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No one’s ever going to get referred to a physical therapist because he or she has heartburn. But that doesn’t mean that a PT can’t—by asking the right questions, calling on his or her clinical tools, and taking appropriate action—address and successfully treat that condition.

— QUOTED —

TONY BARE, PT, DPT, ATC,
in “A Deepening Footprint”
(page 24)
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Expanding Opportunities
In a Compact Way

Do you want to provide physical therapist services in more than 1 state? The Physical Therapy Licensure Compact may help you achieve your goal.

The ever-increasing mobility of the American workforce, the need for better access to physical therapy in underserved areas, and the rise of telehealth prompted development of the Physical Therapy Licensure Compact (PTLC). It provides physical therapists (PTs) and physical therapist assistants (PTAs) with the ability to practice with minimal barriers across the jurisdictional boundaries of participating states.

How It Works

The PTLC provides a path for PTs and PTAs to become authorized to practice or work in multiple states while holding 1 state license. Participation in the compact is optional and occurs on 2 levels: states and individual licensees.

To participate in the PTLC, a state must opt in through the state legislative process, with lawmakers drafting and the governor approving a compact bill. To be eligible for participation, states must require that licensure applicants pass a national exam and undergo a background check. States also must require licensees to complete continuing competence/education for licensure renewal and must provide licensee data to the Physical Therapy Compact Commission (PTCC).

Individual PTs and PTAs who reside and hold a license in a participating state can obtain a “compact privilege” to practice or work in other participating states provided they meet these criteria:

- They hold a license in their state of primary residence. The compact calls this the “home state.” The rules of the PTCC—which were established to implement and oversee the compact—define the home state as “a person’s true, fixed, and permanent home.” It’s the place where he or she “intends to remain indefinitely, and to which the person expects to return if absent without intending to establish a new domicile elsewhere.”

The compact affords active-duty members of the military and their spouses flexibility in determining their home state. These individuals

Angela Shuman, MPA, is director of state affairs at APTA.
can cite their home of record, permanent change of station (PCS), or state of current residence as their home state.

They have no encumbrances on their license and no disciplinary actions taken within the previous 2 years.

They pass a jurisprudence test on their knowledge of the laws and regulations of the state or states in which they’re seeking compact privileges (known as “remote states”), if the remote state requires it.

They pay $45 to the PTCC for each state compact privilege, plus any fee charged by the state(s).

Licensees who meet these criteria can seek compact privileges through the PTCC, which in addition to establishing the rules of the compact is charged with issuing compact privileges on behalf of participating states. Each member state is represented by 1 delegate on the PTCC. Both APTA and the Federation of State Boards of Physical Therapy have nonvoting representation.

Initial Licensure Doesn’t Change

The compact doesn’t change the process for obtaining an initial license after graduation from an entry-level PT or PTA education program, or for foreign-educated PTs and PTAs to seek their initial state license in the United States.

For new graduates seeking licensure for the first time, the compact doesn’t change most existing state licensure processes. New grads still must submit an application and evidence of having completed an accredited entry-level physical therapist education program, must pass the National Physical Therapist Exam, and must meet all other state-specific requirements.

Individuals seeking their initial license in a compact-participating state must undergo a background check whether or not they are seeking compact privileges. (Nonparticipating states may or may not require background checks.)

Foreign-educated PTs and PTAs seeking their first US state license still must complete the licensure process required by that state. Once such individuals hold a license in 1 state, they can apply for compact privileges in participating states provided they meet all eligibility criteria.

The compact also does not change scope of practice in any state. PTs and PTAs delivering physical therapy services in remote states under a compact privilege must function within the laws and rules of the remote state.

Advantages

While PTs and PTAs in compact-participating states retain the option of going through the traditional licensure process to practice beyond their home state, obtaining a compact privilege holds some advantages over traditional licensure in 2 or more states.

Getting a compact privilege is much faster and easier than going through a state’s traditional licensure process. Under the current state licensure system, applying for a license in another state involves many steps and lots of documentation, which can take considerable time to compile and submit. Test scores, transcripts, and validation of holding a current state license all must be submitted, along with a separate application to each state in which the individual wants to become licensed. It can take weeks or months for all of this to be processed and a license to be issued.

Under the compact, a licensee in a compact-participating state can simply visit ptcompact.org, complete the online application process for compact privileges in any or all other compact-participating states, and pay the required fees. The system uses licensee data submitted to the PTCC by member states to determine a licensee’s eligibility for compact privileges. Once that online process has been completed, the individual is immediately issued compact privileges in the selected state or states.

Compact privileges require only 1 set of continuing education requirements. Whether a licensee holds compact privileges in 1 state or 20, the only set of continuing education requirements he or she must meet for renewal are those required for the home state license.
Compact privilege renewal is tied to the home state license. Compact privileges expire along with expiration of the home state license, so licensees need not keep track of different renewal dates for different states. There’s only 1 renewal date to remember.

Compact Privilege vs License

While obtaining a compact privilege has its pluses, if you live in a compact-participating state and are planning to move to another compact state in the near future, you might consider going through the licensure process in the state to which you are moving rather than seeking a compact privilege. Again, eligibility for a compact privilege is tied to your state of primary residence. This means that when you move to another compact state, you will retain eligibility for a compact privilege but must first hold a license in your new state of primary residence.

Let’s look at a few different scenarios involving these types of decisions.

Mary is a PT who resides in Memphis and holds a Tennessee license. She works for a home health agency that operates in both that state and Mississippi. Due to a staffing shortage, her employer wants her to start seeing patients across the state line as soon as possible. Mary does not hold a Mississippi license. Since both states have enacted legislation to join the compact and have begun issuing or accepting compact privileges (see “Compact but Growing” on this page), assuming that Mary meets the requirements she can complete the application process at ptcompact.org, pay the $45 fee and any fee charged by Mississippi, and receive a Mississippi compact privilege in minutes. She then can treat patients in the Magnolia State.
Steve is a PT licensed in his home state of Arizona who wants to take on a 13-week traveling therapist assignment in Utah. Arizona and Utah have enacted compact legislation. Once Arizona has joined Utah in issuing and accepting compact privileges, and assuming that Steve qualifies, he can visit ptcompact.org, complete the application, pay the $45 commission fee and any fee charged by Utah, and receive a Utah compact privilege. Steve then can head to the Beehive State for his new assignment.

Sarah is a PTA who is working and living in St Louis. She has just received a job offer in Portland, Oregon, and is excited to discover that both her home state and Oregon are members of the PTCC that already are issuing and accepting compact privileges. However, because Sarah will be moving and no longer will physically reside in Missouri, she needs to seek a PTA license in her new home state of Oregon through the Oregon Physical Therapist Licensing Board.

Bob is a PT who lives in Fargo, North Dakota. Many of Bob’s patients reside across the border in Minnesota. He’s been exploring telehealth options to better serve Minnesotans who cannot frequently come to his clinic because it’s a long drive. Bob is pleased when he sees an email from the North Dakota Physical Therapy Association stating that his home state has begun issuing and accepting compact privileges. He goes to ptcompact.org to see if Minnesota is a PTLC state, as well. Unfortunately for Bob, however, that state has not yet joined the compact, so obtaining a compact privilege is not yet an option. Bob instead must apply for a Minnesota license through the Minnesota State Board of Physical Therapy.

Spanning the Nation?
The PTLC has the potential to revolutionize the way in which PTs and PTAs obtain authorization to work in more than 1 state. You can’t take advantage of it, however, unless it’s been adopted by law in your home state and in the other state or states in which you’d like compact privileges. (Again, see “Compact but Growing” on page 8 for the status of state participation.)

If your state isn’t yet a PTLC participant, consider contacting your state chapter of APTA. Let officials there know that you’d like to see the state added to the growing list of compact states—and ask them what you can do to help make that happen.

(APTA State Affairs Specialist Isabella De Bono contributed to this column. In addition to ptcompact.org—which provides answers to frequently asked questions, lists state compact privilege fees, and more—read a background article about the PTLC’s formation and goals at www.apta.org/PTinMotion/2016/3/Feature/MultipleStates/)
No Such Thing as a Free Lunch?

A tradition comes with a problematic side dish.

Safety is a hallmark of the physical therapy profession. Physical therapists (PTs) and physical therapist assistants must at all times protect the safety of patients, clients, peers, and team members. Because physical therapy is the science of movement, we tend to think of safety foremost in physical terms, but it has psychological and emotional dimensions, as well. Actions have consequences, but so do words. Consider the following scenario, in which a student feels threatened not only by what’s said, but also by the institutional silence that follows.

Heart of Gold, or a Tin Ear?

Milton is the coordinator of clinical education (CCE) and a credentialed clinical instructor (CI) at West Side Medical Center—serving as liaison to a local doctor of physical therapy program, linking students with CIs, and sometimes taking on the instructional role himself. He greatly enjoys the opportunity, year in and year out, to share his passion for physical therapy with “the kids” as he calls them, facilitating their transition from “caterpillars to graceful butterflies.”

In turn, Milton is a beloved figure among former students, many of whom keep in touch and apprise him of their career activities and transitions. He notes with deep gratification that the very first student he mentored as a CI—many years ago, long before he assumed the role of CCE—now is a prominent acute care clinician and researcher who credits her success, in part, to the grounding and support she received from Milton during her clinical experience at West Side.

Now in his early 60s, Milton has long been regarded as a father figure by students. Like many a stereotypical clueless dad, however, he can seem awkward and oddly anachronistic at times. He typically addresses students as “young man” and

Nancy R. Kirsch, PT, DPT, PhD, FAPTA, a former member of APTA’s Ethics and Judicial Committee, is the program director and a professor of physical therapy at Rutgers University. She also practices in northern New Jersey.
“young lady,” and one of his favorite admonishments is “While you’re minding your patients, be sure to mind your manners.” There’s an exaggerated courtliness to Milton’s interactions that jibes with his avocation as an actor in local dinner theater productions. “Don’t mind me, I’m just a ham!” he’s been known say to puzzled-looking new students who are unfamiliar with his ways.

One of Milton’s longtime traditions has been to take each student—both his own and those mentored by other CIs—out for a 1-on-1 lunch at a popular Italian restaurant. It’s his opportunity, he says, to honor students for “taking an important step toward full membership in our noble profession.” He sometimes adds with a laugh, “You might say that breaking bread with the next generation of physical therapists ‘feeds’ something in me that keeps me young at heart.”

In fact, these “meals with Milton”—as they’re known by alumni of clinical experiences at West Side—have become the subject of lore. One former student, now a prominent private practitioner in a neighboring city, once devoted a now-celebrated blog post to highlights of these lunches. There was the time, for example, when Milton stood and exaggeratedly bowed as he greeted one female student at the table, lost his balance, and fell face-first into his bowl of pasta. On another occasion, he assured a male student that he would be “a knight in shining armor” to his future patients and presented him with an action figure of Sir Galahad. (Milton has read the blog post and self-effacingly tells anyone who brings it up, “That sounds like me, all right.”)

The bowing incident, though, is emblematic of a throwback sexism by Milton that female students have tended to dismiss as harmless—as “Milton being Milton.” They’ve come to expect such questions from him as “How is our lovely almost-therapist today?” and comments such as “I hope your boyfriend knows what he’s got, because you are really going places, my dear.”

A current student, Alicia, is feeling less charitable about Milton’s manner, however, even though he is not her CI and she doesn’t run into him that often when she’s at West Side. When Milton first met Alicia he pronounced her “classy—like a young Faye Dunaway.”

resources

At www.apta.org/EthicsProfessionalism/

- Core ethics documents (including the Code of Ethics for the Physical Therapist and Standards of Ethical Conduct for the Physical Therapist Assistant)
- Ethical decision-making tools (past Ethics in Practice columns, categorized by ethical principle or standard; the Realm-Individual Process-Situation [RIPS] Model of Ethical Decision-Making; and opinions of APTA’s Ethics and Judicial Committee)

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

- “Ethical Decision Making: Terminology and Context”
He once told her, “Steve [Alicia’s CI] says you’re killing it! I’m not surprised. You’re not only dedicated, but you have the ‘It Factor,’ young lady—a certain je ne sais quoi.” Alicia later confided to a PT on staff, “Milton kind of gives me the creeps.” The female clinician responded, “Milton? He’s a teddy bear—and he’s been happily married for 35 years.”

As Alicia nears the end of her clinical rotation, she knows from what she’s heard that Milton’s lunch invitation is due. She dreads the prospect of spending an hour alone at a table with a man who makes her feel uncomfortable. But she knows it’s something every other student has done, she’s willing to concede that she may be overreacting, and she reasons with a resigned shrug that this might one of those situations in life in which “what doesn’t kill you makes you stronger.”

Alicia quickly doubts the wisdom of that saying, however, as she endures what feels like the longest meal of her life. While Milton lauds Alicia’s clinical abilities and judgment, per the reports he’s gotten from Steve, and expresses confidence that she’ll “go far” in her career, he also compliments her hair and clothing, and he says at one point, “If I had a daughter, I’d want her to be as smart, mature, and put-together as you are. You’ve got it all.” While that’s objectively a compliment, there’s something about the way Milton looks at her when he says it that she finds upsetting. There’s a glint in his eye that strikes her as too familiar, somehow.

When they get back to West Side, Alicia’s desire is to immediately return to her rotation and get away from Milton. Before she can do so, however, he’s regaling staff with highlights of his “magical lunch with the Fair Alicia”—as if they’d dined in character at Medieval Times rather than lunching at Giovanni’s. “And do you want to know the best part?” he asks his audience. “There was no wait for a table—at 12:30! Which proves that it pays to have a pretty girl on your arm.”

Alicia scans the faces in the room but sees not one disapproving glance or raised eyebrow—no acknowledgement of the discomfort she endured.

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**Considerations and Ethical Decision-Making**

There is an inherent power imbalance in the relationship between Milton and the students. It is incumbent upon him to accordingly gauge and adapt his words and actions. His failure to do so has placed the onus of protection on his institution.

**Realm.** The realm is both individual and organizational/institutional. Milton’s blueprint for fostering the professional growth of students has serious blind spots that West Side staff appear unable or unwilling to see.

**Individual process.** Moral sensitivity is required of both Milton and West Side, because if even a single student is made to feel uncomfortable by Milton’s actions, it’s a problem. The probability here, it should be noted, is that if past students had harbored concerns similar to Alicia’s, they likely were loath to air them given West End staff’s tolerance for Milton’s behaviors and the wide esteem in which he’s clearly held there.

**Ethical situation.** This is an ethical problem or issue that demands introspection from Milton and from those at the institution that employs him.

**Ethical principles.** The following principles of the Code of Ethics for the Physical Therapist provide guidance to Milton and West Side staff and management:

- Principle 1A. Physical therapists shall act in a respectful manner toward each person regardless of age, gender, race, nationality, religion, ethnicity, social or economic status, sexual orientation, health condition, or disability.

- Principle 4B. Physical therapists shall not exploit persons over whom they have supervisory evaluative or other authority (eg, patients/clients, students, supervisees, research participants, or employees).

- Principle 4F. Physical therapists shall not harass anyone verbally, physically, emotionally, or sexually.
whatsoever that anything inappropriate has just occurred. She files the reaction away, and when she completes the rotation and returns to her school, she seeks out Gail, the director of clinical education (DCE), to discuss Milton and West Side in detail. She tells Gail that she does not believe the school should continue to place students at the medical center, given Milton’s inappropriate behavior and the institution’s culture of support for it.

“Doesn’t anyone see a problem,” Alicia asks, “with an older man taking female students out to lunch by themselves in the first place—let alone with his constant sexist remarks?”

While Gail isn’t sure the invitation is problematic in and of itself—and while no other student, female or male, ever has complained to her about Milton—Alicia’s comments prompt Gail to call the human resources (HR) department at West Side, detail the situation, and announce that the school will be suspending clinical placements at the medical center until an investigation can be conducted and some sort of resolution can be reached.

When the HR director calls in Milton to discuss the issue and tell him that he’s being reassigned indefinitely to duties that will remove him from all direct interaction with students, he is devastated. “What am I guilty of,” he asks plaintively, “other than loving my profession and doing my best to maintain a pipeline of outstanding clinicians?”

**For Reflection**

The principle players in this situation see Milton’s behaviors in very different ways. Alicia feels that lines have been crossed and that medical center staff don’t see the transgressions for what they are. Milton holds himself innocent of any harassment. Milton’s colleagues don’t seem to see a problem that needs fixing. What do you see, taking these various perspectives into account? What, if anything, needs to happen at West Side?

**For Followup**

If you are reading the print version of this column, go online to www.apta.org/PTinMotion/2018/12/EthicsinPractice/ for a selection of reader responses to the scenario, as well as my views on how the situation might be handled. If you are reading this column online, simply scroll down to the heading “Author Afternote.”

Be aware, however, that it generally takes a few weeks after initial publication for feedback to achieve sufficient volume to generate this online-only feature.
By DONALD TEPPER and JONATHAN SIMKINS
The career arc of a PT or PTA often spans many decades. And while the endpoints are separated by age and experience, the lessons learned along the way can be instructive at any point in the journey.

In this article, physical therapists (PTs) who recently were named APTA “Emerging Leaders” share their thoughts and exchange their views on a variety of professional issues with PTs who have been named Catherine Worthingham Fellows of the American Physical Therapy Association. (See “Who Are APTA’s Emerging Leaders and Fellows?” on page 17.)

Technology and the Human Touch

APTA’s Emerging Leaders generally embrace technology, albeit with a few cautions.

“Devices that act as an adjunct to patient care” are plumbing untapped potential, says emerging leader Alexandra Hill, PT, DPT, who is a certified lymphedema specialist. At the same time, PTs and physical therapist assistants (PTAs) should be “mindful of the supporting evidence for any device, while remaining aware of the privacy and security of the patient. Telehealth is an exciting option for providers and patients,” she notes, “and seeing its implementation in a profession that is largely hands-on has been fascinating. We are lucky to have the Frontiers in Rehabilitation, Science, and Technology (FiRST) Council to help us navigate these new frontiers with technology in medicine.”

Hill practices at DukeHealth and has completed a Duke University Medical Center residency in women’s health. Within APTA’s Section on Women’s Health, she is the director of financial development and a leader in the Minority Health Task Force, which focuses on meeting the needs of minority membership and patient populations. Her research has been published in *Rehabilitative Oncology* and *The Journal of the Section on Women’s Health.*

Emerging leader Tarang Kumar Jain, PT, DPT, PhD, also embraces technology, but with some caveats. “Gamification, virtual reality, and telerehabilitation increasingly are being used in rehabilitation settings—not only to make treatment more effective but also to make exercises more engaging and fun,” he says.

While that’s to the good, Jain sees technology as a double-edged sword that’s “rich in options but leaves users vulnerable to attacks. As clinicians, patients, and rehabilitation and assistive devices become more connected,” he says, “training and development of key skills should be required at all levels to leverage the power of technology” He adds, “I believe the biggest threat is of data breach and losing patient’s sensitive information.”

Jain is an assistant professor of physical therapy at Northern Arizona University.

An even more cautious note is sounded by Emily Wilson, PT, DPT, an emerging leader and an 11-year member of the Michigan Physical Therapy Association.

“Our profession is all about connecting with people,” she notes, “so let’s not lose sight of that while using gadgets, sensors, and real-time computer documentation. We still need to look people in the eye and truly listen to them.”

During her involvement with APTA and the Michigan Chapter, Wilson has established herself as an expert in women’s health and has advanced physical therapy among Michigan’s population through the implementation of marketing campaigns, website content creation, social media engagement, and by serving as a trustee for the Institute for Education and Research.

She recently opened her own private practice, New Seasons Physical Therapy & Wellness, which aims to “provide comprehensive care to women and men with pelvic health conditions across the adult lifespan.”

Emerging leader Rania Karim, PT, DPT, says, “Technology should serve as an adjunct to what we do. In leveraging it,” she adds, “we need to be careful not to increase health disparities. While it may seem hard to believe, there still are areas and populations within our nation that don’t have online access, a signal for mobile phones, or computers or laptops.”

Karim, a board-certified clinical specialist in geriatric physical therapy, is an assistant professor of physical therapy at Marshall University in Huntington, West Virginia. She also is membership chair of the Academy of Geriatric Physical Therapy (AGPT), which under her leadership has created a volunteer coordinator position to analyze innovative ways to engage members.

The Catherine Worthingham Fellows interviewed by *PT in Motion* share these mixed feelings about technology.

“Technology, like any support tool, has great potential to aid or interfere,” observes Cathy Ciolek, PT, DPT, FAPTA. “Used appropriately, it makes my practice so much better. Easy access to current materials on drug interactions, for example, is highly valuable. The key is that we can’t lose
the human touch, and we must always make individual determinations. With one person, technology may assist treatment, but with another person it might not.”

Ciolek is a board-certified clinical specialist in geriatric physical therapy and is vice president of AGPT.

Blair Packard, PT, MS, FAPTA, cites specific examples of the limitations of technology. “We are still a profession that deals with human interaction, motivation, and teaching lifestyle changes to our patients and clients,” he says. “Technology may help in efficiencies, data collection, and even patient motivation, but it can be limiting as well. Electronic health records do, in fact, require more time to complete, which can sacrifice some time spent interacting with patients. That is a problem that health professions have not yet solved.

“Sometimes we succumb to the latest marketing fads in technology,” Packard observes. “I started in private practice in the late 1970s, when many practitioners felt that every orthopedic clinic had to have a $30,000 Cybex machine for testing and training patients. Well, how many of those machines remain in operation today? Probably very few. We’ve learned that the human touch and simpler exercise interventions work every bit as well in most situations.”

Packard is co-owner of East Valley Physical Therapy in Mesa, Arizona. He’s a past president of both the Arizona Physical Therapy Association and the Federation of State Boards of Physical Therapy.

Gregory Hicks, PT, PhD, FAPTA, further warns that “technology can create barriers between PTs and patients if its use is allowed to evolve unchecked. The purpose of technology and various media platforms is to improve the connection between provider and participant by streamlining processes or speeding up the flow of information,” he notes, “so, it is up to us as users to ensure that it stays in its proper place.”

Hicks chairs and is a professor in the Department of Physical Therapy at the University of Delaware in Newark.

Mincing no words, Timothy Flynn, PT, PhD, FAPTA, says, “I believe that a focus on technology—versus caring—in health systems is killing the souls of both patients and providers. We have allowed technology to drive more and more medical testing, which on a societal level actually has made us sicker and poorer. We have allowed administrative and payment systems to decide what is needed. Three decades since its inception, our interface with the electronic medical record remains stunningly poor.

“We have lost sight of the fact that technology is a tool, not a way of doing health care,” Flynn continues. “Physical therapists have a pivotal role to play in addressing the vast majority of chronic health-related problems in our society, but our greatest assets are not technological in nature. Rather, they are our compassionate listening skills, caring handling skills, and an unwavering belief in the power of our patients to envision and create a better future. Technology should foster those skills,” he says. “Therefore, it should focus on seamless communication systems that allow us to engage with our patients via text, video, phone, or face to face, unencumbered by regulatory burdens.”

Flynn owns Colorado Physical Therapy Specialists in Fort Collins.

The Role of Research

Research experience is a consideration in evaluating an emerging leader. But taking on that responsibility isn’t always easy.

Jain chairs the Section on Research’s Early Career Research Special Interest Group and its Communications Committee. He acknowledges, however, that he faced a learning curve.

“It took me some time to adjust to the new demands of teaching along with research,” he concedes, “but with the guidance of mentors and great support from colleagues, I was able to clear the hurdle and become settled.”

Steven George, PT, PhD, FAPTA, speaks of the need for continuing research, but emphasizes that it must be high-caliber. “The profession must invest in cultivating high-rigor scientific research,” he says. “We’ve had good success in this, with several very strong initiatives resulting in physical therapist-led research at the highest levels, and there are several well-regarded peer-reviewed journals specific to physical therapy.

“But there are some discouraging signs, too,” George adds. “There are fewer applications to PhD programs, oversight of clinical research being a deterrent, a limited pool of research mentors, and pressure to secure external funding. Now is not the time to coast on past successes,” he cautions. “Research approaches are rapidly changing, which means the profession must invest its resources—time, money, and people—wisely to ensure that the next generation of physical therapists will continue to expand our robust body of knowledge.”

George is the director of medical research and director of musculoskeletal research at the Duke Clinical Research Institute. He also is vice chair of clinical research for Duke Orthopaedic Surgery at Duke University. He is a past program director at the University of Florida, having taught the evidence-based practice sequence for 10 years.
“Members of the profession need to become a lot more research-savvy,” asserts Linda Resnik, PT, PhD, FAPTA. “We need to stop providing treatments that are not effective, and we must follow evidence-based clinical guidelines to reduce unnecessary variation in care,” she says. “We also need to continue our investment in health services research [HSR] and in training physical therapists to participate in it. HSR is needed to demonstrate the value of physical therapy and the interventions we provide. It also is needed to improve implementation of evidence-based practice. HSR evidence can help inform the organization and delivery of care, as well as state and federal regulations and payment policies.”

Resnik is a professor in the Department of Health Services, Policy and Practice at Brown University in Rhode Island. She also is a research career scientist at the Providence VA Medical Center.

Gregory Hicks adds, “We must stay highly engaged in conversations surrounding the future of health care. We cannot sit back and let other health care providers or payers decide how we fit into the equation. We must conduct the research that demonstrates our value to the health care system and the patient—then make sure that everyone hears, loud and clear, what we bring to the table.”

Networking

Networking with an array of subject matter experts from various fields, Hill says, is critical to the profession’s prosperity.

“It could be at a conference, a continuing education course, or on social media,” Hill says. “There are countless ways to connect with like-minded individuals, as well as those who think entirely differently.”

Jain agrees, “One should be a lifelong learner and be open to seeking out mentors and the help of experts in the areas in which one hopes to succeed,” he says. “Never underestimate the power of networking. Use every opportunity to benefit from seasoned researchers and clinicians.”

Closely related is the idea of encouraging interprofessionalism. Patricia Hageman, PT, PhD, FAPTA, explains, “My early practice interests focused on treating older adults in 1-on-1 situations. I witnessed a high prevalence of obesity and obesity-related risk of disease and disabilities among midlife and older adults from rural communities. As an individual therapist, I wondered how I might influence healthy behavior change in those who lacked access to preventive health programs.

“At an opportunity arose,” she continues, “in which I connected with nurses and dietitians who were asking that same question. Our interprofessional team now investigates the effectiveness of health behavior change strategies that use web-based and other technologies to reach vulnerable populations from rural communities.”

Hageman is professor of physical therapy education and the Karen Linder Distinguished Professor of Women’s Health within the College of Allied Health Professions at the University of Nebraska Medical Center.

Education

Few areas within physical therapy are undergoing more changes and feeling more pressure than education. “My concern as an academician is how to make degrees more affordable,” says Mary Lou Galantino, PT, MS, PhD, FAPTA. “Student debt is a cause of tremendous stress. We need to find innovative ways to get people in the workforce

Who Are APTA’s Emerging Leaders And Fellows?

Emerging Leaders

The purpose of APTA’s Emerging Leaders program is to identify and honor 1 PT or PTA nominated from each APTA chapter or section who has shown extraordinary service early in his or her physical therapy career. This includes exceptional overall accomplishments and contributions to APTA, the component, and the physical therapy profession to advance APTA’s vision. Each emerging leader must be a current member of APTA, have been a member for at least 5 years, and be no more than 10 years from graduation.

For more information, contact nationalgovernance@apta.org

Catherine Worthingham Fellows

Catherine Worthingham Fellows of the American Physical Therapy Association (FAPTA) comprise the association’s highest membership category. Consideration for this designation of professional excellence is open to APTA PT members or life-member PTs who have demonstrated unwavering efforts to advance the physical therapy profession for more than 15 years.

For more information, contact honorsandawards@apta.org
Here is a complete list of APTA’s 2018 Emerging Leaders:

Maggie Abrams, PT, DPT
Ohio Chapter
Dublin, OH

Kathryn Bloyer, PT, DPT
Minnesota Chapter
Minneapolis, MN

Karl Burris, PT, DPT
Arizona Chapter
Gilbert, AZ

Nora Bethany Collier, PT, DPT
Georgia Chapter
Dacula, GA

Brendan Connor, PT, DPT
Massachusetts Chapter
Malden, MA

Alexandra Hill, PT, DPT
Women’s Health Section
Houston, TX

Corey Irby, PT, DPT
Alabama Chapter
Hoover, AL

Tarang Jain, PT, DPT, PhD
Research Section
Flagstaff, AZ

Rania Karim, PT, DPT
Geriatrics Section
Huntington, WV

Joseph Kucksdorf, PT, DPT
Wisconsin Chapter
Green Bay, WI

Justin Ledbetter, PT, DPT
Hawaii Chapter
Honolulu, HI

Cariann Litz, PT, DPT
Florida Chapter
Orlando, FL

Bethany Lukens, PT, DPT
Oregon Chapter
Portland, OR

Ryan McConnell, PT, DPT
Tennessee Chapter
Franklin, TN

Brett Neilson, PT, DPT
Washington Chapter
Newcastle, WA

Audrey Paslow, PT, DPT
New York Chapter
Halfmoon, NY

Michael Schmidt, PT, DPT
North Carolina Chapter
Durham, NC

Brandon Smith, PT, DPT
Virginia Chapter
Henrico, VA

Frances Westlake, PT, DPT
Oncology Section
Highlands Ranch, CO

Emily Wilson PT, DPT
Michigan Chapter
Kalamazoo, MI

Jonathan Wood, PT, DPT
Acute Care Section
Baltimore, MD

Ryan Wood, PT, DPT, MHA
Indiana Chapter
Evansville, IN
who are more diverse and find ways to have more affordable academic degree acquisition.

“I think we should give back to underserved populations,” Galantino adds. “We should go to remote areas in exchange for tuition remission or tuition repayment. That could be accomplished across the United States. Also really exciting are innovative ways to use scholarships to give back to communities. For example, I had a Fulbright Scholar award and used it to go to South Africa. There are sources for serving abroad or providing culturally sensitive care. We need to think innovatively.”

Galantino is a professor of physical therapy and the Holistic Health Minor coordinator in the School of Health Sciences at Stockton University in New Jersey.

Flynn, too, expresses concern about the cost of physical therapist education. “In my opinion, the greatest risk to our profession is the untenable student debt load,” he says. “A large student debt makes it difficult for new physical therapists to pursue advanced training via certifications and residencies. It also adds financial anxiety to the other stressors of early-career PTs. If we're to thrive as a profession, individual PTs must thrive in the physical, emotional, and financial areas of their lives.”

Part of the solution may lie in hybrid education (part onsite, part remote). Kim Nixon-Cave, PT, PhD, FAPTA, believes it’s “the next phase” for DPT education. Hybrid education, she notes, can reduce education costs by alleviating the need for physical relocation of students—and possibly their families—away from family and community support systems. “Hybrid DPT models also afford opportunities to increase diversity in our programs,” Nixon-Cave asserts, to more easily include individuals who live in rural areas, working individuals, individuals who don't financially have the ability to move, and parents or older individuals with families who may not be able to move.

Nixon-Cave is an associate professor in the Department of Physical Therapy at the University of the Sciences in Philadelphia. She also is physical therapist manager at The Children's Hospital of Philadelphia.

**Mentors**

Mentors historically have played a key role in the development of PTs and PTAs. That continues to be the case. “Seeking out mentors who already are doing things that you aspire to do, or who can be a resource for you—whether in advocacy, research, lecturing, or a certification—will improve your skillset tremendously,” Hill advises.

Figuring out how her mentors achieved their success helped Karim find the career for which she was best suited—a strategy she says any PT or PTA can employ.

Jain advises, “Identify mentors early, through a proactive, collaborative approach. You will be amazed at what you can achieve.”

Several of the Catherine Worthingham Fellows suggest that PTs define the term “mentors” broadly. “When I think of mentors,” Galantino explains, “I think of people both within and outside the profession. My mentors are a diverse group of people who have helped me cultivate skillsets I didn’t develop in my initial physical therapist training. One of my best mentors was an infectious disease physician during the AIDS crisis. He asked: ‘How do I treat these young people to give them the best quality of life even though I know they won’t be alive 6 months from now?’ That spawned my desire to work with Peter Mansell, MD, at MD Anderson University. At the time, we didn’t even know that AIDS was caused by HIV, just that it was a cancer diagnosis.”

Nixon-Cave advises, “Look for a mentor with whom you have something in common. Don’t base your choice on their reputation or who you think they are. If you identify someone who you think might be a good mentor for you, meet with that person and discuss your goals and ambitions. New professionals should keep in mind,” she adds, “that mentors do not have to be in the physical therapy profession. I see mentors as those who help you work through the process of making decisions about your career, in view of your life circumstances.”

**Explore All Opportunities**

Emerging leader Emily Wilson, PT, DPT, recommends that new PTs or PTAs remain open to opportunities outside clinical practice to avoid closing potential career doors. Spending time interviewing prospective employers also is important, she says.

“I recently was talking with a colleague. She told me that when she relocated to a new city, she went to physicians and asked where they send their toughest cases,” Wilson recalls. “She then interviewed and shadowed PTs at those locations before deciding where to work.”

Anne Swisher, PT, PhD, FAPTA, also advises PTs and PTAs to explore a wide range of opportunities. “Physical therapy continues to be among the most versatile of careers,” she says. “Within 1 profession you can explore so many different areas of focus. Human movement truly is a universal experience. When you are an expert in human movement, you can provide that expertise across the lifespan in
many settings. The profession always will present new challenges and new things to learn.”

Swisher is a professor and the director of scholarship within West Virginia University’s Division of Physical Therapy in Morgantown.

Galantino adds, “I tell my students: ‘You may think you know what you want to do in your profession. But always be open to other opportunities.’”

Best Advice
Each emerging leader and fellow was asked the best piece of advice he or she has received. Specifics varied, but there were some common themes.

“Just go for it,” Hill says, adding, “I’ve taken that advice from my parents and mentors through the years as different opportunities arose. Even if I was hesitant or was experiencing feelings of ‘imposter syndrome,’ I knew that I already had put in the work, and that all I needed to do was to jump in.”

“I took the residency challenge head-on with support from family, friends, and the amazing people within the program and department,” Hill continues. “Both the residency and working for the Section on Women’s Health provided me with so many opportunities to grow my skillset as a clinician and a professional.”

Jain’s advice is this: “Never settle or hesitate to do what is difficult. Set your goals high and work hard. When you’re uncertain about what choice to make, make the one that gives you the most options for the future. Be open-minded, and never fear taking on new challenges. Don’t be afraid of failure. Use it as an opportunity to grow and develop.”

Swisher says, “The best advice I received, and continue to receive, is...
to develop resilience. Our profession involves interacting with people who are vulnerable due to injury, illness, or loss of function. Our best gift to patients is our compassion, but it can be exhausting. So, find sources of strength to refresh your own resilience—faith, humor, friendship, the love of an animal. Don't wait until your ‘tank is empty’ to refresh yourself. I see many graduates and young PTs who are so eager to give that they burn out,” Swisher says, “especially under the demands of high numbers of patients, scarce resources, and working in a broken health care system. All careers have their good and bad parts. Don’t expect that yours will be exclusively one or the other. Find the balance, and keep your motivation focused on enriching the lives of people you meet.”

Galantino also speaks of avoiding burnout and the importance of self-care. “My postdoctoral research looked at the benefits of mindfulness and at burnout among health professionals. You can imagine the burnout in a system that requires seeing more patients with lower compensation. My advice: ‘Physical therapist—heal thyself.’ My research results showed that when we were able to reduce emotional exhaustion and achieve a trending downward of cortisol [a stress indicator in saliva], patient satisfaction increased. The happier and more mindful their practitioner was, the greater the patient satisfaction. That was an exciting finding.” [The February 2019 issue of PT in Motion will contain an article on increasing resilience to avoid burnout.]

Hageman volunteers, “The best advice I received is to purposefully meet and interact with inspiring peers and professionals. By doing so, I found a social network of trusted colleagues. In turn, these colleagues helped me build courage and take risks by saying ‘yes’ in ways I might never have dreamed. For example, my colleagues...
helped me say ‘Yes, I can’ testify at
a legislative hearing, ‘Yes, I can’ be
an effective APTA Key Contact to
our state senator, ‘Yes, I can’ be the
chair of an APTA section-sponsored
conference, and so on. Every new
connection and activity inspired me
to continue, even when the outcomes
of my efforts were less than optimal.
The power of having a trusted and
affirming network of colleagues still
gives me the confidence to want to do
more for our patients and profession.”

Steven George turns the question
around: “Instead of advice received,
here’s advice to give. First, never
lose focus on the big picture. Too
often, individual providers get a very
myopic view of what their role is or
could be. Being aware of what the big
picture is for a given patient problem
leaves one open to exploring different
ways of solving it. The big picture
often is where innovation comes from.

“Second,” George continues, “play to
your strengths as a physical therapist.
Realize that the perspective and
skillset that you bring to a team is
unique, and make efforts to maintain
that uniqueness. That doesn’t mean
being stubborn or obstinate about
what should be done. Rather, it means
making very clear how you would
tackle the problem and being eager
to blend that approach with those of
others on the team.”

Setting Goals While
Maintaining Flexibility

Having goals is important, but so is
flexibility. “I had lofty goals following
graduation,” Karim says. “While the
method I took to achieve my goals
wasn’t exactly what I had planned, I
kept my eye on the prize and tried to
enjoy the detours.”

Detours, as far as Karim is concerned,
are readily available to PTs and PTAs.

She explains, “Physical therapy is
a great career because there are so
many options. Regardless of how long
you have done something or have
been in a certain place, you always
can make a change. Life is too short
to wonder, ‘What if?’ Pursue what
excites you and take advantage of
mentors and networking opportuni-
ties. Identify people you admire and
engage in conversations with them.”

Ciolek suggests, “Take your time to
find your niche. When I became a
PT 30 years ago, we were strongly
couraged to go to an acute care
hospital so we could do rotations and
explore the various areas of practice.
My first experience was at a hospi-
tal system with acute care, a joint
replacement unit, inpatient rehab
unit, outpatient, sports medicine
practice, and home health. In 3 years,
I gained experience in each area and
discovered my love for working with
older adults.”

The Evolving Mission
Of Physical Therapy

Both the emerging leaders and the
Catherine Worthingham Fellows
addressed the evolving role of
physical therapy. Some, like Karim,
cited #ChoosePT. “We need to push
physical therapy as a natural, non-
pharmacological approach to pain
management,” she says. “So often I see
people who have acute and chronic
pain jump to non-evidence-based
approaches,” when being properly
informed could drastically alter their
lives and improve their outcomes.

“Equally important is advocacy,” she
continues. “The #ChoosePT move-
ment cannot be truly effective when
a patient actually choosing physical
therapy over opioids results in a
financial burden.” It must be conve-
nient and cost-effective for people to
access physical therapy, she notes,
and PTs must promote the fact that
they are direct-access care providers.

“Change is natural and ongoing, so
plan on it,” Hageman urges. “If we
truly value the professional skills we
offer to our patients and clients, we
need to take the initiative and find
opportunities within a changing envi-
ronment to meet community needs.”

Ciolek says, “Perfectly reflecting
this idea is the Maya Angelou quote
‘Do the best you can until you know
better. Then when you know better, do
better.’ We were technically trained to
look at specific problems and correct
them. Now we recognize the inter-
connections of the human body and
mind, and we need to be more holistic
to reach both individuals and larger
population groups.”

George advises, “Transitions can be
unsettling, and certainly there are
many transitions occurring right now
in health care. However, transitions
also provide opportunities to disrupt
established systems that may no
longer be fulfilling their original
intent. So, if you are just entering
the profession, look for ways to be a
positive disruption in health care by
keeping in mind that doing what is
best for the patient often is the only
beacon needed.”

Donald E. Tepper is editor of PT
in Motion. Jonathan Simkins is
a freelance writer.

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A DEEPENING FOOTPRINT

BY ERIC RIES
Across the country, PTs are stepping into primary care roles. The journey to wider integration is under way, but obstacles remain.

Tony Bare, PT, DPT, ATC, describes Bare Physical Therapy, his cash-pay private practice in Laramie, Wyoming, as “totally a primary care environment.”

(In 1994, the National Academies of Sciences, Engineering, and Medicine’s Health and Medicine Division, then known as the Institute of Medicine, defined primary care as “the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing within the context of family and community.”)

Bare practices across the gamut of physical therapy—pediatrics to geriatrics, orthopedics to neurology. He fashions orthotics in his garage. He performs cranial therapy in a side gig as part of the concussion protocol team for the University of Wyoming’s football team. He also volunteers twice a month at Laramie’s Downtown Clinic, which offers comprehensive primary health care to low-income, uninsured residents. There, Bare works as part of a collective unit with physicians, pharmacists, nurses, social workers, and other providers.

That last role reminds the retired US Army colonel of his experience in the military—in which physical therapists (PTs) are empowered to work at their full level of training and licensure, share responsibilities with other health care providers in an environment of respectful collaboration, and help get each patient to the right provider without delay.

“It’s a different mindset,” Bare says. “No one is ‘turfy’ about any individual patient.”

Business at Bare Physical Therapy is thriving, based primarily on word-of-mouth testimonials, its owner says. That’s not likely to happen in

“When you expand your physical therapy toolbox and treat patients effectively and efficiently, the PT naturally is going to become that individual’s go-to provider.”

— TONY BARE
a thriving college town that offers a variety of provider options “unless you’re doing something right,” he says. “When you expand your physical therapy toolbox and treat patients effectively and efficiently, the PT naturally is going to become that individual’s go-to provider,” he asserts.

Similar to Bare, Rebecca Byerley, PT, DPT, could describe from experience a compelling primary care model for physical therapist practice long before she opened her own private clinic—Elite Rehabilitation, in Soldotna, Alaska—in 2007. For 2 years in the mid-1990s, Byerley was the sole PT working in private practice in the Middle Eastern nation of Oman. There, she practiced within a model she later would replicate on the other side of the world.

“My private practice in Oman was consistent with what I’m doing now, in terms of having strong support from local physicians and medical facilities, and in terms of educating the community—I worked largely in an expat environment—about my availability. I was operating consistently in a primary care setting,” she continues—“examining and treating individuals, triaging them, and recognizing when care was needed that was outside the scope of physical therapy.”

In Alaska, which has unrestricted direct access to physical therapist services, “people walk in my door with a variety of issues, and I may be their first point of contact with the health care system,” Byerley notes. “So, I have to be able to recognize when something that’s presented as a musculoskeletal issue might, in fact, have another cause. I would describe a physical therapist in primary care as having a broad set of skills—clinical, professional, and administrative—and using those skills to evaluate and identify patient and client needs across a spectrum of presentations, while at the same time understanding and cultivating collaborative relationships with other medical entities,” she says.

Byerley is well-known in rural Soldotna, the town of fewer than 4,000 people where she’s lived for 22 years. Outside her practice, she volunteers at a variety of sports events. She scores diving competitions and provides swimmers with injury-prevention and triage services. In keeping with the National Academies’ definition of primary care, Byerley very much operates “within the context of family and community.”

Ivan Matsui, PT, brings a different perspective to PTs practicing in primary care environments. He’s the assistant chief of rehabilitation services at Kaiser Permanente Northern California and is on the faculty of both fellowship and residency programs at Northern California Kaiser Graduate Education. He’s also a fellow of the American Academy of Orthopaedic Manual Physical Therapists.

PTs have been practicing in primary care at Kaiser Permanente Northern California since the mid-1990s. As of this summer, the health care consortium encompassed nearly 4.3 million members, 21 hospitals, and 242 medical offices and other outpatient facilities. For many years PTs were embedded in family medicine departments, with their own dedicated treatment rooms. Patients were seen upon referral as well as without a prior visit with a physician. Because of growing membership and resulting space demands, Kaiser Permanente moved in 2016 to a “roving PT” model in which PTs no longer are embedded, but they field physicians’ calls by telephone while the patient still is in the examination room.

The process is described in “A Perspective: Exploring the Roles of Physical Therapists on Primary Care Teams,” a 2017 APTA document (see “APTA Resources” on page 30) that was sought by the APTA House of Delegates to investigate and identify the roles of PTs on primary care teams, the services of PTs that may qualify as primary care components, and current and future opportunities for PTs to integrate those roles into practice, education, and research:

The physician presents the case to the roving PT over the phone and, among other things, articulates the problem, question, or other circumstance that warrants a request for a PT’s 10-15-minute consult during the same office visit with the physician in the exam room. The PT helps the physician answer many different questions during these visits. The physician may call and request the consult to find out whether a presenting arm issue is arising from a shoulder impingement or a cervical radiculopathy—or on occasion, to specifically add to the physician’s decision-making with regard to further workup for cardiac, neoplastic, or other non-musculoskeletal disease. More common questions are whether or not imaging, physical therapy, or other specialty referral is indicated.

“People walk in my door with a variety of issues, and I may be their first point of contact with the health care system.”

—REBECCA BYERLEY
The results of such collaboration can be powerful, the APTA document continues:

*Often these clinical questions are explored and answered in the presence of both the physician and the patient. This is uncommon in most outpatient settings, and, inevitably, learning in these teams takes place by both clinicians. Immediately and over time the understanding of each other’s recommendations and practice are more clear and efficient. Besides the improved quality of care for the patient, collaboration between the physician and the PT has been cited as critical in program implementation.*

Matsui, who helped write the APTA paper, attests to all that.

“As a result of our history, physician teams at Kaiser Permanente Northern California are knowledgeable about what PTs bring to the table and are comfortable not only with sending us patients to treat, but also with asking us questions such as whether the patient has a back problem or a hip problem, or a shoulder impingement or a cervical radiculopathy,” Matsui notes. “Or, the physician might ask the PT whether the patient should

“[PTs] can come over to that exam room and provide tier 1 treatment or share our input, as the situation demands.”

– IVAN MATSUI

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**PRIMARY CARE and APTA**

The following are excerpts of House of Delegates and Board of Directors positions related to PTs in primary care. They appear in full in Appendix A of the document “A Perspective: Exploring the Roles of Physical Therapists on Primary Care Teams.” (www.apta.org/ScopeofPractice/PTRolePrimaryCare/

- **Primary Care and the Role of the Physical Therapist** (HOD P06-06-07-02) states that PTs “participate in, and make unique contributions as individuals or members of primary care teams to, the provision of primary care.”

- **Continuity of Care Record** (HOD P06-08-12-10) advocates for “the inclusion of elements of physical therapist patient/client management to key groups including: organizations that are creating CCR specifications and implementation guides, and standards development organizations that are creating terminology codes to be used in the CCR.”

- **Principles and Objectives for the United States Health Care System** (HOD P06-13-20-18) states that PTs “are integral to health care and health care teams, and make unique contributions that are essential for comprehensive health care, regardless of the model of health care delivery.”

- **Physical Therapists’ Role in Prevention, Wellness, Fitness, and Disease Management** (BOD P02-14-02-01) notes that PTs, “like most health professionals, are educated to provide services in the health services delivery environment.” It adds that, “Unlike many health professionals, physical therapists are also uniquely trained to adapt health recommendations to the community environment where individuals live, work, learn, and play.”

- **Physical Therapy as a Health Profession** (HOD P06-99-19-23) cites “promotion of optimal health and function” as the profession’s “primary purpose,” and notes that physical therapy “encompasses areas of specialized competence” to meet “existing and emerging health needs.”

- **Autonomous Physical Therapist Practice** (HOD P06-06-18-12) states the PTs “have the responsibility to practice autonomously in all settings, practice environments, and employment relationships.” Among the characteristics of that autonomy is “ability to refer to and collaborate with health care providers and others to enhance physical therapist patient/client management.”

- **Diagnosis by Physical Therapists** (HOD P06-12-10-09) states that when the patient/client is referred with a previously established diagnosis, “the physical therapist should determine that the clinical findings are consistent with that diagnosis.” It adds, “If the diagnostic process reveals findings that are outside the scope of the physical therapist’s knowledge, experience, or expertise, the physical therapist should then refer the patient/client to an appropriate practitioner.”

- **Annual Visit With a Physical Therapist** (HOD P05-07-19-20) recommends that “all individuals visit a physical therapist at least annually to promote optimal health, wellness, and fitness, as well as to slow the progression of impairments, functional limitations, and disabilities.”
“More and more PTs are working in primary care settings, which benefits not only patients, but also the health care system.”
— BILL BOISSONNAULT

The US Department of Veterans Affairs (VA), meanwhile, began a pilot in October 2017 that is embedding PTs in primary care teams at 7 medical centers and an outpatient clinic administered by the VA Midwest Health Care Network 23, which covers Minnesota, North and South Dakota, Iowa, and Nebraska.

“This initiative is extremely important,” says Mark Havran, PT, DPT, service chief of extended care and rehabilitation at VA Central Iowa Health Care System. “It mimics what the Department of Defense has long done at military treatment facilities. The goals are the same as in the military model—to improve timeliness to care and to reduce downstream costs.”

The results, says Havran—who is president of APTA’s Federal Physical Therapy Section—thus far are encouraging. “We’re seeing improvements in functional outcomes as reported by patients, reduced waiting time for physical therapy, less utilization of imaging, and fewer consults to specialty care.”

That bodes well for potential future expansion of the pilot to all 170 VA medical centers, Havran says. He hopes such expansion might, in turn, further nudge other health care systems to follow Kaiser Permanente of Northern California’s lead and better integrate PTs into primary care provision.

Such prospects energize Bill Boissonnault, PT, DPT, DHSc, FAPTA, executive vice president of professional affairs at APTA. As part of the VA pilot, he traveled to Minnesota in July to teach a course to an audience of PTs, physicians, physician assistants, nurses, and administrators on the PT’s role in triaging of patients.

“What the VA is doing is very exciting,” he says. “Besides the benefits to the health care system, the potential for this program to become a nationwide model has huge implications for the profession of physical therapy. It could have a domino effect in the public sector.”

Boissonnault, who has written a textbook on PTs in primary care, is encouraged by the profession’s trajectory over the past several years, while mindful of the challenges that lie ahead in deepening physical therapy’s footprint.

“More and more PTs are working in primary care settings,” he says, “which benefits not only patients, but also the health care system in terms of appropriate utilization of resources and decreased health care costs. We are experts when it comes to treating people’s musculoskeletal issues—back pain, neck pain, knee pain—and we’re well trained to triage patients with nonneuromusculoskeletal issues. That’s what I see growing in the future.”

Hurdles and Hope

The APTA perspective paper on PTs in primary care—compiled by a work group of association members that included Matsui and APTA staff that included Boissonnault—states that “PTs are well-positioned to provide a larger portion of ongoing primary care services, versus solely episodic care or entry-point encounter.”

Among the existing programs the document highlights to illustrate that point are the military and Kaiser Permanente Northern California models, as well as international models in Canada, the United Kingdom (UK), Ireland, New Zealand, and Sweden. Physiotherapists in the UK, for example, “have the jurisdictional scope of practice to make medicine recommendations, prescribe medications with a physician’s counter-signature, and perform injection therapy,” the paper notes.
But the APTA document concedes challenges to the advancement of PTs in primary care in the United States. They include:

**Terminology.** Outside of the National Academies definition, primary care-related terminology is inconsistent from state to state.

**Education.** Formal entry-level or postprofessional educational opportunities specific to practice in primary care don’t currently exist, and there’s no dedicated curricula on it in doctor of physical therapy programs.

**Regulation.** To date, the document notes, no state practice act designates or lists PTs as primary care providers. Furthermore, “direct access” typically comes with strings attached—“not only coordination with other patient providers, but oversight by a primary care physician or nurse practitioner following the initial evaluation or 30 days of treatment. Work in this area,” the perspective paper states, “needs to include adding regulatory language about the physical therapist’s ability to order and interpret specific imaging and lab tests, and to prescribe medications. If we are going to adopt the military system or that of another country,” the authors observe, “we have a lot of work to do in this arena.”

**Payment.** Medicare does not name PTs among practitioners who can be referred to as primary care providers. In hospital settings in the US health care system, physical therapy is billed as part of a group of services, as opposed to as an independent provider consultation. In outpatient settings, it is deemed a specialty that requires a patient copay. Many insurance companies won’t pay for physical therapy beyond the initial evaluation or beyond 30 days of treatment without a referral from a physician or other primary care provider.

**Public perception and population health.** Few members of the public view PTs as their primary care provider. To that end, APTA encourages annual visits to a PT for a checkout and offers resources, but the service isn’t much provided. Also, while the association supports PTs’ roles in health and wellness (see “Primary Care and APTA” on page 27), that area still is evolving in terms of expanding beyond individual health to community or population health. (Many PTs are active in community health, however, as highlighted earlier this year in PT in Motion.)

**Professional expectations.** APTA, the perspective document notes, “has not taken a stance or clearly defined the roles of physical therapists in primary care, the services they would provide, or a discrete plan to advance the profession under the primary care umbrella.”

To get a better handle on that last area, the association this fall surveyed association members who practice in primary care environments. The goals (survey results were pending at this writing) were to determine the key competencies of primary care delivery by PTs and the qualities that board certification as a clinical specialist might require (should such a designation be pursued). More than 8,000 individuals were asked questions related to knowledge areas, professional roles and responsibilities, and practice expectations in patient and client management.

The survey described prospective candidates as follows: “This specialist has advanced expertise to practice across the lifespan to both evaluate and treat clients across a wide spectrum of health conditions. This specialist may be working in a variety of settings, including a rural setting in which patient choices for health care services are limited, acute/urgent care, hospital-based outpatient, or private practice.”

One thing Boissonnault wants to make clear is that regardless of whether a new specialist certification in primary care is developed, “PTs won’t stop practicing in these settings.” To the contrary, he says, “I see more and more PTs becoming involved in primary care.”

While all of the challenges cited in the perspective paper are real, “those obstacles have been there for a long time,” Boissonnault observes. “We’ve already overcome a lot as a profession.
in just the past few decades. There’s now some form of direct access to the services of physical therapists in all 50 states, the District of Columbia, and the US Virgin Islands, and unrestricted direct access in 18 of them.”

Also encouraging, Boissonnault says, is that “more and more PTs are assuming administrative leadership positions in their workplaces—which is a really good thing, because it helps educate the decision-makers about the important roles PTs are playing and can play in primary care.”

He adds, however, that the profession “must do a better job in terms of outreach. We need to communicate more, and more effectively, with physicians, nurses, pharmacists, and other members of primary care teams. And we need to push more strongly for interprofessional education,” Boissonnault says. “Students and faculty from different health disciplines working together is a powerful way to raise awareness and understanding of PTs’ knowledge, level of training, and expertise—and of the difference they can make as their role in primary care expands.”

That’s one reason he’s so enthusiastic about the VA’s fledgling primary care model.

“So many PT students have clinical experiences within the VA system,” Boissonnault notes. “It’s important that PT students get exposed to innovative care models in which physical therapists can work at the top of their license. The more exposure students get to those types of opportunities, the better.”

Boissonnault encourages PTs to seek out interdisciplinary activities in their communities—such as the clinic at which Tony Bare provides services to low-income residents. “Typically, multiple disciplines are present in those

APTA Resources

“A Perspective: Exploring the Roles of Physical Therapists on Primary Care Teams”
(www.apta.org/ScopeofPractice/PTRolePrimaryCare/)

- Background and history, description of existing primary care models, benefits to society, challenges to wide implementation, and items for further consideration.

Direct Access in Practice Webpage
(www.apta.org/DirectAccess/)

- Links to articles, videos, and a podcast covering an array of aspects—from direct access in hospital-based settings and Medicare to integrating it into clinical practice, addressing payment issues, marketing tips, supporting research, and advocacy assistance.

Imaging Webpage
(www.apta.org/Imaging/)

- Articles, videos, postprofessional learning opportunities and more related to an important skill set for the first-contact practitioner.

Physical Therapy Outcomes Registry
(www.ptoutcomes.com/)

- Information on purpose and goals, benefits, and how to enroll. Visitors can request a free demo.

PTNow
(www.ptnow.org/)

- Clinical summaries, clinical practice guidelines, tests and measures, an article search, and more

Physical Therapy and Society Summit (PASS)
(www.apta.org/PASS/)

- Highlights of a think-tank summit in 2009 that was convened to empower PTs to be leaders in integrating innovative technologies and practice models, and in establishing collaborative interdisciplinary partnerships that address current, evolving, and future societal health care needs.
settings,” he notes—“physicians, medical students, pharmacists, nurses, occupational therapists. Physical therapists are working side-by-side with those providers to help people in the most efficient and effective way possible.”

Bare describes one such interaction at the Downtown Clinic. “I said to the physician, ‘I have a patient with cervical radiculopathy. What do you think about giving him Prednisone?’ She responded, ‘That sounds good. What dose?’ We have those kinds of conversations, in real time.”

Boissonnault urges PTs employed by health care systems that have a primary care model to lobby for inclusion of PTs on interdisciplinary teams if such inclusion doesn’t already exist. “There are models out there that PTs can use as templates to present their case,” he advises—citing the military and Kaiser models and the success of private practitioners such as Bare and Rebecca Byerley.

Data is another key to a wider role for PTs in primary care, Boissonnault says. “The promise presented by the Physical Therapy Outcomes Registry is enormous,” he says. “That data is going to show the effectiveness of PTs who are providing this type of care—which in turn will fuel programmatic development.”

**Patient Stories**

PTs practicing in primary care modes can offer countless examples of its efficacy for patients.

Byerley cites the case of a young adult who self-referred with lightheadedness and prolonged numbness in his arms and legs, but whose symptoms “didn’t add up.” He didn’t have nausea and hadn’t sustained an injury. The neurologic and physical tests she performed yielded “unremarkable” results. Byerley then elicited that her patient, an oil field laborer, had been cleaning equipment without wearing his protective body suit and face mask. She sent him back to his physician, who diagnosed chemical exposure for which the young man was successfully treated.

Expertise in differential diagnosis—determining a condition’s likely root cause by analyzing and synthesizing reported symptoms, medical history, and test results—is central to the skill set of PTs in primary care. Byerley also recalls the case of a patient in her 50s with thoracic pain who ended up being diagnosed with pancreatic cancer after Byerley sent her back to her family physician for additional medical review. Another patient came to Byerley for a “frozen shoulder”—pain and stiffness in her shoulder joint—but the underlying cause was determined to be breast cancer.

“Strong critical thinking skills are key,” Byerley says. “Is what the patient is reporting consistent with your clinical findings? If not, what might really be going on?”

Ivan Matsui recalls a recent Kaiser patient in her 80s whose pain and movement issues, a “roving” PT determined, stemmed from 5-day-old hip bursitis rather than the aftereffects of total hip replacement 2 years before. As a result, possible follow-up steps such as X-rays and additional referrals were avoided. Rather, the patient’s issues were resolved within 2 weeks through exercise and education. Not only that, the woman didn’t have to cancel a long-planned trip.

“She’ll be a happy camper when she goes to Lake Tahoe,” Matsui comments.

To instill patient confidence and thrive as a primary care provider in private practice, it’s imperative, Bare says, that PTs employ “all the tools in their toolbox” to fully explore the array of health issues that individual might be experiencing.

“Almost no musculoskeletal presentation is a simple 1-joint or 1-segment pathology,” he observes. “So, when a patient comes in to see me with shoulder pain, it might be mostly shoulder-related, or it might be mostly cervical spine, or it might be mostly gallbladder. But let’s say that based on the patient history and physical exam, I determine that the shoulder is the biggest pain contributor. So, I treat that.

“The next visit,” he continues, the patient doesn’t need the same shoulder treatment, so I treat the cervical spine—the next-biggest pain contributor. I continue in that manner through a few more visits, and the patient feels better on multiple levels. Now, chances are, I’ve got a patient for the long haul—someone who trusts me to help resolve whatever issue he or she is experiencing.”

Bare says he has tapped his knowledge of lower extremity biomechanics to resolve the heel pain of a patient who’d been misdiagnosed and ineffectively treated by various providers for 18 years. He’s resolved abdominal pain and constipation following hysterectomy by using manual and myofascial therapy for patients’ surgical scars and manual visceral therapy to address colon-related issues.

Bare says he got another patient off medication for acid reflux that the man had been taking for more than a decade—even though, he notes, that condition had nothing to do with reason the patient had come to see him in the first place.

“No one’s ever going to get referred to a physical therapist because he or she...
has heartburn,” Bare observes. “But that doesn’t mean that a PT can’t—by asking the right questions, calling on his or her clinical tools, and taking appropriate action—address and successfully treat that condition.”

Hence, he says, the word-of-mouth success of Bare Physical Therapy. “My patients refer me to their friends and family because they see me as a problem-solver. Some individuals come from Denver to see me in Laramie. That’s a 4- or 5-hour drive,” Bare observes.

Building a Culture

In a blog post5 that appeared on APTA’s website in September, career Army officer Jason Silvernail, PT, DPT, DSc, noted that a critical shortage of physicians in the US military during the wind-down of the Vietnam War gave rise to a “capabilities” care model that affords PTs primary care advantages over their civilian counterparts.

The model, as Silvernail described it, “determines what functions, or capabilities, need to be present for success, then identifies the resources to provide those functions.” In other words, PTs either see patients directly and pass them along to other team members as appropriate, or are in position to quickly treat individuals who are sent their way by another care provider.

Silvernail acknowledged barriers to widespread translation of the military model to civilian health care, citing “high copays and Medicare not recognizing PTs as primary care practitioners.” He noted, however, that those barriers are “based on health policy, not medical necessity or appropriateness.” He closed his post by urging his peers and the profession as a whole to “be willing to confront the policy obstacles that stand between Americans and the quality care delivered by doctors of physical therapy as part of primary health care teams.”

That’s the long game. In the meantime, there are 2 key messages from the military model that Brian Young, PT, DSc, believes need trumpeting in the civilian world: PTs in primary care roles pose no added risk to patient safety, and there is value in “cultivating a culture of PTs being frontlines providers.”

“A takeaway from the musculoskeletal realm in the military is that having PTs in primary care is safe—that’s been published in a large study,” Young tells PT in Motion. He’s the director of curriculum for the DPT program at Baylor University, having retired last year after more than 21 years in clinical, educational, and leadership positions in the US Air Force.

In the military, Young notes, “PTs are out there on the front lines in places like Iraq and Afghanistan, keeping soldiers healthy and able to continue their mission. We’re comfortable and confident in that role. It’s part of our culture in the military, and it’s important that civilian PTs adopt that mindset, recognizing what they can bring to primary care.”

Boissonnault agrees, noting that today’s new graduates already are getting a good introduction. “That ‘primary care culture’ starts in DPT programs, where students are being trained to provide that necessary broad level of service,” he says. “Students get academic grounding in differential diagnosis and medical screening necessary for patient triaging responsibilities.” Boissonnault adds, however, that “the more exposure students can get to primary care models during their clinical rotations—as in the VA model—the better, so they can see this type of care delivery in action and be fully appreciative of the possibilities and opportunities that exist for PTs in primary care.”

The bottom line, Boissonnault says, is that primary care presents “a huge opportunity for physical therapists, the profession, and the health system in terms of producing better care outcomes, ensuring optimal utilization of resources, and decreasing costs. There’s a gap in the provision of primary care that PTs are the best-trained providers to fill.”

Johanna Gabbard, PT, DPT, offers the last word on the subject. She recently retired after working for more than 2 decades as a clinical specialist for Kaiser Permanente in both northern and southern California. She was an eyewitness to the benefits that Kaiser’s PTs afford patients as part of the primary care team.

“Physical therapy to me is an art as much as it is a science,” says Gabbard,
“PTs are empowering patients in primary care to achieve optimal results.”

– JOHANNA GABBARD

who is a board-certified clinical specialist in orthopaedic physical therapy and a fellow of the American Academy of Orthopaedic Manual Physical Therapists. “The art comes in recognizing and integrating the intellectual, emotional, and physical needs of the patient, then using the best evidence and latest scientific knowledge to treat and/or triage that individual. PTs are empowering patients in primary care to achieve optimal results and to be the best they can be.”

Eric Ries is the associate editor of PT in Motion.

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Health Care Employment Rose 25,700 in September

Health care added 25,700 jobs in September following the addition of 33,000 jobs in August and 16,700 jobs in July, according to the US Bureau of Labor Statistics (BLS). That brought the total number of people nationwide employed in that field to 16,092,800.

Ambulatory health care services added 10,300, down from 21,100 jobs the month before. Employment increased by 4,100 in physician offices, 1,000 in outpatient care centers, and 1,300 in home health care services. Hospital employment added 12,000 employees. Community care facilities for the elderly added 1,100 jobs. Nursing care facilities added 200 jobs.

During the past 12 months, health care added 301,500 jobs.

Total nonfarm payroll employment increased by 134,000 in September, compared with an average monthly gain of 201,000 over the prior 12 months. Employment grew in several sectors—including professional and business services, transportation and warehousing, and manufacturing.

Meanwhile, according to payroll services company ADP’s monthly National Employment Report, private sector employment increased by 230,000, up from 163,000 in August. ADP, which uses a different methodology from that of BLS, calculated that employment in health care and social assistance increased by 37,000.

Other large gainers included professional/technical services (25,000), administrative/support services (38,000), leisure/hospitality (16,000), and financial activities (16,000).

Companies of all sizes reported gains. Small businesses (1-49 employees) added 56,000 jobs, medium businesses (50-499 employees) added 99,000 jobs, and large businesses (500+ employees) added 75,000 jobs.

Ahu Yildirmaz, vice president and co-head of the ADP Research Institute, remarked, “The labor market continues to impress. Both the goods and services sectors soared. The professional and business services industry and construction served as key engines of growth.”


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US House Members Echo APTA Call for Reduced Use of Prior Authorization

More than 100 members of the US House of Representatives are pressing for improvements to the way prior authorization (PA) is used—and often misused—in Medicare Advantage (MA) plans. The lawmakers’ call for changes echoes concerns voiced earlier this year by a coalition that includes APTA.

A bipartisan group of 103 legislators signed on to the October 10 letter to US Centers for Medicare and Medicaid Services (CMS) administrator Seema Verma, requesting that Verma direct the agency to conduct investigations into the use of prior authorization in MA, and to issue guidance “dissuading” MA plans from including requirements that impose unnecessary barriers to care.

“It is our understanding that some plans require repetitive prior approvals for patients that are not based on evidence and may delay medically necessary care,” the lawmakers wrote. “Many of these PA requirements are for services or procedures performed in accordance with an already-approved plan of care, as part of appropriate, ongoing therapy for chronic conditions, or for services with low PA denial rates.”

The letter underscores the message delivered to Verma earlier this year in a communication from the Coalition to Preserve Rehabilitation (CPR)—a group of 28 health provider, patient, and care professional and advocacy groups that includes APTA, the American Association of People with Disabilities, the American Occupational Therapy Association, the Brain Injury Association of America, the Epilepsy Foundation, the Michael J. Fox Foundation for Parkinson’s Research, and the Paralyzed Veterans of America.

The CPR letter suggested that CMS take its cue from the private insurance industry, which has been moving away from prior authorization, or at least investigate which prior authorization policies interfere with medically necessary care. The coalition also recommended that CMS impose greater oversight of MA plans, with “stronger directives to MA plans to limit the use of prior authorization to services that are demonstrably overutilized.”

The legislators’ letter to Verma referred to the efforts of “key stakeholders”—presumably CPR and other groups—and requested that “you and your staff engage with these organizations on additional opportunities to improve the PA process for all stakeholders.”

www.apta.org/PTinMotion/News/2018/10/15/HouseLetterMedicareAdvantage/

2019 Physician Fee Schedule Rule Brings PTs Into QPP

Many physical therapists (PTs) will face a new payment landscape beginning in January, now that the Centers for Medicare and Medicaid Services (CMS) has finalized the 2019 Medicare physician fee schedule rule, which moves certain PTs into the Quality Payment Program (QPP). That program, which includes the Merit-based Incentive Payment System (MIPS) and advanced alternative payment models (APMs), is at the center of a sweeping shift toward value-based payment in Medicare.

The final rule by-and-large mirrors the rule proposed by CMS earlier in the year. One welcome confirmation in the final rule is the end of functional limitation reporting, a fraught system that met with criticism from APTA since its implementation.

Other details on the rule are available on APTA’s Medicare Physician Fee Schedule webpage at www.apta.org/ Payment/Medicare/Coding-Billing/FeeSchedule. And read PT in Motion’s November 2018 feature “Moving Toward Quality Payment” for background on the QPP, available at www.apta.org/PTinMotion/2018/11.

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Study: Variation in Pelvic Floor Muscle Function Terminology Hinders Treatment Advances

Researchers use a wide variety of terms and definitions in published studies on pelvic floor muscle function (PFMF), according to authors of a study published in the October issue of PTJ (Physical Therapy). They say that it’s this lack of standardized terminology, combined with too much focus on how to measure versus what to measure, that may be hindering “effective communication, data gathering, and advances in the evidence-based approach” to treating urinary incontinence (UI). (APTA members may access the full article for free through the “sign in via society site” link.)

The study examined terms related to PFMF, as well as their “conceptual” and “operational” definitions, used in 64 cross-sectional studies in women with and without UI. The authors were particularly interested in how definitions of terms (or their lack) affected individual studies and the degree to which studies could be compared with each other.

For the PTJ study’s authors, a conceptual definition involved a description of what needs to be measured. For example, a conceptual definition of the term strength is capacity of a muscle to generate force. An operational definition could be a procedure, such as vaginal manometry, and an explanation of how it was performed.

The authors identified 196 terms used in the various studies and grouped them into 61 categories. For example, “strength” was used as an umbrella term for 11 other terms, such as “pelvic floor strength.” The authors then looked at how well the studies managed terms and definitions.

Here’s what they found:

- Only 29.7% of the studies included operational definitions of terms.
- A single study might use different terms to refer to the same muscle function.
- While “strength” was the most commonly researched muscle function, the term was conceptually defined in only 5 studies—in 3 different ways.
- The operational definitions of “strength” included both dynamometry (measurement of force or power) and manometry (measurement of pressure). However, several different scales were used, making it impossible to compare results.

“Concepts are the building blocks for all thinking,” the authors write. They warned against “operationism”—focusing on how to measure variables, as opposed to “what is relevant to be measured.”

“Once the concept being measured becomes synonymous with the measurement outcomes, even small changes in method produce a new concept,” the researchers write. “This leads to an increasing number of terms and definitions that make it difficult to gather and analyze data or generalize results. It also restricts a study’s results to its particular methodology.”

The study results “pose an urgent need to build and adopt a standardized terminology based on a sound theoretical framework encompassing the different disciplines, related areas, researchers and policy makers, in order to increase understanding of PFMF in women with UI and, hopefully, to provide higher quality of health care,” the researchers write.

www.apta.org/PTinMotion/News/2018/10/10/PelvicFloorTerminologyPTJ/
Getting at the Risk Factors for Falls Post-TKA

Up to a third of patients with total knee arthroplasty (TKA) experience a fall within 6 months to a year after surgery, but a new study suggests that PTs can reduce this risk by targeting specific deficits for intervention.

Researchers followed 134 individuals at a Hong Kong hospital for 6 months after TKA to determine falls frequency, circumstances, and risk factors. All patients had been referred for outpatient rehabilitation. The individuals all were between the ages of 50 and 85, with a primary diagnosis of knee osteoarthritis (OA). Results were published in PTJ (Physical Therapy).

Participants attended physical therapy 1-2 times per week for 8-10 weeks, beginning 2 weeks after surgery. Sessions included electrotherapy, mobilizing and strengthening exercises, and gait and balance training. At 4 weeks postsurgery, PTs evaluated knee proprioception, balance, knee pain, knee extension and flexion muscle strength, range of motion, and balance confidence. Patients also were given a log book to record any falls. After the evaluation, the authors followed up monthly to ask participants about any falls they may have experienced.

Researchers found that 23 participants (17.2%) had fallen at least once, with a total of 31 falls. Most occurred in the afternoon (58%) and while walking (67.7%). Most fallers (87.1%) were not using a walking aid when they fell. Falls most frequently were caused by slipping (35.5%) and tripping (35.5%). Nearly half of falls occurred at home, and nearly a third occurred in “another indoor environment.” These findings, the authors write, “highlight the importance in reducing hazards in the home that could cause slipping or tripping, especially in the early stages of recovery from TKA.”

Fallers were significantly more likely than were non-fallers to have had more severe pain and reduced proprioception in the operated knee, and to have had poorer sensory orientation prior to the fall. The authors write that “Deficits in knee proprioception, coupled with age-related declines in vestibular and somatosensory function, may challenge the ability to effectively reweight information from different sensory subsystems that maintain body equilibrium.”

Surprisingly, fallers also were more likely to be younger. “Younger participants may have been more physically active and subsequently more likely to engage in risky behaviors than our older counterparts,” the authors speculate.

They note that—age aside—these factors are modifiable and “warrant greater attention” in falls risk assessment, education, prevention, and intervention for individuals with TKA.

www.apta.org/PTinMotion/News/2018/09/14/TKAAndFalls/

For more on PTs’ role in TKA, check out APTA’s clinical summary at https://www.ptnow.org/clinical-summaries-detail/total-knee-arthroplasty-tka. It includes sections on prehabilitation and accelerated rehabilitation.

‘Go4Life’ Month Provides Healthy Aging Message

Although the National Institutes of Health’s “Go4Life” month wrapped up in September, the initiative continues to offer resources to providers and the public.

Strongly supported by APTA, Go4Life is an ongoing effort to connect the public and health care providers with information and resources related to healthy aging. In addition to information on how exercise improves health, the Go4Life website (https://go4life.nia.nih.gov/) includes suggested exercises, workout videos, fitness tracking resources, and access to printed materials including infographics, posters, bookmarks, and postcards—all available for free. The program also offers a “Speaker’s Toolkit” to help providers develop presentations to target audiences. It’s available by emailing Go4Life@mail.nih.gov.

www.apta.org/PTinMotion/News/2018/9/24/Go4Life/
Report Calls Surgery a Gateway to Opioid Addiction

The Plan Against Pain (PAP)—a national campaign that promotes nondrug approaches to pain management postsurgery—has issued a new report that focuses on the relationship between opioid prescriptions for surgical procedures and later opioid dependence and abuse. PAP calls surgery “a long-ignored gateway to persistent opioid use, dependence, and addiction.” The bottom line: The overall outlook remains bleak, with 12% of patients who had a soft tissue or orthopedic operation in the past year reporting that they had become addicted to or dependent on opioids after surgery. APTA’s #ChoosePT opioid awareness campaign is a Selected Partner of PAP.

The report, which tracks surgery-related prescribing rates overall and to 7 common surgical procedures—including total knee arthroplasty (TKA), total hip arthroplasty (THA), and rotator cuff surgery—also breaks down statistics by demographic and geographic variables. Researchers relied on data from the National Prescription Audit, the PharMetrics Plus Database, and surveys of 500 US adults who had soft tissue or orthopedic surgery in the past 12 months. In addition, 200 surgeons were surveyed to assess, among other issues, their motivations for prescribing opioids.

Among the findings:

**Overall opioid prescription numbers are declining, but state rates can vary dramatically.**

In 2017, enough opioids were prescribed to supply every person in the United States with 32 pills—only a slight decrease from the 36-pill rate reported in 2016. And while every state reported a drop in opioid use in 2017, those reductions varied widely, and the improvements for some states, while significant, only made a dire situation slightly better. Example: Alabama, the nation’s top opioid-prescribing state, recorded a 10% decrease in opioid prescriptions between 2016 and 2017, but that only brought its opioid pills-per-resident ratio down to 65 pills for every resident—still more than twice the national average.

**Progress has been slow in reducing opioid prescription rates related to surgery.**

Researchers found that among the 7 surgeries studied—TKA, THA, rotator cuff surgery, hysterectomy, hernia surgery, colectomy, and sleeve gastrectomy—the average number of opioid pills prescribed dropped slightly, from 85 to 82 pills per patient.

**The number of pills prescribed doesn’t tell the whole story. The use of fewer pills at a higher potency also poses a risk—especially for orthopedic patients.**

The study found that more than half the patients undergoing TKA, THA, and rotator cuff surgery were prescribed opioids of 50 or more morphine milligram equivalents (MMEs)—more than double the 20 MME dosage recommended by the US Centers for Disease Control and Prevention (CDC). Nearly 1 in 4 orthopedic patients received prescriptions in excess of 90 MMEs per day, an amount that the CDC says poses a serious overdose risk.

**The average rate of later opioid dependence and addiction among surgical patients hovered at 12%, but was higher for TKA patients.**

Patients who received colectomy reported the highest incidence of later dependence, at 17%, but TKA patients weren’t far behind, with a 15.2% rate of later misuse. Rotator cuff surgery and THA patients reported lower rates of later dependence, at 9.5% and 9.3% respectively. The 12% overall average is an increase from the 2017 study, which estimated the later dependence rate at 9%.

**Women—Millennial women in particular—are most at-risk for becoming “newly persistent” opioid users after surgery.**

Women were found to be 40% more likely than men to become “newly persistent” users—individuals who received opioid prescriptions 90 to 180 days post-discharge. Millennial women were found to be particularly at-risk, with more than 10% reporting persistent use, compared with 6% of Millennial men. The persistent use rate for Millennial women in the 2018 PAP study represents a 17% jump from the previous survey.

Authors of the report wrote that until better guidelines are developed it’s unlikely progress can be made in more careful use of opioids related to postsurgical pain. “[The lack of clear guidelines] has left surgeons mainly on their own in determining the appropriate quantity and strength of opioids needed to address their patients’ pain,” the authors wrote. “As this report reveals, the absence of clear guidelines has led to tremendous variation in prescribing patterns and a great deal of overprescribing that can lead to persistent opioid use, addiction, and dependence among patients.”

APTA has been heavily engaged in the fight against opioid misuse on several fronts. In addition to its flagship #ChoosePT opioid awareness campaign, the association hosted a Facebook Live panel discussion and satellite media tour to highlight the effectiveness of nonopioid approaches to pain management. APTA also produced a white paper on reducing opioid use and contributed to the National Quality Partners Playbook on Opioid Stewardship.
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For further information about the APTA Strategic Business Partner Program, please visit APTA.org/Partnerships.
8 Tips to Ensure Your Aquatic Therapy Investment Pays Off

By Troy Moore, PT, DPT

Seven years ago, I opened my physical therapy clinic in Great Bend, Kansas, on a shoestring budget. The first 4 years, we partnered with a nearby fitness center to use their pool for our aquatic therapy patients. While this presented some inconveniences, it was a good initial option for us. Our patients benefited from the pain relief, enhanced mobility, and improved balance that water offers, and we saved initial startup capital. However, one day a patient and I showed up to substandard pool conditions. I determined right then to buy my own pool.

We treated our first in-house aquatic patients more than a year ago. For the most part, adding water to our offerings has been a smooth transition. We avoided many mishaps, but we did make our share of preventable mistakes. The following are a few tips that will help as you contemplate your path to pool ownership.

1. **Analyze costs.** I was not willing to “cut down my corn”—ie, remove a revenue-generating treatment table—without knowing with a high level of certainty that an aquatic program would benefit my patients and my practice. Pools aren’t cheap. Neither are the associated costs that ensue. I developed an in-depth proforma to determine the number of patients we needed each week for this program to work. Take an unemotional look at your costs and potential income. Which leads to the next point …

2. **Study your current patient mix.** Who are you currently seeing? What are your top 10-20 diagnoses? Total knee? Total hip? General weakness? Could you add water to the current treatment plans of patients with those conditions and make a difference in their lives? For us, the answer was yes. Dig into those diagnoses and see if aquatics could benefit your current patient mix.

3. **Study your potential revenue sources.** Who else could you serve if you had aquatic therapy? Running groups, sports teams, fitness clients, more orthopedic patients? Reach out to these groups and the organizations that support them and develop relationships to create interest.

4. **Talk with your top referral sources.** After you’ve researched your current and potential clientele, take the next step by visiting referral sources. Ask them what they like and don’t like about aquatic therapy, their experience with it, and what outcomes they’ve seen. I did not do this! Later, a key referral source made clear that he does not support aquatic therapy. Had I known this beforehand, I would have approached him with less assumption and more collaboration.

5. **Talk with your staff.** When I began to seriously contemplate adding a water element to our clinic, I called an all-hands meeting and discussed the idea with our team. From their perspective, it’s much easier to put a patient on a bike than to figure out the logistics of water. So, I needed their buy-in. Their initial reaction was mixed. But after several discussions, everyone saw the potential benefits to our patients and were ready for the challenge and the necessary training.

6. **Talk with your clients.** While researching pools, I also made it a point to discuss aquatic therapy with as many clients as possible. This provided valuable feedback about barriers we would need to overcome to entice patients into the pool. Privacy, pool attire, and water temperature led this list. Before we opened the pool, we found solutions to these concerns. With current clients on board, we had a strong foundation for our program.

7. **See as many pools as possible.** Part of our intensive research to find the best pool was to see as many pools as possible. Being in central Kansas, this meant a lot of driving. I talked with several pool owners who shared with me their likes and dislikes of their systems, pool rooms, layouts, and programs. That information was invaluable. We ended up with a compact, freestanding unit with an underwater treadmill and resistance jets. I’m certain we avoided pitfalls that otherwise would have cost us time and money.

8. **Market your pool.** They will nod and smile, but people don’t really understand aquatic therapy until they see it in action, especially if you invest in advanced technology such as an underwater treadmill. We kick-started our marketing program by spending about $300 to make a short educational video showing our pool’s application. We bought a boost ad on Facebook for about $40 and received more than 4,000 views from our town of 8,000 people. But our most important marketing comes from existing clients—they see the pool, ask about it, use it, and tell their friends.

We are proud of our pool and the resulting aquatic therapy program we’ve built. I’ve seen water change lives. With proper preparation, research, and collaboration, facilities can confidently add aquatic therapy and provide the healing it offers. If you build it right, they will come.

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Troy Moore, PT, DPT, is the founder of Central Kansas Orthopedic Group Physical Therapy & Sports Medicine. In 2017, he presented a webinar, “How to Kickstart a New Aquatic Therapy Program,” through the National Rural Health Association (NRHA).
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Physical therapist assistants (PTAs) play a crucial role on the care delivery team, and APTA is bringing that message to multiple stakeholders. Here’s a rundown of some of the latest happenings in the association’s advocacy for PTAs.

**Now available: an estimated timeline for PTA inclusion in TRICARE.**

In December 2017, President Trump signed a National Defense Authorization Act that included a change long advocated by APTA: inclusion of PTAs in the TRICARE program used throughout the Department of Defense (DoD) health care system. However, like many federal-level policy changes, implementation wasn’t immediate, and it wasn’t clear just how or when this change would happen.

APTA can now shed a little light on the process. Informed by discussions with DoD representatives and others, the association has developed a timeline at [www.apta.org/Payment/TRICAREVA/](http://www.apta.org/Payment/TRICAREVA/) that provides a sense of just how long it might take for the TRICARE policy change to take effect. The process hinges on when the proposed rule is released to the US Office of Management and Budget (OMB) for review. That release triggers a timeline for a series of steps that involve publication in the Federal Register, a public comment period, and agency reviews. Because the OMB release hasn’t happened yet, and because various actions could take place before their deadlines, it’s hard to pin down a specific date for the end of the process. The only firm date associated with the change is that it has to happen by 2021.

**Yes, PTAs are included in TriWest.**

APTA also has received clarification that TriWest, the entity that oversees administration of the Department of Veterans Affairs “Veterans Choice” health care program in specific regions of the country, does in fact allow for treatment by PTAs. Unlike the TRICARE change, the TriWest statement describes the current environment and is not dependent on any wait for adoption of new rules.

**APTA continues to push back on CMS plans to adjust payment provided “in part” by a PTA.**

CMS is bound by law to establish PTA and occupational therapy assistant coding modifiers that will go into effect on January 1, 2020, and to include a Medicare payment differential beginning in 2022. The problem, in APTA’s view, is that the CMS approach—to assign the modifier to services provided “in part” by a PTA or occupational therapist assistant—could significantly restrict patient access to care, particularly in rural and underserved areas. The CMS approach is mentioned in its proposed 2019 physician fee schedule. APTA made its position clear in comments on the fee schedule, and encouraged members and other stakeholders to provide individual comments critical of the “in part” approach. Additionally, association representatives and representatives from the American Occupational Therapy Association (AOTA) met with CMS representatives in person to discuss the issue. At the same time, APTA and AOTA are advocating on Capitol Hill for Congress to commission a US Government Accountability Office study to examine how access to physical therapy and occupational therapy will be affected by the pending 2022 Medicare payment differential.

**APTA and Laurel Road now offer an option for PTA student loan debt refinancing.**

PTAs now have another option for reducing their student loan debt. APTA has expanded its partnership with Laurel Road, a national lending and banking company, to include student loan refinancing for PTAs. Under the new offering, PTAs who have worked for at least 1 year in the profession are eligible to apply to refinance their student loans to a lower rate.

“It’s important to be a member of APTA and to be engaged on these critical issues that impact PTAs, the profession, and the patients we serve,” said David Harris, PTA, BS, MBA, chief delegate of the PTA Caucus. “We all have a professional responsibility to do everything in our power to provide access to all those in need of physical therapy, and APTA membership gives us all a voice on the national level. Advocacy strengthens with every membership voice.”
State-Level PT Advocates Honored at 2018 Policy and Payment Forum

Recognition of the importance of nonpharmacological pain therapies, adoption of the physical therapy licensure compact, a higher-profile role for PTs in concussion management, and improving the legal scope of practice for PTs were among the accomplishments of this year’s APTA State Legislative Leadership and Legislative Commitment Award winners, who were recognized at the association’s recent State Policy and Payment Forum in Kansas City, Missouri. The event was co-hosted by the Missouri and Kansas chapters of APTA.

Four PTs were honored for their service to the profession at the state level:

Mark Bishop, PT, PhD, FAPTA, was presented with an APTA State Legislative Leadership Award for his work in Florida to address the opioid crisis. Bishop’s leadership and expertise was instrumental in the Florida Physical Therapy Association’s development of a legislative amendment, adopted into the Florida Substance Abuse Act, that requires prescribers of controlled substances to complete a 2-hour continuing education course on prescribing controlled substances that must include information on nonpharmacological therapies.

Cynthia Driskell, PT, also earned an APTA State Legislative Leadership Award in recognition of her achievements over 8 years as legislative chair for the Arizona Chapter of APTA. Her facilitation skills were most recently brought to bear on a multisession effort to include PTs among the providers empowered to make return-to-play decisions for athletes, and a successful effort to include PTs with a sports specialty certification in a concussion-management pilot program.

Derek Gerber, PT, DPT, of Idaho, was the third recipient of a State Legislative Leadership Award. He led a successful push to eliminate the state’s prohibition on dry needling by PTs, a change that was signed into law in March. Thanks to Gerber’s extensive involvement in the effort, Idaho now allows PTs to practice dry needling after they have completed specified education and training requirements.

Emilie Jones, PT, DPT, also was honored with the APTA State Legislative Commitment Award. Jones, who served 3 years as legislative committee chair for the Washington Chapter of APTA, was instrumental in addressing several crucial issues in the state, including assistive personnel revisions, progress on dry needling, and adoption of the physical therapy licensure compact.

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At the gym, my dad taught me how to use all the equipment and told me how movement and exercise helped keep him young so he could keep up with his teenaged daughter. That made quite an impression on me.

Something else that happened that day had an even bigger impact. There was a gentleman in a wheelchair at the gym who had lost use of his legs. Yet he was using the gym equipment to put his body to the test, stretching the limits of his abilities. I remember thinking, “This is what dad is talking about! This man will stop at nothing to get where he wants to be!” He wasn’t feeling sorry for himself or complaining about his limitations. Watching him, I thought about how so many people take their physical abilities for granted and get upset when a minor issue temporarily throws them off-track. The attitude of the man in the wheelchair was the opposite—he seemed to believe that the world was at his fingertips.

His example, combined with my dad’s words and actions, made me realize, right then and there, what I wanted to do. My mission would be to help others see and reach their full potential in all aspects of life—and to model that in myself.

Thus began my educational journey—which started when I was a teenager, extended through work in the fitness industry, PT school, and clinical practice, and will never stop. Over the course of time, I explored exercise science and physiology, the psychological aspects of the mind-body connection, manual therapy, dissection, sports performance and coaching, physical therapy, and how best to develop a lifestyle that addresses all the variables of human performance and longevity. I came to understand that the more knowledge and experience I gained, the more I learned about preventing and...
treating injuries, enhancing performance, and improving overall quality of life.

I made sure at the same time to practice what I’d learned and what I was preaching. How can you speak with authority on a subject if you haven’t experienced all the aspects associated with it, and if you haven’t tried to achieve the goals you’ve set for others? By making my own fitness and wellness a priority—by adding personal experience to my skills and my knowledge base—I enhanced my ability to anticipate results; modify training and exercise programs; detect common trends related to movement mechanics, injury, posture, and prevention; and recognize people’s potential to move and perform at higher levels.

But I also had to learn how best to share everything I’d learned in a way that was easy for my athletes and patients to understand and incorporate into their lives. I discovered that continuous learning and growing is, in a sense, a communication technique in its own right. People see my passion for what I do. When you give off positive energy, you inspire others to recognize their own potential and their ability to make a positive difference in the lives of others.

Not that my journey was easy. As I tried to build my career, there were beautiful times and tough times. I was told that I’d never be able to work with pro athletes because I was female. I was told, “Insurance won’t cover preventative care, so you’re dumb to consider it.” But I figured, if you’re going to do something, why not give it your all? Why not educate yourself and master your field—ensuring that you deliver quality services to everyone, regardless of their gender or age? You owe it to yourself and your patients. Put people before profits. The money will come as long as you treat people from your heart.

That reinforced another message my dad always conveyed: Be kind. Look past people’s faults and frailties. Try to see the good in them. In fact, treat them as if that good is the essence of who they are. You never know what someone else is going through, or the impact that a few sympathetic words or a helpful gesture can have. That’s a realization I carry with me through all aspects of my life. Am I perfect in making kindness my default? No, not any more than any of us. But that’s my aim. We all can grow and be better together. There’s no place for negativity or judgment.

We know that the brain develops nerve connections as we feed it new information to learn and analyze. Conversely, it’s been shown that nerve connections that aren’t stimulated stop being activated. “Use it or lose it,” in other words, is not just a figure of speech. The pattern extends to muscle length, movement patterns, motor control, and development of the central nervous system. So, why not use it? Why not learn as much as you can about your body and efficient movement? Why simply accept injury and aging? Why not, instead, try to optimize what you’ve got? Those are messages I share with people and model in my own life. Be kind to your body by educating yourself on how to keep it health and functioning efficiently.

Remember how I wrote that early in my career I was told to give up my dream of working with top athletes? I didn’t listen! I became the first full-time female physical therapist and strength coach in NASCAR and professional motocross, gaining 4 championship rings in the process. I traveled to races every weekend and worked with drivers such as Kyle Busch, Denny Hamlin, and Martin Truex Jr. Since then, I’ve built a patient and client base that includes the likes of college star and professional football player Saquon Barkley, as well as notable entertainment figures such as actor Mark Wahlberg and film and television director Peter Berg. My practice is thriving—the product of hard work, passion, and modeling the ethics and values that my parents taught me.

My life has evolved in incredible ways since I encountered that gentleman in the gym more than 15 years ago. He never knew it, but he ignited my passion for exploring the biomechanics of movement and the horizons of human potential. Each of us can have the same impact on others if we keep pursuing knowledge and spreading kindness and love.
22.6 MILLION

Expected enrollees to the Medicare Advantage plan in 2019, up 11.5% from 2018. This represents more than 36% of Medicare beneficiaries.

SOURCE

74%

Women who considered health care a critically important issue of the 2018 midterm elections—compared with 60% of men—in a June survey of Americans who said they were “absolutely certain” to vote in November.

SOURCE
Online survey of 1,100 Americans using Qualtrics Panels. www.genderwatch2018.org/what-women-want/.

45%

Patients who said “my out-of-pocket cost is affordable” reflected what they value most in receiving health care. It was the top statement chosen by respondents to a survey on health care value conducted by University of Utah Health. “My health improves” was chosen by 32%.

SOURCE

78.4%

Health care personnel who got a flu vaccination during the 2017–18 flu season. No surprise, employers that required vaccination had the highest coverage among health care personnel (94.8%). Workplaces with no vaccination-related requirements or provisions had the lowest coverage (47.6%). Offering free worksite shots for 1 day increased coverage to 70.4%, and active promotion to staff to get shots elsewhere raised coverage to 75.1%.

SOURCE

32

Schools participating in the American Medical Association’s Accelerating Change in Medical Education Consortium, which provides grants to schools to transform their curricula to better “prepare doctors for the rapidly changing health care landscape.” Existing and potential study areas include using electronic health records, training in leadership and team-based care skills, improving student well-being, and addressing social determinants of health.

SOURCE

57%

American adults who said they’ve received a medical bill they thought insurance would cover. Most respondents blamed the insurance company for the surprise bill rather than a hospital, provider, or pharmacy.

SOURCE

$46 BILLION

Estimated market for remote patient monitoring systems by the year 2020. One key driver: the need to reduce health care spending.

SOURCE
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AND LIVE THEIR LIFE!

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- Entrapment syndromes
- Intercostal neuralgias
- Other peripheral injuries or diseases

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