facilities with wall-mounted monitors and chairs with built-in tablets could encourage collaboration between the patients and providers.

One of the researchers, however, suggested the space might not even be used as a clinic 24 hours a day. Debbie Breunig, RN, MBA, KI’s vice president of health care, told PT in Motion: “We are moving toward a population health mentality—using the facility for community health and wellness, not just when patients need care. Meanwhile, technology is allowing us to provide more care virtually—tests, assessments, and follow-up visits without going back into that space.

“How are we using the spaces to be flexible?” Breunig asks. “By day, it may be used for meetings and conferences. In the evening, it might be used for a Pilates class or a community meeting. The space may require additional amenities. It’s costly, but it will be more efficient,” she says. “The health care provider must make the best use of the space. This is a new approach to health care: looking at it from a wellness perspective. We have a lot of opportunity to learn from the wellness side what the PT can provide.”

“We are moving toward a population health mentality—using the facility for community health and wellness, not just when patients need care.”

DEBBIE BREUNIG
exercised. They tore down several walls to make the clinic feel more open but added Plexiglas panels in certain places to delineate areas and block noise. Finally, they added LED lighting (planning to pay for it through savings in their energy bill) and finished the space off with an uplifting color scheme. “It feels more exciting now,” says Schemper. “It makes it easier for us to nail that first impression. Our patients come in and see that it’s updated and well-kept. That makes a difference in how they experience their care.”

BEST PRACTICE FOR A BETTER CLINIC

Back at the clinic at the University of Delaware where Tara Jo Manal leads her team of clinical faculty and students, there also is the sense that the recent renovation has had a real impact on patient care.

“We did so many things that I would describe as ‘best-practice’ kinds of initiatives,” Manal says. “These changes have helped us do our work more efficiently and have improved our ability to serve our patient population.”

“Our patients come in and see that it’s updated and well-kept. That makes a difference in how they experience their care.”

TODD SCHEMPER
For example, she says, they created a station where patients check in to record their pulse and blood pressure and calculate their body mass index. “We used to be inconsistent about getting those measures, because on the floor it always was hard to find a spot to get it done. Now it’s automatic because it’s part of the process when patients come in.”

Similarly, Manal says, her group designed “touchdown stations” throughout the clinic that contain protocols, rehabilitation guidelines, checklists, and other reference documents that PTs typically need as they work with patients. “Often it’s much easier to see something on paper than it is to have to look it up electronically,” she notes. “This way, everything is in 1 place, and it’s never more than a few steps away.”

There are other functional improvements, too. At every bed, for example, a metal basket built into the half-wall contains equipment a PT might need—a pair of scissors, a new roll of tape, a goniometer, an electrical stimulation machine. Walls used by patients during certain exercises are covered in a special plastic wallpaper that is easy to wipe down and is more durable than drywall. (“In our old clinic we’d wear grooves in the cinderblocks,” Manal notes.)

Standard measurement lines for movement and agility testing have been incorporated into certain areas using stickers on the floor. There are permanent tracks, including one with a harness system, that patients follow around the clinic for their timed walking tests. “We even built a training bathroom and kitchen,” Manal says. “There’s a refrigerator, stove, sink, shower—everything you’d expect to see in a patient’s home.”

One addition that she particularly likes is 1-way mirrors throughout the space that allow her to watch the action from almost anywhere in the clinic. “When I’m in my office, there’s only a 10-by-20-foot span that I can’t see, even when I’m sitting down,” Manal notes. It’s a feature that would benefit any facility, but it’s especially nice, she says, to have in a space meant for teaching: “We have students here who are learning and practicing new skills, so it’s great to be able to keep an eye on everyone and know how things are going at all times.”

Looking back, Manal is glad to have worked with a design firm that was receptive to her and her colleagues’ feedback and open to modifying its plans to suit their needs. At the time, she recalls, she’d been at the clinic for 22 years and for the most part was satisfied with her workplace as it was. But she also felt the space could be better with tweaks here and there. “I knew there were things that we could do to make this clinic function exactly the way we wanted,” she says. “What I wasn’t sure about was how we could get there—what rules we had to follow or square footage was required.”

The architects, Manal says, knew those rules, even if they weren’t that familiar with physical therapy. “That was the beauty of this project: We came together from our different backgrounds and perspectives to create a design that works.”

Chris Hayhurst is a freelance writer.

REFERENCES
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Where Do You Want to Practice?

By Donald E. Tepper

Every state has much to offer physical therapists and physical therapist assistants. It may be quality of life. Employment opportunities. Regulatory and business friendliness. Or any of dozens of other features. Where you decide to practice depends on which factors mean the most to you. Here is PT in Motion’s annual analysis of the criteria that may make a state attractive for physical therapy professionals.

What makes a state a desirable place to practice physical therapy?

The answer of course depends in part on what you value. How important is salary? Quality of life? Future job prospects? Fewer regulatory restraints? Demographic characteristics (such as age and health) of the state’s residents? And so on.

Many rankings of “best states” in fields ranging from health care to retirement use some combination of these factors. PT in Motion’s analysis uses dozens of data sources to build on 8 criteria:

1. Well-being and future livability
2. Literacy and health literacy
3. Employment and employment prospects
4. Business and practice friendliness
5. Technology and innovation
6. Physical therapist (PT), physical therapist assistant (PTA), and student membership in APTA
7. Compensation and cost of living
8. Health and financial disparities

To evaluate states in each category, the average ranking nationwide is assigned a score of 10. An above-average state is awarded additional points; the more it exceeds the average, the more points it receives. Other states receive fewer than 10 points, based on how much below average they scored.

Reader response to past surveys suggests that all 8 factors are important. You, however, might personally rank one higher than another, while your colleague might do the opposite. For PT in Motion’s 2017 report, therefore, we cite the states that ranked highest for each factor, allowing you to adjust the rankings to your personal preferences.
Well-being and future livability.

Quality of life—as it relates to PTs, PTAs, and the general population—and the overall health of the population are included here, as are projections on future living conditions. *PT in Motion* uses 4 data sources. Two—dealing specifically with well-being and future livability—are compiled by Gallup. Each, in turn, is based on multiple inputs. The third is life expectancy at birth—a measure of overall health and well-being. The fourth, which reduces well-being, is drug overdose death data compiled by the Centers for Disease Control and Prevention (CDC).

Leading states for well-being and future livability

1. Minnesota
2. Hawaii
3. Nebraska
4. South Dakota
5. Colorado

Literacy and health literacy.

Both forms of literacy reflect the ease and effectiveness with which health care providers can communicate with patients and clients. *PT in Motion’s* measures of general and health literacy had multiple inputs: Percent of population in poverty (source: Census Bureau), literacy—level of basic prose literacy skills (source: US Department of Education), home access to the Internet (source: US Census Bureau), percentage of population with graduate or professional degrees (source: US Census Bureau), high school graduation rate (source: US Census Bureau), and health literacy rankings compiled by the University of North Carolina.

Leading states for literacy and health literacy

1. New Hampshire
2. Minnesota
3. Utah
4. Vermont
5. North Dakota

Employment and employment prospects.

What’s the job situation? This calculation is based on state population and projections for percentage growth in physical therapy jobs. We used Department of Labor projections for physical therapist employment from 2014 through 2024, current state population estimates, metropolitan statistical area estimates from the US Census Bureau, and a report titled “2016 Best-Performing Cities” compiled by the Milken Institute.

Leading states for employment and employment prospects

1. Utah
2. Georgia
3. California
4. Colorado
5. Washington

Business and practice friendliness.

Many health care professionals say it’s desirable to practice in a state that is friendly toward business in general as well as to PTs in particular. *PT in Motion’s* rankings use 3 sources. The first is the 2016 Thumbtack.com Small Business Friendliness Survey. The second is CNBC, which ranks all states based on more than 60 measures of competitiveness, using input from business groups, economic development experts, companies, and the states themselves. The third source, specific to PTs and PTAs, is APTA’s “Levels of Patient Access to Physical Therapist Services in the States.”

Leading states for business and practice friendliness

1. Utah
2. Colorado
3. Oregon
4. Nebraska
5. Massachusetts
Mississippi

State with the lowest cost of living, at 85% of the national average. Other less-expensive states are Arkansas (87.9%), Oklahoma (89.1%), and Michigan (89.5%). The state with the lowest health care cost of living is Arkansas, at 87.3%.

SOURCE

New Hampshire

State with the greatest percentage of health-literate residents. Also ranking high are North Dakota, Maine, and Connecticut.

SOURCE

33,091

US opioid deaths in 2015. That’s comparable to the 35,092 Americans who died in car crashes that year. The lowest rate of drug-overdose deaths occurred in Nebraska, at 6.9 per 100,000 residents.

SOURCE

34%

Projected increase in physical therapist employment from 2014 to 2024. The largest percentage changes are expected in Tennessee and Kentucky (47% each). The greatest numbers of annual job openings are projected to occur in California (1,040) and New York (940).

SOURCE

55.4%

American adults who are “thriving,” according to the Gallup and Healthways 2016 survey. That’s the highest since 2008, when the survey began. In that year, 48.9% described themselves as thriving.

SOURCE

$120,820

Mean (average) wage for physical therapists in Nevada, the highest in the country. Other high average wages were reported in New Jersey ($96,890) and Texas ($95,240).

SOURCE

76%

Physical therapist assistants in Alaska who belong to APTA, the highest rate in the country. Other states with high shares of PTA members include Nevada (65%), Washington, DC, (28%), and Nebraska (24%). Florida has the most PTA members, at 483.

SOURCE
Technology and innovation.

Health information technology is increasingly important in the practices of PTs and other health care providers with whom they interact. We use 5 rankings: State Telehealth Laws and Reimbursement Policies published by the Center for Connected Health Policy, EHR [electronic health record] Incentive Program Measures for physicians and hospitals published by the Office of the National Coordinator for Health IT, US Department of Health and Human Services, and state technology and innovation rankings published by CNBC and the Milken Institute.

Leading states for technology and innovation

1. Minnesota
2. Colorado
3. Washington
4. Illinois
5. Texas

What’s New in 2017?

Although we try to maintain consistency from year to year, elements inevitably change. In some cases, old data no longer are available. In other cases, new data sources better reflect the rankings’ goals. We also try always to extract the information that will be most helpful to our readers.

Among the changes for 2017 are the following:

- Where to start a practice. This calculation includes states with the highest projected growth in the number of PTs, and those that are most business-friendly.
- Well-being. Previous calculations had included 3 positive measures: life expectancy, future livability, and adult participation in activities. Given current attention on the opioid epidemic, participation in activities was replaced by state opioid rates of death.
- Influence of metropolitan areas. Last year, state rankings in the employment category were adjusted by including the influence of metropolitan areas within those states. This year, the metropolitan areas were given more weight.

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6 PT, PTA, and student membership in APTA.
Greater involvement in APTA suggests stronger commitment in time and money to current and future professional development, and activity in state and national regulatory and legislative issues. Rankings are based on APTA data showing the percent of PTs and PTAs within a state who are association members.18

Leading states for APTA membership
1. Alaska
2. District of Columbia
3. Vermont
4. North Dakota
5. South Dakota

Starting a Practice?
To provide a little more food for thought, we combined business friendliness and projected growth to look at states that may offer characteristics desirable for starting a practice.

Consider starting a practice in...
1. Utah
2. Colorado
3. Georgia
4. Oregon
5. Tennessee

Cumulative State Scores
To arrive at a cumulative state score, each state’s 8 scores were totaled.

The highest-ranking states are:
1. Utah
2. Colorado
3. Washington
4. North Dakota
5. Minnesota
6. Idaho
7. Oregon
8. Iowa
9. Nebraska
10. Texas

For more details and individual scoring of the states, read the online version of this article.

7 Compensation and cost of living.
How much is a PT paid annually? How far does the compensation stretch, as measured by a state’s cost of living? This rating was calculated by dividing average state salary for PTs by the state’s cost of living. Data for hourly and annual rates of pay came from the Bureau of Labor Statistics.19 Cost of living data came from the Missouri Economic Research and Information Center.20

Leading states for compensation and cost of living
1. Mississippi
2. Texas
3. Nevada
4. Tennessee
5. New Mexico

8 Health and financial disparities.
These data consider the amount of financial and health care variation within a state regarding income, health, and women’s health. States with less variation received higher scores than did those with greater variation. Each state’s disparity score comprises 5 elements. Four are health-related: obesity rates among non-Hispanic whites versus non-Hispanic blacks,21 mammogram rates within the past 2 years among non-Hispanic whites versus non-Hispanic blacks,22 prevalence of arthritis by county, and prevalence of obesity by county. The fifth is income-related: ratio of average income of the top 5% of the population within a state versus the average income of the population in the lowest quintile.23

Leading states for lack of disparities
1. Utah
2. Connecticut
3. Hawaii
4. Minnesota
5. Maine

Donald E. Tepper is editor of PT in Motion.

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Follow the Leaders

By Michele Wojciechowski
APTA annually honors Emerging Leaders—PTs and PTAs who are making outstanding contributions to the field of physical therapy early in their careers. Here’s what some of them have been doing.

When Amy Arundale, PT, DPT, PhD, was growing up, she played soccer anytime she could. Back then, she never could have imagined that she would have a career involving sports—something she always has loved. But that’s exactly what she’s doing.

“I grew up with soccer, and it’s always been my passion,” Arundale says. Her goal in becoming a physical therapist (PT) was to work in soccer. After playing soccer for 3 years in college and for 1 year in Scotland on a semi-pro team, she brought those skills with her to Duke University’s DPT program. While enrolled there, Arundale volunteered with a number of different teams, and she continued to do so after graduating. Her job allowed her to spend mornings at the clinic and afternoons at a youth soccer club, she says.

Arundale recently applied for positions overseas to work as a PT in the Premier League in the United Kingdom. She also has applied to work with the Australian Football League (which is its own sport—resembling a mixture of soccer and rugby). Wherever she ends up, Arundale definitely will be working within her wheelhouse. “I eat, breathe, sleep, and live sports,” she says.

Making an Impact

Like Arundale, Bobby Cochrane, PT, DPT, planned to work in sports within the physical therapy profession. He even earned board certification as a sports physical therapy clinical specialist. Although he does work with athletes as a staff physical therapist at OA Centers for Orthopedics, a division of Spectrum Medical Group in Portland, Maine, he’s developed a different sort of sports-related specialty: working with patients with concussions.

Using evidence-based research, OA devised a protocol in 2014 to manage and treat patients following concussions. “We treat people of all ages,” Cochrane says. “Because I’m in a sports and orthopedic practice, the majority of the people who come in with concussions are between the ages of 13 and 30.” While he is the lead PT for the practice’s concussion program, he emphasizes that he doesn’t do it alone.

“I’m not the superhero of concussion; I’m just a piece of the pie,” he says. “When you’re talking about concussions, you often have a diverse, multidisciplinary team.” After the physician diagnoses a concussion, Cochrane usually is the next person the patient sees.

Cochrane became involved in the concussion program because, he says, “There was a need, I had the skill set, and I felt the duty to fill the need.” The OA concussion program is especially important because before 2014 there was no avenue for primary sports medicine physicians in Portland to refer patients with concussions to physical therapy.
Further, there was no clear agreed-upon method of treatment. Today, sports medicine doctors readily refer patients to Cochrane. In fact, patients come to see him from throughout the state, as there is a lack of adequate concussion care, especially in rural areas. His goal is to expand the program statewide from its existing area of the southern coastal sections of Maine.

In addition to treating patients with concussions, Cochrane conducts a concussion outreach program to youth soccer groups in the community. He gives presentations to coaches and administrators about what concussions are, how to conduct a brief sideline evaluation, and what to do if concussion is suspected.

Cochrane says that any motivated PT can learn, as he did, about concussions. “Prior to my digging deep into the subject, I didn’t know much about it, either,” he says. Cochrane took courses and studied the research. Between the concussion program and his outreach, Cochrane says, “It’s helping to advance the profession of physical therapy by broadening the public’s awareness of what PTs can do.”

**Connecting PTs**

**To the World**

When Sarah Stineman, PT, DPT, was a PT student, she became involved with the Wisconsin Physical Therapy Association (WPTA). As other chapter members discussed their desire to expand their social media presence, Stineman—now the assistant director at Capital Physical Therapy in Madison, Wisconsin—took the lead. “Initially, I looked into what other chapters and sections had done with social media and put together a plan that could help us better use it,” Stineman says.

She discovered that many months had passed since WPTA had posted on social media. “We wanted to have a more active presence,” says Stineman. WPTA began sharing items with its membership, including photos and videos, and worked on increasing member engagement. “Facebook has been our biggest push,” she says, “because it covers the broadest span of our membership.”

Social media also has become important for member retention. “Using social media has helped us engage students a lot more, and I think if we can hook that younger population sooner, we’re going to have lifelong members rather than seeing them drop off a year or 2 after graduation,” Stineman says. “Social media is how students communicate with each other. It’s how they ask questions. It engages them more than a newsletter that will get lost in the email shuffle. It’s much harder to capture members once they’re out of school than it is while they’re still enrolled. So, we need to create that value for them early on.”

Steve Wechsler, PT, DPT, a senior PT at Memorial Sloan Kettering Cancer Center, also is a vocal advocate for social media. He joined APTA’s Oncology Section in 2015 and was appointed social media chair of its Communications Committee that May. When he accepted the position it had been vacant for more than a year. As a result, there was much to do. But Wechsler got right on it.

“The section’s social media presence had fallen flat,” he says. Now, though, the section uses Facebook and Twitter to promote section membership, continuing education options, certification opportunities, calls to write and submit papers to the section’s journal (*Rehabilitation Oncology*), and to promote the physical therapy profession as a whole.

“Oncology rehab is booming right now, as more people recognize how important it is,” Wechsler says. “As more evidence is coming out, I’m constantly pushing it out on social media, along with new research and new commentary. I’m drumming up more interest and more followers to keep the conversation going about oncology rehab.”

“It’s helping to advance the profession of physical therapy by broadening the public’s awareness of what PTs can do.”

— Bobby Cochrane

Social media is crucial to physical therapy now and in the future because of its reach, he says. “Social media can reach all corners of the United States immediately. It’s 1 way the Oncology Section easily can communicate with all of its members instantly,” Wechsler notes, adding that on Twitter, in particular, “there’s the opportunity, by using hashtags, to connect with many different disciplines and professionals who specialize in cancer rehab, organizations such as Sloan Kettering, and other thought leaders in the field.”

“What’s been fun for me,” he adds, “is the creation of international connections. A lot of great work is being done in the United Kingdom, and we have a social media relationship with some organizations there.”

Because everyone seems to be so busy, Wechsler says social media can be beneficial. “It’s helping to spread information. A lot of clinicians across disciplines don’t have a lot of time to dive into research and do their own literature searches. We’re providing a platform that members can follow every day, or every other day, to get new and important pieces of information. One of the section’s goals is to promote evidence-based practice, and helping to disseminate the evidence is a way we can do that.”
Social media engagement can enhance patient care, as well. “If we can provide educational material or community resources to the profession that PTs then can pass on to their patients, we can directly affect patient care,” Wechsler observes.

Speaking Up
When Susanne Michaud, PT, DPT, became a PT after having worked as a massage therapist, she was drawn to dry needling—the insertion of a fine filiform needle into targeted dysfunctional muscle or connective tissue to stimulate a change in tone, activation, and mobility of that tissue and the nervous system. Michaud is owner of Stride Physio in Seattle, Washington, and until recently was a teaching associate at the University of Washington.

“Dry needling is a potent technique for PTs because we’re addressing what’s going on with the muscles specifically,” she says. Although she uses other interventions, of course, Michaud wanted to offer dry needling as an option for patients. Throughout the years, she took courses on the technique. But then something happened: In 2013, a small clinic in Seattle was sued by an acupuncture group for hosting a course on dry needling.

“That was, so to speak, the first shot fired,” Michaud recalls. Soon she was going to the state capital of Olympia to testify in favor of dry needling at Department of Health hearings. “A huge consideration is that it’s part of our practice act to engage in innovative practice. Dry needling was not in our understanding until the mid-1990s, when research was being conducted by PTs, physicians, and researchers.”

In 2013, supporters of dry needling defeated a bill that would have prohibited PTs from performing the intervention. The question then was presented to the state’s attorney general, who said

The Emerging Leaders Program
The Emerging Leaders Program enables each APTA chapter or section to identify and honor 1 PT or PTA who has demonstrated extraordinary service early in his or her physical therapy career. Criteria include exceptional overall accomplishments and contributions to APTA and the physical therapy profession as a whole that advance APTA’s vision of “Transforming society by optimizing movement to improve the human experience.”

To be eligible, individuals must be current members of APTA for 5 years and be no more than 10 years from formal graduation. They also must have current or prior service on 1 or more appointed or elected groups at the component or national level.

For more information, see “Policy and Procedures for the Emerging Leader Award” (BOD Y11-04-22-70) within APTA’s policies and bylaws at www.apta.org/Policies or call 703/706-3283.

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Joseph Greenwald & Laake, PA
APTA’s Emerging Leaders

Here’s a complete list of APTA’s 2017 Emerging Leaders:

Amy Arundale, PT, DPT, PhD
Sports Physical Therapy Section

Adam Borg, PT, DPT
Idaho Chapter

Kaelee Brockway, PT, DPT
Michigan Chapter

Robert Cochrane, PT, DPT
Maine Chapter

Jennifer Frerich, PT, DPT
Texas Chapter

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Mariana Wingood, PT, DPT
Academy of Geriatric Physical Therapy

Tamra Wroblesky, PT, DPT
Section on Women’s Health
dry needling wasn’t within PTs’ scope of practice. The senator who chaired the health care committee recommended that PTs take it to a “sunrise review.” Under this process, the Washington Department of Licensing makes recommendations to the legislature on business profession credentialing proposals at the request of the chairs of legislative committees. The legislature’s intent is that all individuals should be permitted to enter into a business profession unless there is an “overwhelming need” for the state to protect the interests of the public by restricting entry. In addition, any changes of existing licensed practitioner’s scope of practice should benefit the public. Enhancement of professional status alone is not justification for regulation.1 Michaud is participating in drafting the sunrise review, which included more than 100 pages of evidence demonstrating why PTs should be allowed to perform dry needling. The review found, however, that the bill as written wasn’t sufficient. So the drafting team worked on the appropriate language for the bill and is planning to meet with the acupuncture group. “There is no law on the books that says we cannot do dry needling,” says Michaud. But because of the lawsuit against the small clinic, PTs are not performing dry needling in Washington.

While Michaud does not yet perform dry needling, she’s involved in the efforts to explicitly permit it. “The benefit is so high for people who are in pain or have stopped moving as a result of their issues. It’s not a be-all, end-all tool, but it’s another technique that has been shown to be effective,” she says. “Part of why I’m passionate about it is because even if I’m not going to be able to do it, I take the long view that somebody will be able to do this. The box has been opened.” Like Michaud, Sarah Suddarth, PT, DPT, trained in dry needling even though in 2015 the attorney general of Tennessee issued a negative opinion that prevents PTs from employing the technique in that state. Suddarth, now a clinical director for Benchmark Physical Therapy in the town of Ardmore, already had been accepted into a fellowship program through the American Academy of Manipulative Therapy, in which dry needling plays an instrumental role. She decided to continue in the fellowship even if she couldn’t practice dry needling. On July 1, 2016—just a few months after Suddarth graduated from the fellowship—PTs in Tennessee once again were allowed to use dry needling. “This technique is helping us advance the profession because it’s giving us the tools that our colleagues across the world—in Europe, Australia, Canada, Brazil, and Spain, among other nations—have been

“Part of why I’m passionate about [dry needling] is because even if I’m not going to be able to do it, I take the long view that somebody will be able to do this. The box has been opened.”

– Susanne Michaud
using for years,” says Suddarth. “The evidence is there. Now that we’re able to do it, we’re getting many people better faster. It’s helping us optimize the human experience in a more efficient way.”

Suddarth had been Tennessee’s student legislative liaison. Two years after receiving her DPT in 2010, she became a federal affairs liaison for the Tennessee Physical Therapy Association (TPTA) and spent time in Washington, DC, lobbying, arranging for practice visits in Tennessee, and grooming other students for similar work.

In 2016, Suddarth was elected TPTA’s vice president. She’s rewriting the association’s policies and procedures. But her favorite activity, she says, is interacting with district chairs—helping them expand their individual communities of PTs, brainstorming with them, and fostering more grassroots involvement.

“Being an advocate for our profession and patients ensures access to care, and that we aren’t trampled on by other professions,” says Suddarth.

Stineman, as federal affairs liaison for the WPTA, says it’s important to be involved in legislation because political representatives generally aren’t health care providers. Sharing with them how policy changes and legislation will affect the care that PTs provide to patients is crucial. “The legislators know about a lot of things, but they may not know about specific aspects of our profession,” she says. “We need to inform them.”

Sharing in Common

When asked what motivates them, all the emerging leaders interviewed for this article shared a specific characteristic: passion.

If you want to be a future leader in the profession, Cochrane says, “Find your passion. If you’re not passionate about it, you’re not going to work until the wee hours of the night on it. But also see where there’s a need. Find your passion, then see where you can apply it in your field.”

“I’m excited about the things I do, and it all comes back to there being things that I’m passionate about,” says Arundale. She adds that it’s also important to move outside one’s comfort zone. “As a student, or early in your career, find a local chapter or a section meeting at a conference, introduce yourself, and become involved,” she advises.

“Show up, ask questions, and get to know people,” Stineman echoes, adding, “There are so many ways to get involved. It doesn’t always take a lot to make a difference. Making a phone call to your senator and representatives to tell them about what you do and how it affects your patients can make a big difference. It takes only 5 minutes. Or, you could go to their websites and send an email. You can contribute to making a big change.”

Mentors: Have Them And Be Them

All the emerging leaders who spoke with PT in Motion had their own mentors. Now they’re returning the favor. While some named specific mentors, others had too many to mention. “I definitely stood on the shoulders of giants,” says Cochrane.

“I’ve had multiple mentors along the way who have helped me greatly. Students should find many—like a clinical mentor, an association mentor, and others,” says Suddarth.

“Mary Insana Fisher, PT, PhD, the current secretary of the Oncology Section, has been amazing in taking me under her wing and giving me support and direction—and also affording me the freedom to figure out issues on my own,” says Wechsler. “She has shown a lot of trust in me, which is motivating in its own way.”

Arundale says that Joe Black, PT, DPT, an active member of APTA’s Sports Physical Therapy Section, has acted as her mentor. “I feel honored to be in the small group of people whom he mentors. He’s also started a pay-it-forward mentorship strategy. If you’ve been mentored, be a mentor for others.”

These emerging leaders also suggest that those who have long experience in physical therapy share what they’ve learned. “It’s important that they feed others with their knowledge,” says Michaud.

“More experienced PTs have so much to offer,” Suddarth seconds. “That’s how we grow as a profession. If they don’t share their expertise with the younger generation, our profession will die.”

“Everyone can help. I’m just a regular person from the middle of nowhere, and people tell me that I’m making a difference,” says Suddarth. “If I can, so can they.”

Michele Wojciechowski is a freelance writer and frequent contributor to PT in Motion.

REFERENCES

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- Movement, Pain, and Aquatic Therapy

**CARDIOPULMONARY:**
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- Foundational Educational Sessions on Lung Disease

**CLINICAL ELECTROPHYSIOLOGY AND WOUND MANAGEMENT:**
- #ChoosePT: Electrotherapy: An Effective Adjunct for Opioid Reduction?
- Wound Evaluation for the Non-Wound PT
- Exploring Polyneuropathy: Differential Diagnosis, Cases, and Current Trends

**EDUCATION:**
- Entry-Level Competencies From APTA Academies: Resources to Guide Curriculum
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- Roll With It! Wheelchair Skills Training From Basics to Extremes
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- The Movement System: Application for Deconditioned and Frail Older Adults
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- Evaluation and Treatment of Upper Extremity Injuries in Tennis Players
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- Rest vs Activity: Debating the Current Evidence in Concussion Management

**ONCOLOGY:**
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- HIV in 2018: It’s Not Over Yet—What Every Physical Therapist Needs to Know
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- Spotlight on Research: Let’s Talk About Pain Studies and Clinical Implications
- 3D Trunk Training for the Female Runner
- Creating and Sustaining Behavior Change Through App-Based Technology

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- Trauma-Informed Care: A New Paradigm for the NICU
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- Muscle Dysfunction From Throwing Athletes to Elderly: Research Informs Clinical Practice
- ACE Talk: eHealth Technology for Rehabilitation and Mobile Health Applications

**SPORTS:**
- Not Just Magic Spray: From Prevention to Return to Sport in Soccer Players
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American Airlines:
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Not available for air travel confirmed online

Delta Airlines:
Phone: 800/328-1111, use file number: NMQJP
Valid dates: February 18–27, 2018
Online: www.delta.com, and select the meeting event code field (No ticketing charge)

United Airlines:
Phone: 800/426-1122, use Z Code: ZYXA and agreement code: 445557
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- Step to the beat: Look for details of our steps-for-charity challenge happening at CSM 2018!
- Choose to cruise: Ride up the mighty Mississippi River for a romantic dinner or jazz cruise on a paddle-wheel boat.
All preconference courses will start at 8:00 am on Tuesday, February 20, and Wednesday, February 21. Please visit www.apta.org/CSM for complete course descriptions, times, and CEU information.

**ACUTE CARE**
- My Patient’s Dizzy, Now What? An Acute Care Approach to Vestibular Dysfunction
  AC-P2-4852 | 1A
- I Found the Vital Sign; Now What? Demystifying the Numbers for Patient Care
  AC-P2-6513 | 1A

**AQUATIC PHYSICAL THERAPY**
- Doing It Right! How to Develop an Aquatic Physical Therapy Program
  AQ-P1-5828 | 1A

**CARDIOPULMONARY**
- Clinical Application of EKG Interpretation for the Rehabilitation Therapist
  CP-P2-9115 | 1A
- Expanding Practice for Mechanical Circulatory and Complete Respiratory Support
  CP-P2-9061 | 1B

**EDUCATION**
- Women Leading Women: Strategies for Lifelong Career Development in Higher Education
  ED-P2-6131 | 1A
- Holistic Admissions Review Workshop for Physical Therapist Education Programs
  ED-P2-6635 | 1A
- Medical Education Research Certificate (MERC) Workshop
  ED-P2-9506 | 1B
- In Pursuit of Deep Understanding: Top-Down Design of a Simulation Curriculum
  ED-P2-6043 | 1A

**FEDERAL PHYSICAL THERAPY**
- Let’s Play! Adaptive Sports Roles and Opportunities for Physical Therapy
  FD-P2-6972 | 1A
- On the Cutting Edge: Defining the Role of Physical Therapy for OA of the Knee
  FD-P2-6378 | 1A

**GERIATRIC**
- The “Invisible” Patient Population: LGBT Older Adults and Inclusive Practices
  GR-P2-0363 | 1A

**HAND REHABILITATION**
- Hand Therapy for the Nonspecialized Clinician: Fundamentals for Practice
  HR-P2-4139 | 2A

**HEALTH POLICY/ADMINISTRATION**
- LAMP Management 101: Practical Skills
  HP-P1-5955 | 2B
- Leadership 101—Personal Leadership Development: The Catalyst for Leading Within
  HP-P1-6204 | 2B
- Leadership 201—Advanced Leadership Development: The Catalyst for Leading Others
  HP-P1-6295 | 2B

**HOME HEALTH**
- Advanced Competency in Home Health Live Training
  HH-P1-5027 | 2B

**NEUROLOGY**
- What You Do Matters: Physical Therapy-Induced Neuroplasticity
  NE-P2-9769 | 2A
- The Academy of Neurologic Physical Therapy Online Education Summit
  NE-P2-9271 | 2A

**ONCOLOGY**
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  ON-P2-0584 | 1A
- A Multifaceted Approach for Patients With High-Risk Digestive and Pelvic Cancers
  ON-P2-9522 | 1A

**ORTHOPAEDIC**
- Keep Calm and Treat Pain: From Research to Clinical Practice
  OR-P2-4708 | 2A
- Trust in Your Thrust! Implementing High-Velocity Techniques Into Your Practice
  OR-P2-4913 | 1A
- Achieving Clinical Correlates: Imaging Implications for Physical Therapists
  OR-P2-6607 | 1A

**PEDIATRIC**
- “Braking Bad”: Eccentric Control From Talking to Walking
  PD-P2-4970 | 1B
- Perspectives on Coaching: Empowering Families to Take the Lead Through Education
  PD-P2-6651 | 1A
- Pediatric Cardiac Rehab: The Impetus, Implementation, and Sustainability
  PD-P2-7099 | 1A

**PRIVATE PRACTICE**
- Kick-Starting Your Private Practice: Keys to Success and Interactive Consulting
  PP-P2-6095 | 1B

**SPORTS PHYSICAL THERAPY**
- ImPACT-Trained Physical Therapist Fast Track Workshop
  SP-P2-5334 | 1A
- Epidemic of UCL Injuries in Adult/Youth Pitchers: Causes, Surgery, Outcomes, and Rehab
  SP-P2-7112 | 1A

**WOMEN’S HEALTH**
- Treating the Female Athlete: A Symposium and Literature Update
  WH-P1-7144 | 1B
- Pelvic Floor Treatment of Urinary Incontinence: An Evidence Update
  WH-P2-3678 | 1B

**LOUISIANA CHAPTER**
- Designing and Implementing Effective Prevention and Health Promotion Models—sponsored by the Louisiana Chapter
  HC-P2-8697 | 1A

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* Membership pricing is based on the individual being a member of the section sponsoring the precon.
Health Care Employment Rose 39,400 in July

Health care added 39,400 jobs in July, following an increase of 36,500 in June, according to the US Bureau of Labor Statistics, for a total of 15,777,300 people nationwide employed in that field. Ambulatory services added 20,000 jobs, while home health care services added 11,300. Nursing and residential care facilities gained 2,100 jobs in July after losing 1,200 jobs in June. That sector’s employment stood at 3,332,500 jobs. Over the past 12 months, health care has added 326,700 jobs.

Looking at the bigger picture, an analysis by Deloitte says that the health care services sector “is a major driver of employment growth in the United States. According to “Driving Healthy Employment Growth: A Look at Occupations in Health Care,” between 2000 and 2016, overall private sector employment grew by 9.8%, while health care employment grew by 42.0%. This caused health care services’ share of total private sector employment to rise from 9.8% to 12.6%.

Of the 4.6 million health care jobs created between 2000 and 2016, 1.1 million were in hospitals, 728,000 were in home health care services, 726,600 were in physicians’ offices, 431,000 were in outpatient care centers, and 130,500 were in nursing care facilities.

Outpatient care centers saw large growth in the use of physical therapists. The report explains, “In 2000 this occupation ranked eleventh at 3.3% and by 2015 this group was the third most prevalent, comprising 5.8% of jobs. This perhaps reflects the aging Baby Boomer generation requiring more repair procedures such as knee and hip replacements.”


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Guidelines and Outcomes Registry*
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OCTOBER
Physical Therapists as Primary Care
Providers for Patients With Lower Back Pain*
Thursday | October 19

NOVEMBER
Issues Impacting Postacute Care*
Thursday | November 16

DECEMBER
Medicare: What’s New for 2018?*
Wednesday, December 6

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learningcenter.apta.org/FW2017
CMS Proposes Scaling Back or Eliminating Bundling Programs

The US Centers for Medicare and Medicaid Services (CMS) has proposed to significantly scale back the knee and hip joint replacement bundled care model and to cancel expansion of bundled care models for cardiac care and for hip and femur fractures. The announcements were made as part of a package of proposals unveiled in August. They also loosen some requirements for a provider to be considered a “qualifying provider” under the joint replacement bundle program.

The hip and knee bundle program, known as the Comprehensive Care for Joint Replacement (CJR) model, launched in 2016 as the first-ever attempt by CMS to mandate bundled care. It applies to 67 different geographic areas, covering some 800 hospitals. Under the proposed rule change, the number of areas required to participate in CJR would drop to 34—leaving participation voluntary for all hospitals in the other 33 areas, or about 350 facilities. CMS estimates that 60 to 80 hospitals will choose to voluntarily participate. Hospitals that can and do decide to opt out of the program will have cancelled episodes beginning at any point during 2018.

In addition to reducing the number of geographic areas required to participate in the CJR, CMS is proposing that low-volume and rural hospitals in the remaining 34 areas also be switched from mandatory to voluntary participation.

Per the same proposed rule, CMS would cancel a planned expansion of mandatory bundling to cardiac care, as well as expansion of the CJR to include care for hip and femur fractures. Those expansions originally were set to begin in February of this year, but later were delayed until October 1, then pushed back to a January 2018 startup date.

CMS also proposed making it easier for clinicians to be included as qualifying participants in the bundling program. Under the proposed rule, providers—including physical therapists—who don’t have a financial arrangement with a facility in the CJR program, but who either are directly employed by or contractually engaged with a participating hospital, would be accepted into the program. It would be up to the hospitals to supply CMS with an “engagement list” of those providers, and CMS would take it from there, using Medicare Part B claims data to decide whether a clinician can be considered a “qualifying provider” in an advanced alternative payment model (APM).

Clinicians who get the nod from CMS for APM participation would not be required to report under the Merit-Based Incentive Payment System (MIPS) and could be eligible for payment bonuses of up to 5%. (Because physical therapists are solely voluntary participants in MIPS as of now, they wouldn’t be subject to the MIPS reporting requirement even if they don’t participate in an advanced APM. But that could, and is expected to, change in future years.)

CMS has issued a fact sheet on the proposal. APTA staff are reviewing the proposed rule and will provide comments by the October 15 deadline.


www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2017-Fact-Sheet-items/2017-08-15.html

New HHA Medicare, Medicaid Participation Requirements Won’t Launch Until 2018

The US Centers for Medicare and Medicaid Services (CMS) has suspended startup of revised conditions of participation (CoP) for home health agencies (HHAs) until January 13, 2018. The new CoP originally were set to begin on July 13, 2017. CMS says the updated minimum standards for HHAs that serve Medicare and Medicaid would strengthen patient rights, encourage more effective communication between patients and caregivers, and result in better outcomes reporting. HHAs had expressed concern that they didn’t have enough time to prepare for the changes.

In addition to pushing back the launch date, CMS also finalized July 13, 2018, as the phase-in date for related performance-improvement projects. A preliminary draft of revised CoP guidelines will be available to HHA stakeholders this fall, with a final version to be published in December.

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National Academies Report Recommends More Public Education, Reimbursement Supporting Nondrug Approaches to Pain Treatment

Recommendations contained in a new National Academies of Sciences, Engineering, and Medicine (National Academies) report on pain management and the opioid crisis identify the need to support nonpharmacologic approaches to pain treatment through better reimbursement models, and the necessity of continued efforts to educate the public on effective alternatives to opioids.

The positions on reimbursement and public education were among 21 recommendations included in the National Academies’ report titled “Pain Management and the Opioid Epidemic,” which examines the opioid crisis from multiple perspectives. The overarching theme of the report: If America is serious about solving the opioid crisis, it’s going to require work and change at nearly every level of health care, public policy, and even clinical education.

In a chapter devoted to approaches to pain management, National Academies authors evaluate the status of several nonpharmacologic approaches to pain—including acupuncture, manual therapies, and physical therapy. They assert that more research is needed on acupuncture, and that the evidence supporting chiropractic and osteopathic manipulation is “sparse.” Physical therapy, they write, is in a slightly different situation: it’s been proven to work, but an understanding of how it works, and guidelines for specific interventions, are harder to come by.

But there are “barriers to the successful use of exercise therapy for pain management,” according to the report. These can include patient-related factors such as lack of knowledge about exercise, but barriers also are within the health care system itself, including “the system’s overly rigid focus on the biomedical model for pain, a lack of attention to or education about the value of exercise, a lack of supervision to ensure patient safety and comfort, and a lack of insurance coverage of the costs of exercise and physical therapy.”

Those barriers are among the reasons the report’s recommendations include a call to facilitate reimbursement for comprehensive pain management by developing reimbursement models that “support evidence-based and cost-effective comprehensive pain management encompassing both pharmacologic and nonpharmacologic treatment modalities.”

The report also examined strategies for addressing the opioid epidemic through public education. In that section, the authors recount how the report’s drafting committee “was struck particularly by the relative lack of attention to the impact of education of the general public … about risks and benefits of opioid therapy and the comparative effectiveness of opioid and nonopioid analgesics and nonpharmacological interventions.”

“This plan aims to help the millions of people who suffer from chronic pain while reducing unnecessary opioid prescribing,” said committee chair Richard Bonnie, MD. “We also wanted to convey a clear message about the magnitude of the challenge. This epidemic took nearly 2 decades to develop, and it will take years to unravel.”

Both the need for better reimbursement models and the importance of public education on effective alternatives for pain treatment are at the center of APTA’s public policy and public relations efforts. The association continues to advocate for more extensive direct access provisions, elimination of the Medicare therapy cap, and lower cost-sharing and copays for services provided by PTs, among other policy areas; also, APTA’s #ChoosePT campaign message has reached millions of Americans through a video public service announcement and the efforts of state chapters and individual APTA members.

http://www.moveforwardpt.com/ChoosePT/Toolkit
https://www.youtube.com/watch?v=RWpnMsAjX5k

UPDATE ON OPIOIDS

Majority of Opioid Prescriptions Go to Patients With Mental Health Disorders

A study in the Journal of the American Board of Family Medicine has found that more than half of US opioid prescriptions go to the 16% of Americans who have anxiety, depression, or other mental health disorders.

An estimated 60 million prescriptions each year—51.4% of the 115 million prescriptions for opioids—are written for adults with mental health disorders, according to Matthew Davis, PhD, MPH, of the University of Michigan and his colleagues. Higher opioid use among those with mental health disorders persists across key variables, including cancer status and various levels of self-reported pain. The researchers found that patients with mental health disorders had more than 4 times the odds of opioid use than did other adults.

Researchers were unable to fully account for their findings. They said, “There exists a complex interaction of factors related to the patient, provider, and medical and social conditions that ultimately results in the decision to prescribe an opioid. … [O]ne could hypothesize that increased opioid use in patients with mental health disorders may be related to a variety of psychological factors that may contribute to an increased subjective experience of pain or to increased likelihood of using opioids irrespective of pain level.”

Study details were reported by MedPage Today.

Chemical ‘Marker’ Sheds Light on Cognitive Benefits of Aerobic Exercise Among Older Adults

The connection between physical activity (PA) and slowing or prevention of cognitive decline in people who are older has been widely recognized, but an explanation has been more elusive. Now researchers in Germany believe they’ve isolated a chemical marker that helps identify PA’s neuroprotective effects.

The research project split 53 cognitively healthy individuals 65 and older into 2 groups—the first of which received 3 half-hour supervised cycle training sessions per week for 12 weeks. The second group did not increase their PA. The study then measured a host of factors associated with cognitive decline at the beginning and the end of the 12-week training program. Researchers didn’t limit their investigation to chemical markers; they also included evaluations of gray matter volume and results of cognitive performance tests. Findings were published in Translational Psychiatry.

At the end of the 12 weeks, only 1 major difference between the 2 groups was found: the amount of total choline (tCho) present in the brains of participants. A combination of 2 types of choline, tChol is associated with pathological membrane turnover and inflammation, and often is present along with elevated creatine levels in the brains of individuals with Alzheimer’s disease and dementia. The tCho levels of individuals who participated in the exercise program remained stable, while the non-exercise group’s tCho levels rose over the 12-week timeframe. Researchers were not able to link PA and lower levels to tCho to aerobic capacity, which did not increase significantly for the exercise group compared with the non-exercise group. Instead, they said the effect could be due to an increase in cardiac efficiency among the exercise group.

The authors acknowledge that their study was limited. Still, they assert, the notable difference in tCho levels could be a window into the chemistry behind the beneficial effects of PA. “As choline is a marker of neurodegeneration, this finding suggests a neuroprotective effect of aerobic exercise,” the authors write. “Overall, our findings indicate that cerebral tCho might constitute a valid marker for an effect of aerobic exercise on the brain in healthy aging.”

Older, Sicker, and Stressed: Survey Analysis Looks at Individuals With Chronic Pain

An analysis of responses to a national health survey attempted to tease out the distinct characteristics of Americans with chronic pain. The portrait that emerged was of a chronic pain population that is older, under more financial stress, and more likely to live with 1 or more comorbidities compared with the average respondent.

MedPage Today conducted the review, which analyzed results of the 2016 National Health Interview Study (NHIS), an 805-question survey administered to 33,000 Americans. MedPage staff focused specifically on data related to pain—comparing respondents who reported daily pain with NHIS averages. Here’s what they found:

The chronic pain group was older. The median age of the daily-pain group was 59, compared with 52 for the entire survey group. Within the pain group, about 33% were over age 65—an age range that made up 25% of the whole.

The chronic pain group worries more about money. About 18% of the pain group reported being “very worried” about paying monthly bills, compared with about 8% of all respondents. At the other end of the spectrum, about 47% of all respondents reported being “not at all” worried about paying monthly bills, an attitude shared by only 38% of the chronic pain group.

Comorbidities were more likely in the pain group. Respondents with chronic pain reported higher rates of hypertension, diabetes, and depression than the group as a whole. The percentage of respondents in the chronic pain group who reported hypertension approached 60%, while the whole-group average was closer to 30%. Similarly, diabetes diagnoses were reported by about 23% of respondents in the chronic pain group—twice as high as the overall rate. Respondents with chronic pain also were more likely to report taking medication for anxiety and depression at some point (nearly 40%, compared with approximately 28% overall).

Respondents with chronic pain also were more likely than the overall group to see receive regular preventive care, but the difference was slight—66%, vs 64% for the overall group.

www.nature.com/tp/journal/v7/n7/pdf/tp2017135a.pdf

www.medpagetoday.com/PainManagement/PainManagement/66940
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APTA Reaches 100K Member Milestone

It’s official: APTA now is 100,000 members strong. How many people is 100,000? It’s more than would fit in the Rose Bowl, the Cotton Bowl, or Wembley Stadium in London. The APTA population is larger than that of Atlantic City, New Jersey, and just about the same as Charleston, South Carolina, or Green Bay, Wisconsin. It’s a big number, to be sure. But more important for APTA, it’s a number that represents an opportunity for the physical therapy profession to give even stronger voice to its commitment to patient-centered care.

The association reached the milestone in August, after a spring and summer campaign highlighting the ways in which APTA membership benefits both individuals and the profession as a whole. The accomplishment comes as the association begins preparing for its centennial in 2021, and amid a rapidly changing health care environment.

“I could not be more pleased that APTA has reached this incredible milestone,” said APTA President Sharon L. Dunn, PT, PhD. “Membership enables personal development and accelerates our profession’s collective progress. With health care rapidly evolving, there’s never been a more important time to combine our strengths in pursuit of APTA’s bold vision of a society transformed through optimized movement.”

The physical therapist whose membership got APTA to the 100,000-member milestone is Sam Seybold, PT, DPT, of Guthrie, Oklahoma. Seybold rejoined APTA after taking an assistant professor position at Langston University.

“With rapidly changing technology and research, now more than ever it’s important to keep up and stay abreast of all the new stuff,” said Seybold, who cited the camaraderie of interdisciplinary health care teams as 1 of his favorite aspects of being a physical therapist.

www.apta.org/Media/Releases/Association/2017/8/7/

‘Choosing Wisely’ App Now Available

It’s easier than ever for consumers to make well-informed health care choices—including choices about physical therapist interventions.

The American Board of Internal Medicine Foundation has unveiled the first “Choosing Wisely” app for iPhone (iPad and Android versions to follow soon)—a tool that enables consumers and clinicians to access more than 500 specialty society recommendations on procedures that tend to be done frequently, yet whose usefulness is called into question by evidence. The program was developed in partnership with Consumer Reports.

Through the new app, clinicians and consumers will be able to search the recommendations using keywords and filter by specialty, age, setting, and service (for example, imaging, medication, treatment, lab, or test). Recommendations are linked to relevant patient-friendly resources, and information can be shared via text or email.

APTA was the first nonphysician group to release a “Choosing Wisely” list in the fall of 2014, joining more than 50 medical specialty societies participating at the time.

APTA’s participation in “Choosing Wisely” is part of the association’s Integrity in Practice campaign to support the profession of physical therapy as a leader in the elimination of fraud, abuse, and waste in health care. The APTA Center for Integrity in Practice houses information on the “Choosing Wisely” program, as well as a primer on preventing fraud, abuse, and waste, an online course on compliance and professional integrity, and other resources.

www.choosingwisely.org/doctor-patient-lists/american-physical-therapy-association/

www.integrity.apta.org/home.aspx

Recommendations for APTA Board, Nominating Committee Due November 1

The APTA Nominating Committee is seeking recommendations for the 2018 slate of candidates for elected positions. Positions open for election are Board of Directors president, vice president, and 3 directors; and 1 Nominating Committee member.

To submit names of qualified members willing to be considered for the upcoming election cycle, visit APTA’s Nominations and Elections webpage and use the online form under the “2018” header. The deadline is November 1.

www.apta.org/NominatingCommittee/

www.apta.org/Nominations/
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<td>S1 - Spinal Evaluation &amp; Manipulation: Impairment Based, Evidence-Informed Approach</td>
<td>21 Hours, 2.1 CEUs</td>
<td>Las Vegas, NV</td>
<td>Yack</td>
<td>Oct 27-29</td>
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<td>Houston, TX</td>
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<td>Washington, DC</td>
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<td>Birmingham, AL</td>
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<td>St. Augustine, FL</td>
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<td>Mar 2-4</td>
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<tr>
<td>S2 - Advanced Evaluation &amp; Manipulation of Pelvis, Lumbar &amp; Thoracic Spine Including Throast</td>
<td>15 Hours, 1.5 CEUs</td>
<td>New York, NY</td>
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<td>St. Augustine, FL</td>
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<td>S3 - Advanced Evaluation &amp; Manipulation of the Cranio Facial, Cervical &amp; Upper Thoracic Spine</td>
<td>27 Hours, 2.7 CEUs</td>
<td>Chicago, IL</td>
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<td>S4 - Functional Analysis &amp; Management of Lumbo-Pelvic-Hip Complex</td>
<td>15 Hours, 1.5 CEUs</td>
<td>Atlanta, GA</td>
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<td>Boston, MA</td>
<td>Lonnenmann</td>
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<tr>
<td>MFT - Myofascial Manipulation</td>
<td>15 Hours, 1.5 CEUs</td>
<td>New Orleans, LA</td>
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<td>Ft. Myers, FL</td>
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<td>Raleigh, NC</td>
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<td>Spicewood, TX</td>
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<td>Jun 16-17</td>
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<tr>
<td>E1 - Upper Extremity Evaluation &amp; Manipulation</td>
<td>15 Hours, 1.5 CEUs</td>
<td>St. Louis, MO</td>
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<td>Las Vegas, NV</td>
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<td>Baton Rouge, LA</td>
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<td>Honolulu, HI</td>
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<td>E2 - Extremity Integration</td>
<td>21 Hours, 2.1 CEUs</td>
<td>Boston, MA</td>
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<td>New York, NY</td>
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<td>Philadelphia, PA</td>
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<td>Phoenix, AZ</td>
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<td>E3 - Advanced Manipulation of the Spine &amp; Extremities</td>
<td>15 Hours, 1.5 CEUs</td>
<td>Austin, TX</td>
<td>Irwin</td>
<td>Dec 9-10</td>
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<td>Birmingham, AL</td>
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<td>St. Augustine, FL</td>
<td>Irwin</td>
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<tr>
<td>Manual Therapy Certification</td>
<td>Preparation and Examination</td>
<td>St. Augustine, FL</td>
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<td>Oct 8-14</td>
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<td>Oct 22-27</td>
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<td></td>
<td>Cranio-Mandibular, Head, Neck &amp; Facial Pain Certification</td>
<td>32 Hours, 3.2 CEUs</td>
<td>St. Augustine, FL</td>
<td>Jul 22-27</td>
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<td>(Prerequisites: CF 1-4, S1 and S3)</td>
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<td>Spinal Boot Camp</td>
<td>15 Hours, 1.5 CEUs</td>
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<td>(Prerequisites: S1, S2, S3, S4)</td>
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<td>Movement &amp; Control</td>
<td>Impairment of the Spine, Pelvis &amp; Shoulder Girdle</td>
<td>St. Augustine, FL</td>
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<td>19 Hours, 1.9 CEUs</td>
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**ADDITIONAL SEMINAR OFFERINGS**

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<th>Seminar</th>
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<th>Instructor(s)</th>
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<tr>
<td>Animal-Assisted Therapy: Improving Treatment Outcomes</td>
<td>15 Hours, 1.5 CEUs</td>
<td>St. Augustine, FL</td>
<td>Redner &amp; Scherke</td>
<td>Nov 11-12</td>
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<tr>
<td>Running Rehabilitation: An Integrative Approach to the Examination and Treatment of the At Risk Runner</td>
<td>14 Hours, 1.4 CEUs</td>
<td>St. Augustine, FL</td>
<td>Vighetti</td>
<td>Apr 16-15</td>
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<tr>
<td>CF2 - Intermediate Cranio Facial</td>
<td>15 Hours, 1.5 CEUs</td>
<td>Chicago, IL</td>
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<tr>
<td>CF3 - Advanced Cranio Facial</td>
<td>15 Hours, 1.5 CEUs</td>
<td>Chicago, IL</td>
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<td>Mar 3-4</td>
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<td>CF4 - State of the Art Cranio Facial</td>
<td>15 Hours, 1.5 CEUs</td>
<td>Little Rock, AR</td>
<td>Stockland</td>
<td>Nov 4-5</td>
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<td>Indianapolis, IN</td>
<td>Daugherty</td>
<td>Dec 9-10</td>
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<tr>
<td>Exercise Strategies and Progression for Musculoskeletal Dysfunction</td>
<td>15 Hours, 1.5 CEUs</td>
<td>Ft. Myers, FL</td>
<td>Chaconas</td>
<td>Oct 14-15</td>
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<td>Tampa, FL</td>
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<td>Oct 21-22</td>
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<td>Indianapolis, IN</td>
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<td>Nov 4-5</td>
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<td>Cincinnati, OH</td>
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<td>Feb 17-18</td>
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<tr>
<td>Geriatric Rehabilitation for Physical Therapist Assistants and Occupational Therapy Assistants</td>
<td>15 Hours, 1.5 CEUs</td>
<td>St. Augustine, FL</td>
<td>Gray</td>
<td>Oct 21-22</td>
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<td>Atlanta, GA</td>
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<td>Nov 11-12</td>
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<td>Applied Musculoskeletal Imaging for Rehabilitation Professionals</td>
<td>13 Hours, 1.1 CEUs</td>
<td>Ft. Myers, FL</td>
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<td>Oct 20</td>
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<td>Tampa, FL</td>
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Taking a Stand
The power of stubbornness, physical therapy, and prosthetics.

I never intended to go to college, let alone pursue a degree that would challenge me in every way and shatter perceptions of my physical limitations.

I was born in Russia with a congenital condition that affected both of my lower extremities. The fibulas never developed, the tibias were deformed, and a mass of disorganized tissues constituted my “feet.” From birth, it was determined that, were I ever able to walk, I would require amputation and prostheses—services that the medical system at that time and place could not provide.

Thus, my parents made the unimaginable sacrifice of allowing me to be adopted into an American family that could help me get the services I needed to live the best possible life. I was 18 months old when I arrived in the United States. The necessary procedures were swiftly scheduled. I received physical therapy to learn to navigate my environment using prostheses.

Given the obstacles I faced as someone with bilateral, trans-tibial amputation, I frequently was told, when I was growing up, what I likely wouldn’t ever be able to do. All that did was make me very stubborn. Eventually—after undergoing various childhood surgeries, using and discarding multiple prostheses, and benefiting from many years of physical therapy—I was a high school graduate who aspired to follow in the footsteps of the individuals who had helped me. With only a narrow knowledge of the variety of available medical professions, I set my sights on becoming a nurse and dove headfirst into my collegiate studies.

Before long, however, something inside me shifted. I was all set to apply to the nursing program, but I couldn’t bring myself to commit to it because I knew that I wasn’t “all in.” Somehow, it didn’t feel like the right fit. I needed to take a long look at myself and ask what I really wanted to do with my life.

During my semester off from college, I heard rumors of a physical therapist assistant (PTA) program that was in development at my school. I was overcome with a sense of urgency. “That is for me.” I simply knew it.

At this time, I was working 3 jobs—2 at restaurants and another at the front desk of a gym where I also exercised. It’s important to note here that, at that point, very few people who knew me had any idea that my “legs” actually were prostheses. I always wore long pants, and physical therapy had done wonders for my mobility and gait.

One morning at the gym, a woman approached my desk and bluntly inquired about...
my legs. I was annoyed that she'd even noticed anything was different about me, because I was used to fooling people and I didn't want the attention. But she introduced herself as a physical therapist who owned a local outpatient pediatric facility. She told me that she'd noticed a few subtle compensations—typical of people with amputation—that I'd made one day while I was working out. She added that she wasn't sure if my amputation was bilateral or unilateral—a testament to the excellent physical therapy I'd received.

The PT invited me to spend time at her facility and meet families with children who were just beginning physical therapy, in hopes that their seeing how much I'd achieved with the help of physical therapy might encourage them. Little did I realize at the time that this facility would be the site of my first full-time job as a new PTA.

After months of preparing my application, I had the honor of being part of the first group of students accepted into the Tyler (Texas) Junior College PTA education program. This was where the real work began. Not only were the academics challenging, but I quickly learned that I sometimes needed to creatively modify traditional classroom methods in order to complete tasks. This occasionally could be daunting, but remember: I am stubborn.

Sometimes I had to surrender to the idea that asking for help was not only okay but also necessary to best ensure a patient's safety and my own. There were situations in which I needed to request a little extra time to determine how best to complete a task. For example, I can't demonstrate heel raises because my ankles are immovable, yet I wanted to show a patient how to do them. I learned to laugh and simply ask someone else to demonstrate.

In school, I also had to overcome what I call my “physical bubble.” Because I'd long hid my prostheses for fear of being seen as “different,” I'd grown to shun close contact with other people, as they might accidentally bump into my lower leg and discover it was a prosthesis. This was my biggest obstacle to successfully completing the PTA program.

I'll always remember the first day we were required to wear shorts to lab in order to identify physical structures. I was terrified and even tempted to excuse myself from the activity. I stepped into the lab room feeling terribly bare—I hadn't worn shorts in public since childhood. I anticipated lots of stares and whispering, as I so often had experienced when I was younger. My classmates, however, were great. They acted as if they didn't even notice. I became more at ease being “out there.” It helped, too, that midway through the PTA program I acquired a fabulous new set of prostheses that further enhanced my comfort level with being “exposed.”

I cannot say precisely why I knew I needed to be a PTA when I first learned about the Tyler program, although physical therapy obviously always had been a big part of my life. But I thank God for guiding my steps toward and through the program, outside of my own bubble, through the PTA board exam—I cried tears of joy as I discovered this summer that I'd passed—and into my career as a pediatric PTA.

My full patient load is challenging, but in these early months of my career in physical therapy I savor the reassurance I can offer parents that I know, to some degree, what their children are experiencing. I'm enjoying my ability to encourage those kids to reach higher ground. I'll never forget that I once was a child learning to take her first awkward steps.
By the Numbers

$186 BILLION

Amount spent in the United States on musculoskeletal conditions in 2012 (the most recent numbers available). Such conditions ranked third—behind “ill-defined conditions,” at $247 billion, and circulatory conditions, at $241 billion.

SOURCE

86%

Health care, pharmaceutical, and biotechnology firms reporting a cyber incident in the past 12 months. The most common types were virus/worm infestation, email-based phishing attacks, and data breaches resulting in loss of customer or employee data.

SOURCE

33%

Portion of the US population that ranks obesity as an extremely serious problem. Another 40% rank it as very serious.

SOURCE

52%

Parents of athletes who feel that their children’s school and coaches are adequately trained to deal with concussions.

SOURCE

$105,857

Mean total cost of a physical therapist education program at a private college or university as of the 2016-2017 school year. The mean cost at a public school is $59,210.

SOURCE

8,961

Female college athletes annually injured in both practice and competition playing all sports, as reported by the National Collegiate Athletic Association. The injury rate is 6.4 per 1,000 athlete exposures.

SOURCE

17%

Americans who say health care is the greatest family financial concern. Other responses include too much debt (11%), lack of money (10%), college expenses (10%), and cost of owning/renting a home (9%).

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