The Role of Therapy And Service Animals In Physical Therapy

PTs, PTAs, And Disaster Response

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I definitely had patients who I strongly disliked for various reasons— their health behaviors, their attitudes, their beliefs, their presumptions. In fact, I spent much of my first year in practice with a counselor, working through the dichotomy of wanting to care well for my patients yet having these negative feelings.

ZACHARY RETHORN, PT, DPT, in “BATTLING BIAS’S DISTORTED IMAGES” (PAGE 18)
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Looking at Physical Therapy Holistically

July 2019

Why do we have to keep repeating the same logical steps for optimal treatment of patients? When will this system/approach to medical care and treatment become the expected and understood approach to optimal treatment? What will it take to ensure that in America this is the basic expected system of medical care and treatment for all patients, regardless of the treatment or delivery care center?

Anne Kenny

Providing Onsite Physical Therapist Services

July 2019

There is such great value in providing onsite opportunities at the college and university level, especially if the institution has a robust physical therapy program. Live Every Day has worked closely with Massachusetts’ Springfield College to create an interdisciplinary clinic that allows learning from the classroom across programs in a consistent teaching environment. This allows clinicians to gain critical clinical education experience while exposing students to layers of learning between integrated clinical education, full-time students, and our orthopedic residency program. It yields well-rounded students entering the profession with repeated and consistent experiences from the clinical faculty to the Springfield College physical therapy program.

Matthew Calendrillo

Addressing Social Determinants of Health

July 2019

Excellent article and an important topic. But you start off talking about health care. Whether it is pro bono or aimed at marginalized populations, it is still health care, which is not addressing the social determinants of health. Yes, health care access is important, but later in the article you discussed more clearly the importance of housing, education, employment, transportation, and the role PTs can play in a community to improve these conditions. Providing pro bono care is important, and setting up clinics is, as well, but that charity work does not address the problem of the lack of social justice in these areas, whether they are domestic or international.

We must get PTs to work in public health and advocate for those who have poor outcomes by improving their social conditions, not just the health care they receive. We do that by voting, getting involved in communities, and changing social environmental conditions. Good start, but PTs need to know there is more to do than just providing charity care.

Ira Gorman

Ethics In Practice:
Beyond the Law

July 2019

In the past, I have seen physical therapists use aides as physical therapist assistants. I even had a colleague told by a treating physical therapist “that’s how things are run here” when she questioned why aides were doing the work of therapists. Certain outpatient clinics are all about numbers. They want to see as many patients as possible and don’t have the personnel to properly treat.

So, why not use an underpaid and underqualified aide to perform the tasks and bill for them? I’ll tell you why not. Because it’s unethical and illegal. And yet these larger companies continue to get away with it. It truly does sicken me to think that this takes place.

Carlos Lopez

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

May 2019

As a brain injury survivor from a car collision in 2000, I have had physical therapy over many years. The most valuable impact on my healing during therapy is cognition—the ability to have a clear mind and understand the value of therapy. Magic helps.

Performing magic will help with cognitive skills for those who have had a head injury or stroke. There are magicians who advocate magic for therapy in helping disabled people. David Copperfield sponsors Project Magic, and Kevin Spencer sponsors The Healing of Magic.

A person’s ability to attend to a task is enhanced by the process of learning a magic effect. This is true even of reading directions or watching an explanation on a DVD. A person’s attention skills are a necessary component of cognitive thinking. Magic is of great value in enhancing thinking skills, resulting in clearer thought patterns about life and one’s perspective on his or her disability. There is attention value in understanding how a trick is performed, and further benefit in the process of performing magic through a sequence of moves and verbal dialogue. That helps understanding of therapy goals and process cognition.

By having a clearer mind, I can make connections about how various exercises will affect my physical improvement. This has had a tremendous impact on my progress. Therefore, my interest in magic has been a catalyst in my physical improvement—helping not only fine motor skills but also general social and physiological aspects of improvement that are essential components of any physical therapy instruction.

The process of improving cognition is cumulative. The clearer the mind is in understanding the reasons for certain exercises, the more a person will apply and complete these exercises at home.

It has been said, “You can lead a horse to water, but can’t make him drink.” But you can salt the oats! Performing magic to improve cognition is the salt to affect attitude. This will result in a higher level of improvement through a better ability to see a connection for the therapeutic intervention.

William C. Jarvis, EdD

Physical Therapy for People With Autism

July 2018

Gracias por tan buenos aportes. Actualmente trabajo con niños con autismo como fisioterapeuta y los cambios son significativos para los niños. Cuando aprenden un buen comportamiento motor se les hace más fácil aprender actividades más complejas tanto sociales como académicas. Hay poca evidencia del trabajo tan importante de la fisioterapia en niños con autismo que cuando veo estos aportes, me alegra saber que ya se está dando un cambio.

Lester Alberto Rivas Tapia

[English translation]

Thank you for such great contributions. I currently work with children with autism as a physiotherapist, and the changes are significant for them. When they learn good motor behavior, they find it easier to learn more complex social and academic activities. There is little research on the important work of physiotherapy in children with autism. When I see these contributions, I am glad to know that a change is already taking place.

Lester Alberto Rivas Tapia
On January 26, 2015, the US Department of Health and Human Services (HHS) announced measurable goals and a timeline to move the Medicare program and the American health care system at large toward a “better, smarter, healthier” system in which payment to providers would be based on the quality, rather than the quantity, of care provided to patients.¹

A report published by the Health Care Payment Learning & Action Network (LAN) in October 2018² showed that, in 2017, 34% of US health care payments across all payer types—representing nearly 226.3 million people, or 77% of the covered US population—were tied to alternative payment models (APMs) based on value. Although that number constituted a “steady” increase from 23% 2 years earlier, it seemed clear that HHS’s goal of 50% APMs by the end of 2018 would not be met.

Why is it that even though 90% of payers expect APM adoption to accelerate, according to the LAN report, progress to date has lagged? The report cited the following as the top 3 challenges to APM adoption: willingness to take on financial risk, ability to operationalize these models, and interest or readiness of providers.

What about physical therapists (PTs)? Some PTs may feel the move to value-based payment more this year, with the inclusion of PTs in the Merit-based Incentive Payment System (MIPS). But many PTs still do not.

APTA has been talking about the shift to value for several years. In 2017, the association began surveying members³ to learn whether, in terms of payment, their current workplace reflects “Where We’ve Been,” “Where We Are,” or “Where We’re Going,” as described on page 9. The results are not encouraging: last year only 4% of survey respondents reported practicing in an outcomes-based environment in which most of their services were “paid for under an innovative or alternative payment model.” That compared with 10% of respondents who answered that way in 2017—a step in the wrong direction.

Heather Smith, PT, MPH, is APTA’s director of quality.
So, why the decrease? Contributing factors include the end of mandated participation in the Physician Quality Reporting System, scaling back of mandated Medicare Comprehensive Joint Replacement model areas, and the low number of APMs for rehabilitation providers.

**What Now?**

You may be thinking that value-based payment may never happen, or that PTs do not need to worry about these changes. But we do. The drive to become more efficient in health care while achieving good outcomes for patients is going to continue. Yes, there has been a slowdown on the Medicare side in recent years, but that is beginning to change, with more APMs being introduced and the inclusion of PTs in MIPS this year.

Also, commercial payers are increasingly interested in looking at value. What’s lacking is data. But that’s changing, too.

PTs who are participating in MIPS this year and using registries are collecting quality measures for all patients regardless of payer. This information could be used to demonstrate outcomes to commercial payers.

“In some markets,” notes APTA senior practice management specialist Elise Latawiec, PT, MPH, “PTs already have begun to contract with commercial payers using outcomes data to gain better payment rates.” She adds, however, “This has been very limited to date.”

Although we are talking about MIPS, the impact of value-based payment is not specific to outpatient therapists. Both the home health and skilled nursing settings are moving to new payment models this year that will focus on patient characteristics in determining payment—as opposed to volume of rehabilitation services received. Additionally, although not all PTs may be aware of this, all care settings are subject to value-based payment programs under Medicare. (See The Changing Quality Environment Under Medicare & Its Impact on PTs on page 12.)

The impact that PT services have on quality measures certainly will increase as we move toward more value-based payment models. For PTs in the outpatient setting, quality measures will be tied to the PT’s or the practice’s performance. For PTs in facility-based settings, including acute and postacute care,
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quality measures will look at the impact of all provider services on the facility’s performance.

Data-collection across all settings will push the profession, and health care, to use that information in practice to achieve the best outcomes possible. While many PTs are used to collecting and using data at the individual patient level, value-based care requires data’s use at the population level.

The need for population-level data will require many to invest in additional technology. Registries, such as APTA’s Physical Therapy Outcome Registry (the Registry; www.ptoutcomes.com), allow providers to look at a variety of quality measures at the population level to navigate value-based payment. While use of yet another technology may sound like an added administrative burden for PTs, the Registry is working with several vendors of electronic health records (EHRs) to extract the clinical data needed to calculate quality measures. This will yield robust quality reports without the need for significant added documentation.

What Should I Be Doing to Prepare?

As data will be the currency of value-based payment models, PTs must consistently collect and use it in practice. Recent studies have shown that while PTs in outpatient settings consistently collect data at evaluation, collection throughout the episode of care is significantly lower. This is a problem because, without consistent data collection across the episode of care, PTs will not be able to demonstrate their value on key quality measures such as those that look at functional improvement. Also, as the move toward functional outcomes continues, other key
The Changing Quality Environment Under Medicare
And Its Impact on PTs

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Abbreviations: Comprehensive Joint Replacement (CJR); Bundled Payments for Care Improvement (BPCI); Accountable Care Organizations (ACO); Postacute Care (PAC); Tax Identification Number (TIN); National Provider Identification (NPI); Quality Payment Program (QPP); Merit-based Incentive Payment System (MIPS)

variables—such as comorbidities, smoking status, and chronicity—will need to be consistently documented to consider the underlying health status of patients in quality measures, affording a more accurate comparison of providers and facilities.

PTs in all care settings also must plan to adopt EHRs if they haven’t already done so. There are several reasons why this shift in documentation is important. First, again, data can be extracted from EHRs for the purposes of quality reporting and use in clinical quality improvement. Second, EHR use standardizes documentation, helping to ensure that all clinically important information is collected, such as data on comorbidities. Finally, although PTs are not yet required to use Certified Electronic Health Record Technology (CEHRT)—which is required by many providers as a key component in APM participation—such use may be mandated in the future.

It’s important that PTs know about changes in their practice setting. APTA provides a variety of resources to that end, including webpages dedicated to value-based payment (www.apta.org/VBC/) and tools for navigating APM participation (www.apta.org/Payment/Medicare/AlternativeModels/).

APTA staff is here to help. We welcome questions at advocacy@apta.org.

REFERENCES


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YOUR future IS SO bright
All physical therapists (PTs) and physical therapist assistants (PTAs) are faced with the multiple demands of meeting patient needs, satisfying employer dictates, and working both lawfully and ethically. But those elements are not always in sync. Consider the following scenario.

Is the Phone Really Smart?

Patty has been happily employed as a PT by Right At Home Therapy Services for the past 15 years. She’s found the agency to be a model employer, taking a person-first approach to patient care and treating its employees—including a large number of PTs and a much smaller number of PTAs—with great respect.

In addition to providing home care for Right At Home, in recent years Patty also has worked for the company at The Cottages, a graduated-care community for seniors that features an assisted-living apartment building for individuals with complex medical conditions. In the building, Patty often works with Alex, a veteran PTA who the PT highly values for his skills, experience, and judgment. Alex, in turn, appreciates Patty’s supervision and guidance.

Patty particularly admires Right At Home’s willingness to exceed state practice act standards in the interest of high-quality patient care and safety. For example, although general supervision of PTAs by PTs is acceptable under the state practice act, Right At Home requires direct PT supervision, regardless of the payer. Both Patty and Alex feel that close proximity—Patty is on the premises even when she’s not in an apartment with Alex—makes their PT-PTA bond that much stronger and best ensures that patients receive optimal, uninterrupted care.

At a monthly staff meeting one Monday morning, however, Right At Home staff are surprised to learn that Right At Home has been sold to Excel Home Care—a much larger company that is making its first move into the state. Patty, Alex, and their colleagues are understandably apprehensive about the change, but they feel largely reassured when, during a “Ready To Excel!” welcome party a few weeks later, the company’s regional manager takes the microphone to announce: “We’d be crazy to change anything in a business
model that’s first and foremost a care model—a way of doing things that literally and figurative profits by putting patients first.”

Indeed, for the first few months, Patty and Alex continue working together at The Cottages exactly as they had before. The new owners also have undertaken extensive remodeling efforts that have brightened the facility’s physical appearance. In fact, staff’s only real “complaint” is that they’re gaining weight because Excel keeps the breakroom stocked with cookies from a local bakery.

But then things change. One day, Linda, the scheduler at The Cottages, informs Patty that Excel will be increasing Alex’s part-time hours and assigning him more patients, while widening the geographic area that Patty will serve and decreasing the amount of time she will be spending with people with complex needs at The Cottages.

“How’s that going to work?” a skeptical Patty asks.

“By smartphone!” Linda cheerily responds.

Alex isn’t happy about the situation, either. While he’s confident in his abilities and knows that Patty will never be more than a phone call away, “What part of ‘patients with complex needs’ does Excel not understand?” he asks Patty. “These patients benefit from your being onsite with me at all times. I benefit from that, too. The way we’ve been doing things isn’t broken, so why does anyone need to ‘fix’ it?”

“You’ve got me,” Patty says. “Let’s go speak with Leonard.”

Leonard is Excel’s onsite manager at The Cottages. He warmly ushers the PT-PTA teammates into his office and says, “I frankly anticipated your concerns, but if we’re going to continue to grow the company and bring outstanding service to increasing numbers of patients, we need to be fully utilizing the talents of every team member.

“Alex,” he continues, “I know that Patty highly values your abilities and your smarts. Well, so do we! In fact, we’re certain that you don’t need direct supervision. And, Patty, we see no reason that you and Alex can’t continue being as dynamic a duo at a slight distance as you’ve always been here at The Cottages at the same time. We’re in an era in which phones are smart,” Leonard adds, “and smart business is allowing every member of the team...
Considerations and Ethical Decision-Making

Patty and Alex are questioning the ethics of a situation in which neither the law nor their employers’ decision is on their side. They must consider their ability to alter Excel’s thinking, or, failing that, whether they should change jobs.

**Realm.** The realm is institutional/organizational. Excel’s decision about PTA supervision has implications for PTs, PTAs, and patients at The Cottages.

**Individual process.** Acting ethically in this situation will cause adversity to Patty and Alex by forcing them either to stand up to their employer—with uncertain consequences—or to seek new employment. Moral courage, therefore, is required of the PT and the PTA.

**Ethical situation.** This is an ethical distress, because both Patty and Alex believe they know the right course of action, but they have encountered a structural barrier to acting on it.

**Ethical principles and standards.** The following principles of the Code of Ethics for the Physical Therapist offer guidance to Patty:

- **Principle 2A.** Physical therapists shall adhere to the core values of the profession, and shall act in the best interest of patients/clients over the interests of the physical therapist.
- **Principle 3A.** Physical therapists shall demonstrate independent and objective professional judgment in the patient’s/client’s best interest in all practice settings.
- **Principle 5B.** Physical therapists shall have primary responsibility for supervision of physical therapist assistants and support personnel.
- **Principle 7A.** Physical therapists shall promote practice environments that support autonomous and accountable professional judgments.
- **Principle 7F.** Physical therapists shall refrain from employment arrangements or other arrangements that prevent physical therapists from fulfilling professional obligations to patients/clients.

The following standards of the Standards of Ethical Conduct for the Physical Therapist Assistant offer guidance to Alex and largely mirror the ethical principles applicable to Patty:

- **Standard 2A.** Physical therapist assistants shall act in the best interest of patients/clients over the interests of the physical therapist assistant.
- **Standard 3A.** Physical therapist assistants shall make objective decisions in the patient’s/client’s best interest in all practice settings.
- **Standard 5B.** Physical therapist assistants shall support the supervisory role of the physical therapist to ensure quality care and promote patient/client safety.
- **Standard 7A.** Physical therapist assistants shall promote work environments that support ethical and accountable decision-making.
- **Standard 7E.** Physical therapist assistants shall refrain from employment arrangements, or other arrangements, that prevent physical therapist assistants from fulfilling ethical obligations to patients/clients.

to operate as independently as his or her license allows.

“That in no way compromises patient care,” Leonard adds. “Rather, it optimizes staff usage.”

“I understand what you’re saying,” Patty responds, “and Alex knows that I have every confidence in him.” Alex smiles when she says this. “But I believe it should be up to the PT to decide what to delegate to the PTA.”

“And I believe,” Alex jumps in, “that the PTA’s comfort level should be taken into consideration in all situations. The patients who Patty and I are seeing aren’t The Cottages’ typical population. These folks have highly idiosyncratic needs—which makes close PT-PTA collaboration on their care all the more important.”

Leonard beams. “I love your dedication—both of you! It’s inspiring. You both excel—pardon the pun! And I can assure you that nothing is lost or goes by the wayside when onsite supervision is supplemented by general supervision when and where it’s needed. It’s been working for years for Excel—and, more important, for patients. It’ll work fine in this state, too. You’ll see.”

Later that day, before they go their separate ways for the evening, Patty and
Alex meet in the breakroom to discuss their lingering unease. Alex sums up the situation by saying, “I keep thinking of that saying: ‘Just because you can do something doesn’t mean you should do it.’”

Patty nods solemnly. Looking down at her chocolate chip cookie, she observes, “Somehow this thing doesn’t taste quite as good today as it usually does.”

**For Reflection**

In this scenario, general supervision of the PTA is lawful. Patty and Alex, however, feel that direct supervision is in patients’ best interest because it empowers the PT to exercise her professional judgment to its fullest extent and offers the PTA the reassurance that his supervising PT is onsite at all times for assistance in managing patients with complex needs. Have you been in situations in which you felt that the “letter of the law” and the goal of person-centered care were in conflict? What, if anything, did you do?

**For Followup**

If you are reading the print version of this column, go online to www.apta.org/PTinMotion/2019/10/Ethics inPractice/ for a selection of reader responses to the scenario, as well as some of 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.
Looking in the mirror is the first step.

By Eric Ries
Think of this article as the fourth part of an interconnected story in the pages of this magazine.

In June 2018, *PT in Motion* looked at the importance of the profession of physical therapy embracing cultural competence and striving to better mirror in its own composition the ever-increasing diversity of the American population.¹

In July of this year, the magazine examined the need for physical therapists (PTs) and physical therapist assistants (PTAs) to consider the role of social determinants of health in their interactions with patients and clients, and in subsequent clinical decisions.² (The US government defines social determinants of health as “conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.”)³

This August’s issue of *PT in Motion* followed up on the 2018 piece and looked at specific efforts by PTs, PTAs, students, and educators to better ensure that the physical therapy profession of tomorrow will reflect changing demographics and make all newcomers to the field feel welcome in a multicultural society.⁴

This feature concerns implicit or unconscious bias—which, The Joint Commission observes, “can lead to differential treatment of patients by race, gender, weight, age, language, income, and insurance status.”⁵ The organization adds, “This difference in treatment and clinical decision-making, though unintentional, could lead to failures in patient-centered care, interpersonal treatment, communication, trust, and contextual knowledge.”
The way that Zachary Rethorn, PT, DPT, looks at the interplay of all of these elements—cultural competence, efforts to diversify the physical therapy profession, consideration of social determinants of health and their role in exacerbating health disparities, and the broad effects of implicit bias in health—is this:

“If all we’re looking at is the patient in front of us—without respect to the environment within which that individual lives, grew up, and functions, and how that environment shapes that person’s beliefs, culture, and attitudes—we miss the boat. We’re not really treating the whole person.”

Human beings naturally like to think of themselves as nonjudgmental and bias-free, Rethorn notes. We like to think—we may even boast—that we treat everyone the same way. But there are 2 problems with that when it comes to physical therapy, Rethorn says. First, no PT or PTA—indeed, no one at all—is free of bias. Second, treating everyone the same isn’t desirable, because that approach doesn’t account for the different experiences and attitudes that each patient brings to physical therapy.

Factoring in the social determinants of health, then, “provides a neutral frame—environments within which individuals live, grew up, and functions, and how those environments shape that person’s beliefs, culture, and attitudes—we miss the boat. We’re not really treating the whole person.”

Rethorn, a faculty development resident at Duke University and a board-certified clinical specialist in orthopaedic physical therapy.

“The great thing about social determinants,” he continues, “is that they allow you to put your own biases to the side, if you can, and instead ask the patient, ‘How are conditions in your neighborhood shaping you? What is your community safe? Because all of those things can produce health disparities that may, in turn, impact the plan of care,” Rethorn says. “Or, rather, those elements should affect the plan of care—and how it’s executed. If that’s not happening, then we aren’t doing our job very well.”

When he was fresh out of PT school in 2015, however, he wasn’t thinking about any of those things.

Rethorn, who is white, grew up in upper-middle-class neighborhoods among people who looked like him. As he puts it, “My lived experiences”—including the composition of his faculty and classmates in his DPT program—“did not produce much contact with people from other cultures or ethnicities.” He adds, “I wouldn’t have been able to tell you what a health disparity was when I graduated with my DPT. It wasn’t discussed in the curriculum.” After graduation, however, Rethorn found himself working at an outpatient clinic in a low-income area of Chattanooga, Tennessee, whose population was predominantly African American.

It was far from a match made in heaven.

“Absolutely I came in with biases of my own,” Rethorn says now. “First, I’d concede that I had a hero complex when I started working there. I believed that I was going to fix people’s pain and movement problems. I thought that I’d deserve my patients’ thanks and praise for ‘fixing’ them.”

Such praise was not forthcoming. Most patients seemed wary of him. Some shunned him altogether.

“I think I also held some unexamined biases against people in poverty and racial minorities,” Rethorn reflects. “I definitely had patients who I strongly disliked for various reasons—their health behaviors, their attitudes, their beliefs, their presumptions. In fact, I spent much of my first year in practice with a counselor, working through the dichotomy of wanting to care well for my patients yet having these negative feelings. That’s part of what drove me to better understand the community and the societal-level drivers of health there—which, in turn, helped me reframe my negative feelings.”

Also, Rethorn says, “another part of working through my unexamined biases came from my church. I attended a very ethnically diverse church and was able to build close friendships with people of color who grew up in the community that I served—people who had long histories and lived experiences with health care providers and other white folks in the area. My friends gently but firmly challenged and changed my understanding of my cultural biases and my expression of them. That was invaluable.”

One of the big things Rethorn learned upon looking into the clinic’s history was that “not only did a lot of patients not trust me, but they had legitimate
reasons for that.” For example, “In the year before I started there, 14 clinicians came and went. PTs didn’t want to be there because the high no-show rate among patients meant PTs couldn’t get performance bonuses.” But Rethorn could see the patients’ perspective, as well: What incentivized them to show up, when they were likely to be seen by a new PT every time—or, at best, by a short-timer whose demeanor likely telegraphed ambivalence and an itch to leave?

Rethorn gradually won over patients partly by just showing up—week after week, month after month. But that hardly was all he did. He asked his patients a lot of questions about themselves and their lived experiences—taking his church friends’ advice to heart and striving literally to understand where people were coming from. He organized cookouts in the parking lot to which everyone in the community was invited. He took on an advocacy role, as well, working with the neighborhood association and city council to improve local sidewalks for better safety, utility, and recreation.

He stayed at the clinic for 3 years and spent a few additional months as a home health PT in the same community. “One of my patients ended up telling me, ‘For a white guy you’re not so bad,’” Rethorn recounts with a laugh. “That was one of the best compliments I received during my time there.”

He continues to receive occasional phone calls and texts from his former patients in Chattanooga, seeking advice or just wanting to check in. Many tell him that things haven’t been the same at the clinic since he left. His reaction to that is mixed.

“He said, ‘What if you do the same for me?’” Rethorn says. “That was great.”

For her part, Marie Vazquez Morgan, PT, PhD, will never forget a patient who’d sustained a spinal cord injury from a gunshot wound. “He was wearing a blue bandana, which in that particular place suggested gang membership. That was my immediate assumption,” she recalls. “It certainly explained the gunshot wound.”

To this day, Vazquez Morgan, now as associate professor in the Department of Rehab Sciences at LSU Health Shreveport in Louisiana, shudders to think what might have happened had her dialogue with the man and her body language toward him conveyed her bias—which at that point in her career she hadn’t yet identified and examined—that, if that individual indeed was a gang member, he “probably didn’t want to be there, wasn’t going to be a good patient, and probably wouldn’t adhere to the plan of care.” Such signals “would have been detrimental to the PT-patient relationship and to goal-setting with that patient,” she notes.

Upon close questioning, however, she learned that her patient had been shot accidently by his cousin, simply liked to wear bandanas, and hoped to recover sufficiently to put his recently acquired master’s degree to work. “Once I had the entire picture, he and I worked together to set the goals that were important to him,” she says.

Her takeaway, Vazquez Morgan says, was, “I had to do a better job of getting to know my patients. I needed to have some general understanding, at least, of the culture from which each person was coming.”

— MARIE VAZQUEZ MORGAN
“The more IATs you take, the more you’ll know about where your biases may lie. The tests are for self-knowledge and personal growth. What you learn from them will make you less likely to act on your biases and will help you be a better health care provider.”

– BERNADETTE WILLIAMS-YORK

and vice chair of the Diversity, Equity, and Inclusion (DEI) consortium of the American Council of Academic Physical Therapy (ACAPT)—says, “As a person of color in a profession that’s predominantly white, I’ve been in a number of situations in which my skin color has been perceived negatively. But we all have biases,” she acknowledges. “I’m not exempt or excluded from that.”

To better identify and understand her biases, Williams-York has taken tests offered by Project Implicit, a nonprofit that seeks “to educate the public about hidden biases and to provide a virtual laboratory for collecting data on the internet.” Subjects of the quizzes, known as Implicit Association Tests or IATs, run the gamut from race and ethnicity to gender, sexuality, religion, weight, and other matters.

The results that surprised her most, Williams-York says, were from the test on disability.

“I was like, ‘Wow!’ I had no idea I had biases there,” she says. “But now that I know that, when I come into contact with individuals with disabilities, I am much more conscious of my interactions with them and more focused on preventing my implicit biases from coming out in ways that could have a negative impact on them.”

Testing Self-Awareness

In fact, Williams-York advocates that everyone involved in the physical therapy profession—from school admissions officials, to faculty, to students, to PTs and PTAs—take as many IATs as they can as an important step toward battling the health consequences of implicit bias in patient care. And the pervasiveness of bias and its potential effects are substantial, the research shows.

Implicit bias is “generally consistent across studies, [which] suggests that clinicians have similar implicit biases to others in society.” It is “significantly related to patient-provider interactions, treatment decisions, treatment adherence, and patient health outcomes.” It needs to be addressed in health care, although “more research in actual care settings and a greater homogeneity in methods employed to test implicit biases in health care is needed.”

“The more IATs you take, the more you’ll know about where your biases may lie,” Williams-York says. “The tests are for self-knowledge and personal growth. What you learn from them will make you less likely to act on your biases and will help you be a better health care provider. Once we’re aware of what our implicit biases are, we’re going to be much more conscious of things like making appropriate eye contact, speaking in the proper tone of voice, sharing the best and latest information with patients in the most digestible way, and presenting the home exercise program in a manner that’s easy to understand and complete.”

At the University of Washington, Williams-York notes, since 2015 students have been allotted class time to take the IAT on race and are encouraged to take other IATs, as well. Additionally, since 2017 members of the DPT program’s admissions committee and faculty have been “strongly encouraged” to take the IAT test on race. Coincidentally, Williams-York reports, in recent years the number of the university’s DPT students identifying as African American, Hispanic, Pacific Islander, and multiracial has risen. The proportion of Caucasian students has dropped from 71% in the class that entered the program in 2015 to 50% this fall.

Although it’s impossible to know how increased student diversity within the DPT program and enhanced student and faculty awareness of their implicit biases may affect the future clinical actions of University of Washington graduates, Williams-York reasons that the effects can’t help but be positive.

“I’m hoping that our emphasis on addressing bias and enhancing diversity will become a trend,” she says, “and that other PT and PTA education programs will adopt these practices to confront implicit biases—and also to support APTA’s ongoing efforts to increase the numbers of underrepresented minorities in the profession.”

To the latter point, Williams-York notes several initiatives that the association is undertaking. “Making APTA an inclusive organization that reflects the diversity of the society the profession serves” is among the association’s strategic plan’s goals and objectives for 2019-2021. APTA already has in place at least 25 policies related to diversity, equity, and inclusion, and the association annually awards scholarships to students from underrepresented minorities. In addition, APTA has backed pending congressional legislation to provide federally funded diversity-based scholarships and stipends.

As Hadiya Green Guerrero, PT, DPT, sees it, “Tests like the IAT”—there are other tests of implicit bias, she notes,
but IATs are the best known and most widely used—“bring your biases to the forefront of your awareness. They may confirm biases you suspected you had, or they may highlight biases you had no idea were so strong. Once you’ve taken the test, you have a reminder. The next time a related bias shows up, in whatever form, you’ll be alert to zero in on it and try to mitigate any negative impact.”

Green Guerrero, a senior practice specialist at APTA, wrote a post on implicit bias for the association’s #PTTransforms blog in 2016.13 In it, she noted that “We all possess biases that impact every interaction we have with our patients,” and she presented illustrative examples of implicit bias in clinical practice. Green Guerrero concluded the piece by noting, “We may never rid ourselves completely of implicit bias, but we can be honest with ourselves and do whatever we can to see to it that our biases aren’t making clinical decisions for us. Our patients—all of them—deserve that much.”

The Role of Educators

Senobia Crawford, PT, PhD, directs the DPT program at Hampton University in Virginia. Recognition of the importance and value of diversity in physical therapy is inherent in Hampton’s mission as a historically black college, but Crawford laments the overall pace of progress. The profession (as reflected in APTA membership), its educational pipelines, and its student enrollments remain overwhelmingly white.3,14-16 And that, Crawford says, abets inherent bias by ensuring that fewer PTs and PTAs will share the lived experiences of the diverse patient mix they serve—and that patients, in turn, will encounter fewer PTs and PTAs who might best understand their concerns and enhance their comfort level and trust in the care they receive.

Crawford chairs ACAPT’s DEI consortium. She would like to see, in particular, implementation of the recommendations of the academy’s Diversity Task Force, on which Williams-York served. That panel’s report17 issued in 2016, urged in part, that:

- Physical therapy be better promoted as a viable career option for students from underrepresented minorities (URM),
- A new pre-DPT admissions structure be created to simplify standards and prerequisites across programs,
- PT education programs explore “new and creative avenues” to provide URM students with greater financial assistance,
- APTA and its Student Assembly team up to “reinvent” a mentoring network matching URM professionals with URM students, and URM students with URM prospective students, and
- Schools pool their URM data and “prioritize a research agenda to further understand factors and provide evidence to support URM student choice of a physical therapist career.”

Such efforts are vital, Crawford says, because, “When you talk about different issues in class and have people from many different backgrounds participating in the conversation, the dialogue is much richer than it would be if everyone’s experiences were similar.” Such dialogue, she adds, “presents a great opportunity for growth, learning, and change.”

PTs interviewed for this article cite a variety of ways in which PT and PTA education programs can and in many cases do inculcate bias awareness in students and seek to familiarize them with the lived experiences of people...
Given that everyone has implicit biases, PTs and PTAs often are on the receiving end of them—from both patients and peers.

Having grown up and begun her physical therapy career in South Africa, Thubi H.A. Kolobe, PT, PhD, FAPTA, had a lot of experience with bias before she came to the United States in 1978. That, however, was explicit bias under apartheid, the government’s policy of racial segregation and economic and political discrimination. In South Africa, Kolobe, who is black, worked in a 1,200-bed hospital that served black patients only. Of the facility’s 14 PTs, she alone was nonwhite.

A lot has changed in South Africa since then. In the United States, where bias against both practitioners and patients of color tends to be implicit, unconscious, or hidden—Kolobe calls it “bias with kid gloves”—much still needs changing, she says, more than 40 years after her arrival.

“When you talk about different issues in class and have people from many different backgrounds participating in the conversation, the dialogue is much richer than it would be if everyone’s experiences were similar.”

— SENOBIA CRAWFORD

When you’re the Target

The Power of Exposure

“Knowing your own biases is nothing without exposing yourself,” Green Guerrero says. That’s why she encourages PTs and PTAs to seek opportunities in both their professional and personal lives to interact with people whose racial characteristics, ethnic background, socioeconomic status, and PTA faculty and students, and among PTs and PTAs in the field. A researcher herself (in pediatrics), she’s well-versed in the literature linking health care biases, inadequate diversity, and health disparities among underserved populations.

Even now, Kolobe says, she’s sometimes talked around in meetings and roundtable discussions by white speakers who don’t make eye contact with her. She attends professional conferences at which sessions on diversity ironically lack diverse panelists.

Her proposed solutions start with the “low-hanging fruit” of ensuring that diversity- and social determinants of health-related elements (which reflect implicit biases) are incorporated into the case scenarios presented to PT and PTA students. Similarly, she says, continuing education courses and workshops for PTs and PTAs need to explicitly include diversity-related case scenarios and address implicit bias.

From there, Kolobe advocates that APTA and the Foundation for Physical Therapy Research join forces to seek out and fund innovative model programs to better educate students and clinicians about the value of diversity and the dangers of inherent bias. She urges that lessons culled from those programs, then, be broadly disseminated throughout the physical therapy profession.
Hadiya Green Guerrero, PT, DPT, who also is black, began encountering implicit bias very early in her professional journey, when she and several white DPT-student classmates entered a patient’s hospital room dressed identically, but the white patient assumed Guerrero was maintenance staff and asked her to take out the trash.

When she was working at the Mayo Clinic in Minnesota, in a couple of instances children described Green Guerrero as “dirty” because of her skin color—reflecting societal or parental biases. Another time, the father of a nonverbal patient tried to project onto his son fears of working with a black female PT that the parent himself clearly harbored.

“These are teachable moments,” Green Guerrero says. “The beautiful thing about kids is that they operate with their id but they’re usually very-open minded. I explained that I’m not dirty, just brown. I put my arm next to theirs and we compared. It didn’t come up again.”

Green Guerrero doesn’t kid herself that she vanquished the racial biases of the father of the nonverbal child. “But I did gain his trust in the way that I handled his son,” she says. In that particular instance, she not only exhibited strength of character by keeping things professional, but also physical strength that impressed the dad.

“I’ve power-lifted since I was 14 years old,” she says. “The patient was a big kid who’d undergone spinal realignment surgery, but I was able to handle him safely and effectively.” At one point, Green Guerrero overheard the father describe her on the phone as being “like Superman.”

Like Green Guerrero, Marie Vazquez Morgan, PT, PhD, and Bhupinder Singh, PT, PhD, have experienced their share of “teachable moments” with patients and colleagues. Vazquez Morgan came to the United States at age 5 from Argentina. Singh, who’s from India, is a Sikh who sports a full beard and wears a turban. He’s an associate professor in the Department of Physical Therapy at California State University, Fresno. Most instances of bias have been rather benign, they say—such as Vazquez Morgan fielding incorrect assumptions that she’s from a large family because she’s Hispanic.

But there have been a handful of times in his career, Singh says, when he has determined, “This person is too hung up on my looks and religion for us to be able to work effectively together.” In such cases, he says, “I think it’s my job as a health care professional to leave my ego out and refer that individual to a therapist who can better ensure the person gets the care that’s needed.”

“But I always try to take the conversation in a positive way,” Singh adds. “I don’t complain and say, ‘I am of the Sikh religion, and I came to this country after 9-11, so stop stereotyping me.’ I’m happy to talk about my background if people ask, and we then can move on to focus on the patient’s needs.”

Matt Huey, PT, MPT, also has faced bias based on his physical appearance. But he’s not a member of a racial, ethnic, religious, or gender-based minority. The way he dresses doesn’t attract undue attention. He’s simply a big, buff guy.

“I’m, like, 6-1 and 225 pounds,” Huey says. “I weightlift and run. So, I have a very muscular build. I also have a goatee. My wife has told me, ‘You have this resting angry face.’ But I’m not angry. That’s just how I look.”

Certain patients—older women especially—find Huey intimidating, he says.

“They’re reserved around me,” he says. “Nervous, timid. Short answers, lack of eye contact. They think I’d going to hurt them.”

He addresses that “resting angry face” thing by taking care to smile and do everything he can to appear unthreatening. He’s “very engaged” with his patients, making clear that he wants to know as much about their health issues and concerns as they’re willing to share—and that he’s there to help. He makes certain that patients know in advance every move he’s about to make—and why he’s going to make it. And he proactively talks about pain—why the individual is experiencing it, what’s needed to best address it, and, perhaps most important, that there’s absolutely nothing to be gained by his doing anything to exacerbate their pain.

Typically, Huey says, “patients who were clearly fearful of me come out of that first session feeling much more comfortable and ready for us to work together. They go from sometimes flat-out saying ‘You’re going to hurt me!’ to telling me, ‘Matt, you are the gentlest person.’”
gender role, religion, body type, or what have you differ from their own.

“If you feel uneasy around black people or Muslims, for instance, volunteer to work in a pro bono clinic, or seek work at a hospital or health center that serves people who are underserved and/or disenfranchised,” Green Guerrero advises. “Do your best to think about your biases and check them at the door. Seek to learn and understand what brought each patient or client to the clinic, what constitutes his or her biggest health concerns, and what barriers that person faces to optimal well-being and needed interaction with the health care system.”

“Similarly,” she continues, “instead of giving money or footwear to Shoes 4 Kids—or in addition to it—be part of that event at Annual Conference. Meet the kids who need the shoes and are thrilled to be receiving them. You’ll gain a little insight into their family life and economic circumstances. You’ll experience emotional uplift, for sure, but you’ll also add awareness and sensitivity that will help you be a better PT or PTÀ moving forward.”

Opportunities abound, Green Guerrero notes, to serve others while learning more about them—and, in the process, to educate oneself. “How about working with the Special Olympics, or with local events that give people with disabilities opportunities to enjoy the fruits of athletic competition?” she asks. “Any biases you might have toward that population are bound to be challenged by your exposure. It’s easy to stereotype what you don’t know, but it’s much harder to reconcile your unchallenged beliefs with the skills, determination, and effort you’re experiencing with your own senses.”

Unchallenged biases threaten to become “isms,” observes Johnette Meadows, PT, MS, director of minority and women’s initiatives in APTA’s Department of Practice—racism, sexism, et cetera. When that happens, “You’re a complete failure as a professional,” she says. “If you don’t make every effort to respect an individual by taking a thorough patient history, then working with that person to develop goals that are specific to his or her circumstances and needs, you have wasted that patient’s time. If you let your biases interfere with how you’re supposed to be performing your duties, it’s a big problem. You’re helping to perpetuate the health disparities that unfortunately are so evident in health care today.”

Eric Ries is the associate editor of PT in Motion.

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Therapy and Service Animals

IN PHYSICAL THERAPY
As an adjunct to physical therapist interventions, a well-trained animal often can make a difference.

BY CHRIS HAYHURST

Carolyn Tassini, PT, DPT, is confident in her skills as a physical therapist (PT). Still, she says, she always welcomes a little help, and she really appreciates assistance from her friend Seamus.

Seamus, she explains, is a highly trained therapy dog who’s played a role in her work for the better part of 8 years. The golden retriever and Labrador mix was bred and initially raised, with the help of a volunteer, through Canine Companions for Independence (CCI), a nonprofit organization in Santa Rosa, California.

CCI matches most of its dogs with individuals with disabilities, but some, like Seamus, are trained as “facility dogs” and are placed with professionals in a variety of settings. Early in her career, Tassini worked on the neurology floor at Massachusetts General Hospital and watched as a woman with a severe brain injury emerged from an extended period of nonresponsiveness during a visit from a therapy dog.

(Therapy dogs and service dogs serve different functions. Service animals are trained to perform major life tasks to assist people with physical disabilities, such as pulling a wheelchair or retrieving dropped objects. Therapy animals interact with many people. When used in animal-assisted therapy, they help PTs and occupational therapists meet goals that are important to a person’s recovery. When used in facility therapy, they work in hospitals, nursing homes, and similar settings. See “Animal Semantics” on page 30.)

“The first word the woman with the brain injury said was ‘dog,’” recalls Tassini, a board-certified clinical specialist in neurologic physical therapy. “I just stood there thinking, ‘This is amazing.’” In her next job, at MossRehab Center in Philadelphia, Tassini also worked with people with brain injuries. She noticed that many had pictures of their dogs in their rooms.

“I remembered that experience at Mass General,” Tassini says, “and something just clicked for me. Because of their [impaired] cognition and confusion, you really want to engage these patients in something that is meaningful and purposeful. I thought, ‘Wouldn’t it be great if we had a dog here that could really make a difference for them?’” She did some preliminary research and soon learned that therapists at Kessler Institute in New Jersey had 2 working therapy dogs onsite. She contacted the facility and paid a visit. “Once I saw the dogs in action, I realized that was exactly what I wanted to do.”

Fast forward more than a decade, and Tassini now is the rehabilitation supervisor at Bancroft NeuroRehab in Mount Laurel,
While service dogs and therapy dogs both can play a role in physical therapy, legally and functionally they are very different animals.

**SERVICE ANIMALS**

Under the Americans with Disabilities Act (ADA), a service animal is a dog “individually trained to do work or perform tasks for people with disabilities.” Examples or tasks include guiding people who are blind, alerting people who are deaf, pulling a wheelchair, alerting and protecting a person who is having a seizure, and reminding a person with mental illness to take prescribed medications. Properly trained miniature horses also can be used as service animals under current ADA regulations. Service animals are commonly referred to as “assistance animals.”

According to the US Department of Justice, “Service animals are working animals, not pets. The work or task a dog has been trained to provide must be directly related to the person’s disability. Dogs whose sole function is to provide comfort or emotional support do not qualify as service animals under the ADA.”

New Jersey. Seamus, who was born in 2009, partnered with Tassini in 2011 at MossRehab and moved with her to Bancroft in 2014. When the dog is not on the job, he lives with her and spends his days like a normal pet. At the clinic, however, it’s an entirely different story—especially when a patient might benefit from his help. “We don’t use him with everyone, because sometimes people have allergies or a fear of dogs, and sometimes we just have something else planned. When he does work, though,” Tassini says, “he’s an adjunct to the therapy—like a modality we might use for 15 minutes or half an hour.”

For example, she’ll often bring Seamus into a session when the goal involves working on the patient’s balance, or the individual exhibits 1-sided neglect. For a patient who is balance-challenged, she explains, she might have that person play tug-of-war with the dog. Or, she might have the patient bend down, pick up the dog’s leash, then walk the animal across the clinic floor.

“He’s an adjunct to the therapy—like a modality we might use for 15 minutes or half an hour.”

— CAROLYN TASSINI

**THERAPY DOGS**

Therapy dogs and other animals have been trained to interact safely with many different people. Although termed “pets,” their functions and abilities are used by PTs in interventions. As described by the Alliance of Therapy Dogs, “Therapy dogs also receive training, but have a completely different type of job from service dogs. Their responsibilities are to provide psychological or physiological therapy to individuals other than their handlers. These dogs have stable temperaments and friendly, easygoing personalities. Typically, they visit hospitals, schools, hospices, nursing homes, and more. Unlike service dogs, therapy dogs are encouraged to interact with a variety of people while they are on duty.” They are not afforded the same legal protections (such as access to public areas) as are service animals under the ADA.

Facility dogs are a subset of therapy dogs. As explained by Therapy Dogs United: “A Facility Therapy Dog is a highly trained and skilled therapy dog used to enhance the quality of life and education for children or adults with disabilities or special needs and Seniors. Facility dogs are handled by professionals and can be used to assist a select group of clients to better manage their daily tasks. Facility Therapy Dogs typically work hand-in-hand with therapists, counselors, guidance counselors, psychologists, and rehabilitation therapists.”
There are different types of, and functions for, therapy animals. Pet Partners offers the following definitions:4

**ANIMAL-ASSISTED INTERVENTION**
Animal-assisted intervention (AAI) comprises goal-oriented and structured interventions that intentionally incorporate animals into health, education, and human service for the purpose of therapeutic gains and improved health and wellness. Animal-assisted therapy (AAT), animal-assisted education (AAE), and animal-assisted activities (AAA) all are forms of animal-assisted intervention. In all these interventions, the animal may be part of a volunteer therapy animal team working under the direction of a professional, or an animal belonging to the professional.

**ANIMAL-ASSISTED THERAPY**
A subset of AAI, AAT is a goal-oriented, planned, structured, and documented therapeutic intervention directed by health and human service providers as part of their profession. A wide variety of disciplines may incorporate AAT. Possible practitioners could include physicians, occupational therapists, physical therapists, certified therapeutic recreation specialists, nurses, social workers, speech therapists, or mental health professionals.

A patient with 1-sided neglect, on the other hand, might be asked to pet Seamus using the affected extremity, or to throw him a ball in a close-up game of fetch. For the last several months, Tassini says, she and her colleagues have been conducting a study to determine how Seamus’ presence during treatment affects patients’ activity levels. “We’ve found that the difference often is drastic,” she reports—usually because the task suddenly becomes enjoyable. “There’s another level of motivation, and of effort and engagement, that we almost never see when we work with a patient on our own.”

**Animal Impact: Like “Magic”**
It’s unclear how many PTs currently use animals in their work. What is apparent, however, is that those who do so feel the animals are indispensable—an additional responsibility, to be sure, but one that pays dividends time and again.

“What Seamus can do is like magic,” Tassini says, describing a patient in the Moss medical unit who had been able to walk only 40 or 50 feet before needing extended rest. With the consent of the patient’s primary PT—Tassini worked for Moss’s brain injury service—she brought the dog for a visit, “and the patient immediately fell in love with him and asked if we could bring him on his walk.”

Carolyn Tassini (left) observes as a patient and Seamus play tug-of-war.

FOR MORE INFORMATION:
- Canine Companions for Independence: www.cci.org
- Assistance Dogs International: www.assistancedogsinternational.org
- American Hippotherapy Association: www.americanhippotherapyassociation.org
- PATH International: www.pathintl.org
- Therapy Dogs United: www.therapydogsunited.org/

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Tassini agreed, of course, “and we were about 25 feet into it, at his typical turnaround, so I asked him if he was ready to go back.” The man told her no, Tassini says, and continued down the hall, greeting everyone he saw. “He was like, ‘Look! This is Seamus, this is my dog!’ He kept going and going—a full loop around the unit. We walked over to the elevator and took it down to the cafeteria. He introduced Seamus to everyone in there, as well.” When they finally finished and returned to the patient’s room, he was tired but also elated, Tassini recalls.

Other PTs tell similar stories about facility dogs who have inspired patients to get out of their wheelchairs, client-owned service dogs who assist home-exercise programs, and even horses who have made a significant difference in their patients’ success in rehabilitation.

“I had a patient who had a severe brain injury and also was blind,” recalls Mary Beth Osborne, PT, DPT, now a senior PT with Duke University Health System. “He could remember his past really well, but he had a lot of trouble remembering where he was at that moment.” Osborne, a board-certified clinical specialist in neurologic physical therapy, had met the patient for a physical therapy session at the North Carolina Therapeutic Riding Center in Mebane. She’d volunteered earlier with the organization as a PT student, then continued on as a volunteer, and also to work with paying clients after graduation.

This particular patient had horse-riding experience, “so it was a very meaningful environment for him, and he bonded with the horses right away,” Osborne says. He’d get up on a horse, and “he could feel what normal walking movement felt like as the horse shifted its weight from side to side.” With the horse as her helper, she didn’t have to tell her patient what to do—which was good, because of his difficulty with short-term memory. Osborne—chair of the APTA Academy of Neurologic Physical Therapy’s Brain Injury Special Interest Group—instead could let him be in the moment as his body swayed and he naturally found his balance.

“Hippotherapy,” explains Osborne, “involves using the horse’s movement to achieve therapy goals.” (See “Purposeful Horseplay” in the March 2019 issue of PT in Motion for more on the subject.) “It’s not teaching someone to ride a horse; it’s getting them on a horse, then using the animal’s movement to improve symmetry, balance, posture, or something else.” In terms of physical therapy, she adds, “it goes along with motor learning principles and practice. People may not be able to walk for 45 minutes, but on a horse they can get that walking input—the repetition they need in order to understand what it takes to walk.”

Likewise, says Sheila Schaffer, PT, DPT, outpatient therapy manager at the University of Maryland Rehabilitation & Orthopaedic Institute in Baltimore, the rationale for using therapy dogs in physical therapy revolves around helping patients “resume their activities by giving them as much practice as you can.”

At her facility, a dog named Dayne lives with the institute’s director of therapy services. Dayne participates in physical, occupational,
and speech therapies, as well as therapeutic recreation services. The dog, she says, has been critical to the successful treatment of patients with brain injuries, strokes, spinal cord injuries, and amputations. “The goal in any session always is to work on skills—the functional activities that will improve the patient’s condition,” she notes. “If we think the best way to do that is by using a dog in therapy, then that’s what we’re going to do.”

On any given day, Dayne might be found playing ball or Frisbee with a patient in the facility gym, helping patients pick up dropped items from the floor, or opening a cabinet or refrigerator door, Schaffer says. Studies have shown that use of a therapy dog can decrease a patient’s heart rate and blood pressure while boosting endorphins and morale.2-6

Dayne’s presence during treatment almost always helps patients feel more relaxed, Schaffer says. “Even if he’s not directly involved in the therapy, he provides emotional support.” Patients with difficult conditions become more amenable to doing the hard work that’s required for healing when the dog is in the room, “and especially for people who have their own dogs at home, Dayne just being there while the therapist is working with them can help them make significant progress.”

Canine Collaboration

Marley Owen, PT, DPT, a staff PT in the pediatrics department at Shirley Ryan AbilityLab (SRALAB) in Chicago, also is familiar with the power therapy dogs can have to drive patients beyond their perceived limitations. SRALAB currently has 2 facility dogs—a pair of Labradoodles named Wrigley and Louie. Therapists including Owen and her colleague Colleen Zale, PT, DPT, OTR/L, MOT, who is both a PT and an occupational therapist in the organization’s Spinal Cord Innovation Center, schedule the dogs for patient appointments when they believe they can have the biggest impact.

Not long ago, Owen recalls, she was working with a teenage girl with Down syndrome who recently had undergone hip surgery. “She was afraid to move, especially in new ways, so she was having a hard time making progress.” The girl would talk about the pet dog she had at home, so with her permission Owen introduced the teenager to Wrigley and Louie. “One of the things she was having trouble with was transitioning to the floor and then standing up again.

“The goal in any session always is to work on skills—the functional activities that will improve the patient’s condition. If we think the best way to do that is by using a dog in therapy, then that’s what we’re going to do.”

— SHEILA SCHAFFER
SIZED FOR THERAPY:

Miniature Horses

While dogs are by far the most common animals employed in animal-assisted therapy, they can’t compete with miniature horses when it comes to their ability to turn people’s heads. “When you bring a horse into a facility, everyone wants to see it,” says Debbie Garcia-Bengochea, education director at Florida-based Gentle Carousel Miniature Therapy Horses. “In physical therapy especially, it can help distract from the really hard stuff. It just lightens the mood and gives people a lift.”

Gentle Carousel is an all-volunteer nonprofit organization that brings teams of miniature horses free of charge to hospitals and other institutions around the country. The horses go through a 2-year training program before they graduate to therapy-animal status. The program includes teaching the horses to walk up and down steps, ride in elevators, walk on unusual floor surfaces, carefully move around hospital equipment, and work in cramped patient rooms. They need to be able to calmly handle sounds such as ambulances, alarms, and hospital helicopters. And yes, they must be house-trained.

The horses work with medical professionals in oncology and intensive care units, and with physical therapists, occupational therapists, and speech-language pathologists. They support patients who have sustained strokes, traumatic brain and spinal cord injuries, amputations, and burns.

They also work up to 2 days a week in places such as UF Health Shands Rehab Hospital in Gainesville. Volunteer handlers accompany the horses during their visits with individual patients. When physical therapy is involved, handlers direct the animals according to the PT’s needs.

Garcia-Bengochea describes a patient she met at Shands who had come to physical therapy as part of his treatment for a burn injury. “Instead of just having him do regular exercises, the PT gave him a lightweight brush and he groomed the horse, reaching his arms back and forth.”

Another patient had been seriously injured in a fall, and the PTs weren’t sure if he’d be able to walk again. He was in an electric wheelchair and worked with several horses over many months. Garcia-Bengochea remembers a particular day when his favorite horse was in the clinic: “He said, ‘This is for you,’ and he stood up.” He eventually left for his home in New York, still unable to walk on his own, but he vowed that he would work to get better and would return to the horse for a demonstration. A few months later, the patient was back at Shands. “And just as he said he would,” Garcia-Bengochea says, “he got up and he walked to that horse.”

Gentle Carousel’s miniature horses are nothing like the pet miniatures some people keep in their homes, Garcia-Bengochea says. They’re taught to work safely around patients who may be in poor physical condition, she says, “so there are a lot of subtle things they do that most people probably wouldn’t notice.” For instance, she explains, if a patient is in a wheelchair, the horses know to keep their feet back to avoid interfering with the patient’s movement. Similarly, they stay away from people’s feet, “because many of the patients we work with are barefoot or in socks.” For everyone at Gentle Carousel, in fact, the primary concern, all the time, is patient safety, Garcia-Bengochea says. “And beyond that, it’s to make sure we provide a positive experience for everyone—not only for the patient, but for the PT as well.”

For more information: www.gentlecarouseltherapyhorses.com
University of North Georgia graduate students Tommy Otley (walking dog), Mitchell Aarons, and Erin McCarthy have been working with associate professor of physical therapy Sue Ann Kalish on guide dog research.

So I sat down on the floor with one of the dogs and asked her, “Do you want to come sit with me and the dog?” She transitioned right to the floor with no help whatsoever and started petting him like he was her own.”

Soon Owen was able to get the patient on her hands and knees to play with the dog by her side. After a while, Owen placed the dog on a table. That enticed the girl to stand up as well. “That session became one of the turning points in her therapy, because I saw what she could do when she wasn’t scared,” Owen says.

Zale says she’s seen adult patients experience the same kind of success working with dogs in their therapy sessions. One recent patient with multiple sclerosis depended on her walker to move anywhere, Zale recounts. “So, we wanted to challenge her—not to get rid of the walker altogether, but to see if she could do without it in certain circumstances.” The woman had several...
dogs at home, so Owen and Zale knew she’d be up for working with a facility dog. “We brought the dog in and she didn’t give it a second thought.” With Zale at her side to support her if needed, “she stood straight up and started walking on her own.”

Occasionally, Owen and Zale say, they’ll meet patients who bring in their own service dog to accompany them during treatment. “In a situation like that, we’re not going to bring one of our dogs in, but we’ll work with them just as if they were at home,” Zale says. If a patient, for example, is learning to use a walker, they’ll teach her to do so with her dog by her side. “It’s like working with any patient; it’s important to have what you do in the clinic carry over to their lives in the real world.”

At Your Service
One PT who testifies to the importance of the clinic-real world connection is Christina Durrough, PT, DPT, a staff clinician with Pi Beta Phi Rehabilitation Institute at Vanderbilt Bill Wilkerson Center in Nashville, Tennessee. The facility is an interdisciplinary outpatient clinic that works with adolescents and adults with a wide range of neurologic diagnoses. Like Owen and Zale at SRALAB, Durrough—a board certified clinical specialist in neurologic physical therapy—sometimes sees patients with their own service dogs, but most of the time the star of her clinic is a 4-legged friend who goes by the name of Norman. “Norman has been such a game changer,” she says. “He’s definitely the biggest celebrity I know.”

Norman, a Labrador-golden mix, is a certified facility dog who graduated from CCI last January. He lives at Durrough’s home and accompanies her to the clinic 5 days a week. When she walks him around the Vanderbilt University campus—or even down the sidewalk in her Nashville neighborhood—she’s sometimes stopped by passersby who wonder if he’s the dog they’ve heard about from their friends.

“He changes people’s lives,” she says. “He puts people at ease. Our patients all have been or are going through so much. They and their family members are stressed out. As much as we try to bring them comfort, there’s nothing we can do that comes close to what Norman does just by being there.”

The dog, she explains, engages and motivates people while accepting them for who they are. “He allows them to take a deep breath and relax. This animal doesn’t care that they can’t move 1 side of their body. He doesn’t care that they’re in a wheelchair. Around him, they feel like the most important person in the world.”

While the emotional support that Norman can provide often proves key to patient rehabilitation, the fact that he was trained to have the skills of a service dog means that he’s also ready to work physically as needed. “When he grad-

“He changes people’s lives.”
— CHRISTINA DURROUGH

uated he knew more than 40 commands, and since then he’s continued to learn,” Durrough says. Now with 50-plus commands at her disposal, she has used Norman with everyone from a 94-year-old patient with Parkinson disease to a 16-year-old boy with a severe brain injury.

She often deploys him for help during balance activities, but she’s also had him help patients remove their shoes and socks, and has used him for dual cognitive memory tasks. “I’ll put 20 different items on the floor and tell the patient to pick up all of them except for

Christina Durrough, facility dog Norman, and Durrough’s pet dog, Huckleberry.
the yellow ones, for example,” Durrough says. “When they come to a yellow item, they remember the specific instructions I gave them—not to get that one because it’s for Norman—and they can give the dog the command to pick it up.”

She can remember, from her days in PT school, how her professors would talk about the clinical-skills toolbox. Norman, Durrough says, is her “highest-utility tool,” one that consistently gets good results. “Whether it’s balance, strengthening, or whatever patients need to regain their independence, there are hundreds of things we can do to help them achieve their goals. But when Norman can be involved, people usually want him there. It’s a lot more fun when he is around.”

Chris Hayhurst is a freelance writer.

REFERENCES
PTs and PTAs have much to offer patients and health care teams before, during, and after disasters. Part of the challenge, however, is educating other providers about those benefits.
In August 2017, Jessica Jane West, PT, DPT, fervently tracked Hurricane Harvey’s progress. If it made landfall, there would be people who’d need help.

“The hurricane hit South Texas, and that area was destroyed from the winds. Then the rainstorm came and stayed over Houston,” says West, a Houstonian who works at MD Anderson Cancer Center. “We knew it was going to come through. But we didn’t know it was just going to stay there for 5 days. One part of town got 50 inches of rain in that time.”

West rode her bicycle through the flooded streets to the George R. Brown Convention Center in Houston’s downtown area. The 2-million-square-foot facility had been used as a shelter during past hurricanes Katrina and Rita. The hurricane made landfall on Saturday. By Tuesday’s end, the convention center was maxed out with more than 10,000 people—double the expected number of evacuees.

West signed up as a volunteer on the medical staff but found that the organizers didn’t know how to use her skills. “They didn’t seem to think that I belonged there. They didn’t have an assigned role for a physical therapist. I could tell that they had a system, working with the Red Cross, but that system was overwhelmed by the number of people there. So, when I arrived, they turned me away from providing any kind of medical assistance.”

At the tented medical area, West saw about a half-dozen workers tending to evacuees on cots that acted as hospital beds. Physicians and nurses cared for the most serious cases. Tables overflowed with bandages and over-the-counter medications. “They were equipped to deal with medical emergencies, but that was about it,” West recalls. “They weren’t taking care of the whole person, and I didn’t see a big role for myself in that medical tent. “Undoubtedly, the roles of the physical therapist and the physical therapist assistant were underutilized in this disaster situation.”

Jamie Dyson, PT, DPT, now president of APTA’s Florida Chapter, had similar experiences in 1992, when Hurricane Andrew devastated the state. “I drove down to Miami, and nothing was organized,” he says. “I told them I was a physical therapist, but nobody really knew what we could do. So, on my own, I went to an old site where I previously had done a clinical.”

“They told me to go check on a local patient who was on a ventilator,” Dyson continues. “The ventilator was running on a generator, and they were running low on fuel. The volunteers weren’t sure how to move this person or how to safely mobilize him—other than putting him on a gurney and carrying him away. The patient needed a lot of equipment. And they would have left all that equipment there because all they were concerned about was moving the man.”

While there typically is no statutorily assigned role for physical therapists (PTs) or physical therapist assistants (PTAs) in the event of disasters in Florida, Dyson is working with state officials to change that.

“I could have played a bigger role in helping before, during, and after disasters,” he says. “PTs and PTAs have something to offer during all 3 of those times, and we need to raise awareness of that potential. We’re in emergency departments and acute care hospitals. We treat movement disorders, and many such disorders can occur during and because of these disasters. It is our professional responsibility to work at the highest level of our education. It also is our professional responsibility to inform others that we are ready and able to assist in times of disaster.”

The PT and Preparedness

The first step to involvement in disaster service is to be part of the planning process—and that begins in one’s own community, says Laura Cohen, PT, PhD. She is certified by the Rehabilitation Engineering and Assistive Technology
"Often, [volunteers] don’t know how to do simple things like disengaging the motor on a power wheelchair."

- Laura Cohen

Association as an assistive technology professional and a seating and wheeled mobility specialist. Educating the health care community about the potential roles of PTs and PTAs begins locally, Cohen says, emphasizing that both health care and responder personnel need such awareness. She suggests that PTs reach out to disaster preparedness and volunteer groups, as well as medical organizations, to educate them before a disaster strikes.

"Everything is done locally when it comes to emergency disaster planning and action," says Cohen, who also is a member of the Medical Reserve Corps, a national network of volunteers under the US Department of Health and Human Services that engages local communities “to strengthen public health, reduce vulnerability, build resilience, and improve preparedness, response, and recovery capabilities.”

“Emergency planners have different actions and an emergency operation plan that has a surge plan protocol. They have job action sheets that relate to protocols, rules of engagement, and a playbook. There is an opportunity for physical therapists to bring value to emergency planning and the emergency operation plan to help educate first responders,” Cohen says.

Disaster locations frequently fill up with eager volunteers who may not have the knowledge or skills to safely lift or transport victims. For example, Cohen notes, “Often, they don’t know how to do simple things like disengaging the motor on a power wheelchair. That is a great place for us to plug in, where we can bring value.”

If PTs and PTAs participate in the planning stages, she says, they can help others identify needs and locations where their peers would be useful. “When do you call a PT?” she asks rhetorically. “I am a member of Virginia’s Medical Reserve Corps, but I have never been used. Even down at the mall when they have special events, they have first aid tents. I can take blood pressure, or, if someone twists an ankle, I can teach that person to use crutches or a cane. But we’re not even on the list of people who can be of service.”

In addition to her work in the emergency room at Cincinnati VA Medical Center, Stephanie Christman, PT, DPT, is a PT in the United States Army Reserves. She also is part of the Disaster and Emergency Management Personnel System (DEMPS), the Veterans Health Administration’s main program for deployment of clinical and nonclinical staff to an emergency or disaster.

“Health and Human Services helps coordinate the federal responses to these disasters. It can call on the VA to deploy members of the DEMPS team to sites to help with emergency management and response,” Christman explains. “I was deployed for Hurricane Maria in Puerto Rico as a member of the DEMPS team.” She served in a Federal Medication Station (FMS), which she describes as basically a field hospital, in the sports arena in Manatee, Puerto Rico.

She adds, “Health and Human Services stages before a disaster when we know a major event is going to happen, so that we have teams on the ground. But typically we don’t get there until after—in the aftermath of whatever the emergency is.”

In advance of a disaster, Christman says, PTs and PTAs should connect with other clinicians to let them know their capabilities. “You have to have a strong enough personality and communication skills to exert your authority and expertise without being
threatening,” she says. “Once we educate our coworkers on what we can do to help them, as well as the patients, it is amazing to see the magic that can happen. You can lend them your expertise, and they can lend you their expertise. It is probably the most important thing you can do.”

If you intend to be part of disaster management operation, Christman advises, beef up your skills—particularly in areas of relative weakness. “For example,” she says, “if you are a PT with orthopedic skills, you need to be ready to perform acute care and get familiar with early-injury management of fractures. Becoming a better-rounded PT also lends itself to being prepared to be deployed, because you have to be willing to do whatever needs doing. You don’t get to pick and choose in a disaster.”

Megan Mitchell, PT, DPT, trains to anticipate disaster response as a member of the Lakewood Community Emergency Response Team (CERT) in Colorado. The term “disaster,” in her opinion, should be left very broad. “Internationally, the role of the physical therapist in disaster response is undefined, but we are helping to conceptualize what our involvement could look like in the US,” she says.

“In Colorado, we’ve had several incidents over the past 12 months in which even in small communities we’ve had avalanches, flooding, and evacuations that have needed all hands on deck to respond. We need to be able to use every resource available, and that requires including the skill set of physical therapists,” Mitchell says. “In the field, as part of search and triage, or even the search and rescue team, we can assess the medical stability of a patient in the field to help with the triage process and extrication of a survivor.

“As a PT,” she continues, “my specialty is movement, and I can help move people out of the field, and train and educate other first responders in body mechanics so they don’t injure themselves. I can help relieve some of that physical burden so they don’t develop ‘provider fatigue.’ PTs also can help with basic emergency care, as West discusses. First responders typically are focused on rescue and relocation, not on the equipment people may need immediately after rescue. “My experience is working in assistive technology with people with severe disabilities who use power wheelchairs or custom and expensive seating systems that might be molded to the person,” she notes. “In emergency situations, users often are separated from their equipment. Many nonprofits come in with big containers full of wheelchairs and cushions, but they don’t have skilled, knowledgeable people matching the technology to the person. PTs can develop modules and trainings to help first responders and rescuers in a playbook.”

Cohen recognizes the dilemma of equipment being separated from its user and offers this suggestion: “If you are going to rescue somebody and you can’t rescue the whole chair, take a picture of it. Get a picture of the serial number so that we can recreate it if they become separated. If you can’t bring the whole power wheelchair, maybe you can remove the wheelchair seating or the more expensive components, so the equipment can be put back into action faster. The turnaround time for people to get something new can be lengthy. With no medical records—which could be lost—it can take up to a year to get a replacement. If you have a serial number, however, the manufacturer can tell you exactly what was on that chair. Physical therapists can bring value to emergency planning and the emergency operation to help educate first responders.”

PTs also can help with basic emergency care, as West discovered when she arrived at the Houston facility. “Another friend who had some experience with wound care had a bag full of wound care equipment,” she says. “There wasn’t a clear place for us to help in the medical tent area, nor was there a clear area where we could have provided much assistance. While walking around, we found needs that weren’t being addressed. We found a couple, both of whom were in need immediately after rescue. “My experience is working in assistive technology with people with severe disabilities who use power wheelchairs or custom and expensive seating systems that might be molded to the person,” she notes. “In emergency situations, users often are separated from their equipment. Many nonprofits come in with big containers full of wheelchairs and cushions, but they don’t have skilled, knowledgeable people matching the technology to the person. PTs can develop modules and trainings to help first responders and rescuers in a playbook.”

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wheelchairs. One of them had ulcers, and the leg wrapping had gotten completely immersed in the floodwaters.”

In addition, West found, people with mobility issues often were hemmed in by other cots and patients. “Many people didn’t seem to want to ask for help, but they clearly needed it. One woman had soiled herself and had been in that condition for at least 12 hours,” West recalls. “There was little accessibility for people with handicaps. The George R. Brown Convention Center has handicapped-accessible bathrooms, but she clearly needed assistance getting there. No one was helping these people go to the bathroom or access everything in their area.”

West also noticed that many people didn’t have their medications. Further, there was a need for screening. “They needed someone to come and talk to them and screen them and see how serious it was that they didn’t have their blood pressure or diabetes medications. One man was about to experience a medical emergency if he didn’t get his medications,” says West. “Sometimes their health literacy is low, or they’re in shock about what’s going on, so they’re not problem-solving these things well. We would start talking to them and find that about half of them had some significant conditions that needed to be addressed before they became major problems. Typically they were medication-related. So, I would walk them over to the medication tent and connect them with a nurse.”

Cleaning Up

Sharon Gorman, PT, DPTSc, is a board-certified clinical specialist in geriatric physical therapy who volunteered during the aftermath of Haiti’s earthquake in 2010. “When I got there at the 6-month anniversary, there still were a lot of rehab needs,” she says. “The facility where I was working had some prosthetists who were volunteering from Central America. Because so many people experienced limb loss during the earthquake, we had a specific emphasis on

Resources

APTA
The American Physical Therapy Association promotes the highest use of PTs and PTAs in disaster planning and management by providing resources to members and reaching out to related agencies. The House of Delegates has recognized the importance of these activities and in 2018 charged APTA to engage and collaborate with disaster management agencies to identify the professional roles of the PT and PTA in disaster preparation, response, relief, and recovery. APTA also is expected to promote the role of the PT and PTA to members and to agencies that study and manage disasters so that PTs and PTAs can contribute their expertise appropriately. Following is a sampling of APTA’s online resources.

Emergency Preparedness
www.apta.org/DisasterPreparedness/

Fact Sheet: CMS Finalizes Emergency Preparedness Requirements for Medicare and Medicaid Providers
November 2016
www.apta.org/EmergencyPreparedness/FactSheet/2016/CMSRequirements/

Compliance Matters: “Before Disaster Strikes” (PT in Motion) October 2013
www.apta.org/PTinMotion/2013/10/ComplianceMatters/

“The Role of Physical Therapists in Disaster Relief” (PT in Motion) May 2011
www.apta.org/PTinMotion/2011/5/Feature/DisastersRelief/

OTHER

HHS Healthcare Emergency Preparedness Information Gateway
asprtracie.hhs.gov/technical-resources

Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers
asprtracie.hhs.gov/cmsrule
getting those individuals a prosthesis and training them on its use. There was no infrastructure for that situation. They had no prosthetic developers in the country. They barely had any physical therapy.”

Many disaster survivors had fractures that had healed. But without physical therapy they lacked range of motion, strength, and coordination. “We saw individuals whose amputations had healed, but a prosthesis would make them much more functional and mobile,” Gorman says. “They needed to get training so they could use it and wear it appropriately.” For these people, she says, “the disaster can go on for a long time,” and the large number of amputations resulting from the earthquake “really opened the eyes of some people in disaster management” to that long-term aspect.

Gorman found that her work in Haiti made her think outside her comfort zone at home. She became more flexible and even more person-centered as a result. “Haiti was an interesting combination of a major disaster and a very low-resource country,” she notes. “You had to think outside of what you might normally do as a PT and use what was actually available. In the United States, in your normal

“You can’t assume that somebody’s house has a chair that they can hold onto to do the exercise you’d like them to do. In fact, they might not have a house, period.”

SHARON GORMAN

Medical Fraud. Are You Concerned?

The government is cracking down on RUG rate fraud. Brian J. Markovitz, attorney at Joseph Greenwald & Laake, recently helped the federal government recover over $9.7 million in a settlement of a False Claims Act case where his occupational therapist client received an award of over $1.9 million for reporting improper RUG rate billing. If you are being pressured to bill therapy services that were not performed or that are incorrect, don’t be on the wrong side of the law. Contact Brian to discuss your situation with full discretion.

State Operations Manual
Appendix Z - Emergency Preparedness for All Provider and Certified Supplier Types: Interpretive Guidance


The Role of Physical Therapists In Disaster Management
(World Confederation for Physical Therapy)


Brian J. Markovitz
Labor & Employment Whistleblower
(False Claims Act, Qui Tam)

240-553-1207
bmarkovitz@jgllaw.com
jgllaw.com
practice, you’re asking somebody to put ice on a sore body part after exercising. ‘Put some ice on it.’ We say that without even thinking. But then you come into a disaster area where things aren’t available or there isn’t power. Simple things can become scarce.”

Another consideration in low-resource countries, Gorman says, is the difference in living conditions from those in the United States. “For example, toilets are more like latrines. That’s a different kind of toileting. If we’re working on mobility skills, somebody squatting over a latrine uses a completely different muscular pattern than does somebody using a toilet. You can’t assume that somebody’s house has a chair that they can hold onto to do the exercise you’d like them to do. In fact, they might not have a house, period.”

**How Technology Plays Into the Role of the PT**

In the event of a disaster, some technology will not be available, and volunteers should know how to respond without it, says Christman. However, Dyson notes that PTs and PTAs can play a long-distance role by gaining experience in telehealth or using other forms of technology to reach the disaster area.

“I don’t think we’re taking advantage of available technology yet,” Dyson says. “For example, the American Burn Association used to have a burn response team. The association would physically fly folks to a disaster. Now we can do a lot more of that via telehealth. There may be trained people onsite who just need some guidance on how to treat a particular patient. Not a lot of physical therapists focus on burn treatment, but in cases of mass burns, we could have a PT with that expertise talking other health care workers through processes remotely, as opposed to having to physically be there to care for the patient.”

Gorman agrees: “There’s a good nexus of the possibility of telerehabilitation in recovery and preparation. California has a state emergency preparedness system for people who are health care providers. I’m a member. I can watch their webinars, go to trainings, and stay involved. Even that group is a bit confused about a physical therapist’s capabilities,” he says. “They don’t always think of physical therapy because, again, they’re thinking of initial trauma and lifesaving techniques, not what to do afterward.”

**Taking Action**

In each stage of a disaster—before, during, and after—PTs and PTAs must be proactive and confident in approach, emphasized the PTs interviewed for this article.

“If we really want to help and be effective, we need to pre-plan. The process must be set up so that others understand what we can do,” explains Gorman. So, “Invite yourself to something or sign up for something. Sell yourself. When I first joined the local county emergency preparedness group, I had to help them understand what I could potentially offer.”

West has a similar vision, on a larger scale.

“What I really want is for the Red Cross to have a defined role for physical therapists and to seek us out at all phases of disaster management,” she says, adding, “I think physical therapists always should be involved in that planning phase. If you are a physical therapist who’s employed by a skilled nursing facility or retirement home, that should be part of your role there, too—to help them plan if some sort of disaster were to happen. Don’t assume that somebody else is going to do that job.”

“Owning our skill set in our scope of practice is professional behavior, and being able to interact in a team is part of what we do every day,” says Mitchell. “Taking ownership of what we can do, inserting ourselves into the system, and redefining our role is autonomous practice. Along with recognizing that we have skills that can and should be used in a helpful way, we must ensure that other health providers understand this.”

Rosie Wolf Williams is a freelance writer based in Vermont.

**REFERENCES**

The Physical Therapy Outcomes Registry empowers you to:

• Benchmark outcomes—without additional data entry
• Provide the most effective patient care
• Optimize your practice with insights from easy-to-use dashboards
• Easily participate in MIPS and maximize your payment incentive
• Market your practice to referring physicians, payers, patients, and employers
• Maximize payment from private payers with outcomes data

Watch a free demo at ptoutcomes.com
Proposed 2020 Fee Schedule Rule From CMS Is Problematic

Despite serious questions and criticisms from APTA, the American Occupational Therapy Association, and other stakeholders, the Centers for Medicare & Medicaid Services’ (CMS) proposed physician fee schedule rule for 2020 would move ahead with plans to require providers to navigate a complex system intended to identify when therapy services are furnished by a physical therapist assistant (PTA) or occupational therapy assistant (OTA). The proposal would require new code modifiers that designate when more than 10% of services to a patient, measured in minutes, is delivered by a PTA or OTA. APTA took issue with the plan and provided strong comments to CMS in September. The proposed rule also would increase payment slightly and change performance thresholds for PTs participating in the Merit-based Incentive Payment System. A final rule is expected later this fall.

www.apta.org/PTinMotion/News/2019/07/30/Proposed2020PFS/

New Payment System for SNFs Finalized

As of October 1, Medicare pays skilled nursing facilities (SNFs) via a new system known as the Patient-Driven Payment Model (PDPM). The PDPM is based on a resident’s classification among 5 components (including physical therapy) that are case mix-adjusted and employs a per diem system that adjusts payment rates over the course of the stay. Confirmation of the change was announced in a final rule issued in July. That rule also included a win for APTA and its members: CMS moved away from a rigid 4-person definition of “group therapy” and adopted the association’s recommended definition of 2 to 6 patients doing the same or similar activities—the same definition used in inpatient rehabilitation settings. APTA offers multiple resources on the PDPM at apta.org.

www.apta.org/PTinMotion/News/2019/07/31/FinalSNFRule/

IRFs Get a Payment Increase—And Additional Reporting Requirements

CMS announced that beginning in October, inpatient rehabilitation facilities (IRFs) will see a 2.5% Medicare payment increase—an approximate boost of $210 million. But they’ll also need to prepare for some expanded reporting measures in the years to come, including a requirement to report data on social determinants of health. IRFs now must provide certain standardized patient assessment data to CMS, aimed at bringing IRFs up to speed with provisions of the 2014 IMPACT Act, which mandated more uniformity in reporting across postacute care settings.

www.apta.org/PTinMotion/News/2019/08/02/IRFFinalRule2020/
Study: Americans Today Are No More Physically Active Than They Were in 2007

Authors of a study published in JAMA Network Open found that since the release of national physical activity (PA) guidelines in 2008, Americans haven’t made a dent in improving PA rates—while “significantly” increasing the amount of time engaged in sedentary behavior. Rates of Americans meeting US Department of Health and Human Services PA guidelines continue to hover just above 60%, while average daily sedentary time increased from 5.7 hours to 6.4 hours. Sedentary behavior increases were particularly notable among individuals 40-49, non-Hispanic whites, Americans with a college or other advanced degree, people with obesity, and individuals with family income less than 1.31 times the poverty level. Non-Hispanic black individuals were among the few demographic groups to better their PA guideline adherence rates.

www.apta.org/PTinMotion/News/2019/8/7/JAMA/ Gregory Hicks Joins APTA Board of Directors

Gregory Hicks, PT, PhD, FAPTA, chair of the Department of Physical Therapy at the University of Delaware and director of the school’s Advancing Diversity in Physical Therapy program, has been appointed to complete the leadership term of Sheila K. Nicholson, PT, DPT, MBA, MA, who died in June. Hicks’ board service began in July and ends with the completion of Nicholson’s 3-year term in June 2020. At that point the vacant seat will be filled through the annual slate of candidates process and election by the House of Delegates.

www.apta.org/PTinMotion/News/2019/07/31/HicksAppointedToBoard/

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APTA LEADING THE WAY

Here are a few recent examples of the association’s efforts on behalf of its membership, the profession, and society.

APTA-Backed Bill to Provide Diversity-Based Scholarships And Stipends Is Introduced in US House

A bill introduced in the US House of Representatives in July seeks to provide $5 million per year in scholarships and stipends aimed at increasing the number of students from underrepresented populations in physical therapy and other health education programs. The Workforce Diversity Act of 2019 would set aside money for accredited academic programs in physical therapy, occupational therapy, audiology, and speech-language pathology to issue scholarships or stipends to students from underrepresented populations, including racial or ethnic minorities and students from disadvantaged backgrounds such as disability and low economic status. APTA, the American Occupational Therapy Association, the American Speech-Language-Hearing Association, and the American Academy of Audiology were instrumental in crafting language for the bill.

www.apta.org/PTinMotion/News/2019/07/10/WorkforceDiversityActIntroduced/

APTA Programs in Education and Financial Literacy Receive National Recognition

APTA once again has received national honors from the American Society of Association Executives (ASAE). This year, ASAE bestowed Power of A awards on 2 programs: APTA’s Financial Solutions Center, which offers resources on financial literacy and student debt management, and the Education Leadership Institute fellowship, a collaborative program that helps aspiring PT and PTA education program directors advance their leadership skills. ASAE describes the Power of A awards as its highest honors, “recognizing the association community’s valuable contributions on local, national, and global levels.”

www.apta.org/PTinMotion/News/2019/07/16/ASAEAwards2019/

APTA and Alliance for Physical Therapy Quality and Innovation Collaborate on Report That Explores Benchmarks of Quality Care

Given a patient’s individual mix of comorbidities, socioeconomic status, payer type, and other elements at the onset of treatment, how can PTs, payers, and patients know what constitutes a “typical” amount of improvement? And, can currently available data provide any insight? APTA and the Alliance for Physical Therapy Quality and Innovation are getting a handle on those questions in a report that analyzes patient baseline data supplied through electronic medical records. The report, described as “the largest multipractice analysis of open-source, risk-adjusted clinical outcomes in the outpatient physical therapy industry,” supports the need for widespread, standardized data collection and outcomes reporting throughout the profession.

www.apta.org/PTinMotion/News/2019/07/19/APTAAllianceBenchmarkData/
Highlights From the October Issue

- Many milestones mark the path toward APTA’s centennial year. For instance, this year is the 50th anniversary of the graduation of the first cohort of physical therapist assistants (PTAs). “Reflection on Nancy T. Watts’ Division of Physical Therapist and Physical Therapist Assistant Responsibility in Clinical Practice: Future Directions” is a timely Point of View by Hayward et al, who call for renewed commitment to the intraprofessional education of PTs and PTAs. That commitment, notes Alan Jette, must go “beyond checking off the Commission on the Accreditation of Physical Therapist Education curricular requirement box that fosters ‘parallel play versus collaborative interdependence’ of the PT with the PTA.”

- Read the full 50th McMillan Lecture by Thomas McPoil, PT, PhD, FAPTA. McPoil addresses both clinical and academic excellence. Even after 25 years of discussion about evidence-based practice, he notes, questions remain. Should an intervention be used in the clinic before there is evidence to support it? What about the continued use of methods proven decades ago to have no evidence? Look for Jette’s podcast interview with McPoil at https://academic.oup.com/ptj/pages/podcasts.

- Many PTs manage vestibular, oculomotor, cervical, and aerobic impairments following concussion. “The CDC Guideline on the Diagnosis and Management of Mild Traumatic Brain Injury Among Children: What Physical Therapists Need to Know” provides take-home messages for intervention and shines a light on key research questions: Does some provocation of symptoms improve rather than impede recovery? Should all symptoms, “regardless of magnitude, duration, and timing,” be avoided? Or, does the expression of some symptoms actually speed recovery?

October Research Articles

- Global upper extremity functional ability increased with supervised, combined aerobic and resistance exercise to improve metabolic syndrome in women who were overweight or obese and had breast cancer; findings support clinical exercise programs based on American Cancer Society/American College of Sports Medicine exercise guidelines incorporated into current rehabilitation oncology practice following adjuvant breast cancer treatment.

- Therapeutic exercise was found to reduce pain intensity in primary dysmenorrhea.

- Presurgical and postsurgical physical therapy for patients opting for major abdominal surgery varies widely among hospitals—with some hospitals not involving PTs at all prior to surgery.

- Evidence is promising for the use of virtual reality (VR) in chronic neck pain and shoulder impingement syndrome. VR and exercises have similar effects in rheumatoid arthritis, knee arthritis, ankle instability, and post-anterior cruciate reconstruction.

- The first study on the impact of low back pain (LBP) in people with Parkinson disease shows an association between greater LBP-related disability and greater motor sign severity, lower physical activity level, and lower quality of life.

- Research on the effects of PT health coaching on health behavior outcomes is mixed, but data show statistically significant changes in some health behavior, physiological, and psychological outcomes.

- Studies validating low-cost movement analysis systems are limited in quality; PTs should consider measuring only certain variables when using these tools.

- A patient with chronic vestibular hypofunction showed improved oculomotor performance following use of the newly developed incremental vestibulo-ocular reflex adaptation technique.

Read these articles and more in the October 2019 issue of PTJ. academic.oup.com/ptj/issue/99/10
You’re Getting a Doctorate, So Why Get Another Degree?

When I tell people that I want to get a master of public health degree alongside my doctor of physical therapy (DPT) degree, there’s a question I’m asked more often than not: I’m studying to be a physical therapist (PT); shouldn’t a DPT degree be enough?

The answer to that question has its roots in my career goals and what it’s going to take to get there.

The DPT degree offers the basis to treat any patient population, but as our profession grows, PTs striving to be expert clinicians are increasingly turning to residency programs to hone their skills and become board-certified clinical specialists.

In a similar way, I’ve realized that I want my expertise to be in a different area from clinical care. After being exposed to health care policy and physical therapy advocacy through my experience as a student, I know that my greatest potential for impact in the profession will be through those avenues.

After arriving at that understanding, I started to search for other health care professionals who are tackling policy and advocacy to see how they navigated their careers.

Overlapping clinical and public health education allows me to apply a different lens to the physical therapy profession and what can be done to drive it forward.

Many students have clinical passions, and specializing through a residency program is the perfect way to set up a career surrounding a specific population. But as much as physical therapy needs expert clinicians, we also need people to support the profession in other ways. Whether it’s through public health, health administration, business, or something else entirely, explore your interests and how you can mold your education to fit your career.

Read the full story from March 26, 2019, in The Pulse. www.apta.org/AnotherDegree/
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**APTA MEMBER VALUE**

APTA’s mission is “building a community that advances the profession of physical therapy to improve the health of society.” This community includes an environment of involvement for its members, and APTA Engage is well-suited for the job. Read all about it, and find an opportunity to engage!

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**Inspiration Through APTA Engage**

It’s October and National Physical Therapy Month. You’re inspired to volunteer a few hours. Perhaps you’ve wanted to share your expertise and don’t know where to begin. Maybe you’ve wanted to expand your public speaking or writing skills. How do you find the opportunity to develop your skills, offer your expertise, or just have a little fun with other PTs, PTAs, and students? Start with APTA Engage.

APTA Engage is a volunteer portal that enables you to search and apply for a wide range of opportunities. Even if you’re not ready to volunteer today, you can sign up and indicate your expertise or interests. Matching opportunities will be sent to you as they arise.

Check out this sampling of opportunities:

**Tell your APTA love story.** The easiest volunteer opportunity yet. Tell APTA in 300 words or fewer about the moment you fell in love with your association, and include a photo of yourself making one of those 2-handed heart shapes (you know what we’re talking about), and your love story could be posted in APTA’s social media feed. Can you feel the love?

**Contribute to the student blog.** This one’s a little more involved, but a great opportunity for physical therapy students and new graduates to share insights: APTA’s *The Pulse* blog series for students is one of the association’s most dynamic and popular offerings and is always on the lookout for potential contributors. Add “published author” to your list of accomplishments. Your post even could be picked up for the Student Focus section of *PT in Motion* magazine.

**Shout out for ChoosePT at Good Morning America.** Help celebrate National Physical Therapy Month and join your colleagues at a Good Morning America broadcast in New York City on October 25. The first 200 who RSVP will be provided signs and other materials to display.

**Give an APTA value talk.** Brush up on your public speaking skills by giving an APTA Value Talk. Using a presentation designed to be delivered at educational programs, clinics, component events, or other gatherings, you can show how APTA is your partner, and inspire colleagues and students to join the APTA community.

**Share your volunteer story.** Maybe you’ve volunteered with APTA in the past—so share your thoughts! The APTA Engage webpage includes a rotating “Volunteer Spotlight” that shines on member experiences with the association—all based on their answers to a few questions.

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**Ready for More?**

APTA Engage isn’t just a place for short-term opportunities—it’s also your connection to longer-term involvement in your profession at national and component levels. For example, APTA nominates individuals to serve on the committees and advisory panels of federal agencies and other entities.

Practice your presentation skills, expand your community, and share your expertise by giving an hour or more of your time in support of your profession. Sign up at engage.apta.org/home and check out what’s available.
CSM APTA Combined Sections Meeting

DENVER, CO • FEBRUARY 12–15, 2020

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APTA.org/CSM
Visit APTA.org/CSM to see all 500+ educational sessions, meetings, and events. Here is a sneak preview of the hot sessions.

**ACUTE CARE**
- A New Standard: Building an Acute Care Physical Therapy Obstetrics Program
- Securing the Future of Acute Care Physical Therapy Clinical Education
- Where Am I Working Today? Successful Floating in Acute Care

**AQUATIC PHYSICAL THERAPY**
- Hip Osteoarthritis Aquatic Therapy and Exercise: Clinical Practice Guidance Statement and Clinical Implementation
- The Fragile Patient: Using Aquatic Interventions for Positive Outcomes
- Aquatic Therapy to Improve Fitness and Function in Children With CP: Intervention and Dosing Considerations

**CARDIOVASCULAR AND PULMONARY**
- Maximizing ICU-Based Rehabilitation: Evidence and Team Collaboration
- Frail or Fail? Skeletal Muscle in Lung Transplant and Critical Illness
- Exercise Testing by Physical Therapists: Moving Forward One Step at a Time

**CLINICAL ELECTROPHYSIOLOGY AND WOUND MANAGEMENT**
- Neuromusculoskeletal Ultrasound Imaging
- Entry-Level DPT Wound Management Education in a Hybrid Format: Considering the Possibilities
- Demystifying the Evaluation of Brachial Plexopathy to Enhance Patient Treatment and Outcomes

**EDUCATION**
- Deja Vu All Over Again or Moving in the Right Direction? Revisiting Cerasoli Lectures
- Student Performance Assessment in the Deja Vu All Over Again or Moving in the Right Direction? Revisiting Cerasoli Lectures
- Emotional Intelligence Across the Professional Student to Expert Practitioner Learning: APPT Research Forum

**FEDERAL PHYSICAL THERAPY**
- What Is All the Hype About Running Shoes? Practical Implications for the Running Tactical Athletes
- Real Sports: #Adaptiveathletes
- Does This Sensor Go With My Health Condition? Using Wearable Sensors in Physical Therapist Practice

**GERIATRICS**
- Challenges and Future Directions for Geriatric Physical Therapy (Carole B. Lewis Lecture Series)
- Leveraging Existing Abilities in Dementia Parts 1 & 2
- The Role of Physical Therapists in Addressing CDC Public Health Priorities for Aging

**HAND AND UPPER EXTREMITY**
- Interdisciplinary Management of Common Wrist Soft-Tissue Injuries: Bridging a Surgeon’s Perspective With a Therapist’s Sensorimotor Rehabilitation Paradigm
- The Elbow: Managing the Clinical Sequelae of Traumatic Elbow Injuries
- Thumbs up! A Detailed Analysis of an Amazing Appendage

**HEALTH POLICY AND ADMINISTRATION**
- Technopathology: A Playground for Clinical, Assistive, and Educational Technology
- To Err Is Human: Engaging the Physical Therapy Profession in an Interprofessional Patient Safety Discussion
- Turning the Road to Success Into a Highway: Strategies to Facilitate Success for Young Professionals

**HOME HEALTH**
- D, DD, DDD, One Size Never Fits All: Evidence-Informed, Exciting Interventions for Cognitive Challenges
- A Balancing Act: A Discussion on the Updated Home Health Toolbox Balance and Vestibular Measures
- Better Together in Diversity, Equity, and Inclusion: Engaging Diverse Populations to Improve Rehabilitation Outcomes

**NEUROLOGY**
- High-Intensity Interval Training in Stroke Rehabilitation: State of the Evidence and Clinical Implications
- A Bit of a Stretch: The Lived Experience of Spasticity After SCI and Promising Interventions
- Removing the Kid Gloves in Neurologic and Geriatric Rehabilitation

**ONCOLOGY**
- Cross-Collaboration to Reduce Preventable Falls: An Onc/Geri/Neuro Balance and Falls SIG Tri-Alliance Symposium
- If You Build It, Will They Come? Community Engagement for Vulnerable Populations in Oncology Rehabilitation
- Geriatric Oncology: Aligning Across Specialty Practice to Meet the Needs of Cancer Survivors

**ORTHOPAEDICS**
- Bone Stress Injuries in Runners: An Exercise in Load and Its Tolerance
- Muscle Degeneration of the Rotator Cuff: Scientific Advances to Guide Surgery and Rehabilitation
- Sports Medicine Secrets. Evidence-Based Lower Extremity Sports Movement Analysis: Sprinting, Cutting, and Jumping

**PEDIATRICS**
- The Roles of Variability and Error in Movement Learning: APPT Research Forum
- Physical Therapy Management of Children With Developmental Coordination Disorder: An Evidence-Based Clinical Practice Guideline

**PRIVATE PRACTICE**
- Telehealth: How to Leverage for More Than Just Treatment
- If You Think It’s Broken, FICS It: A Relationship-Centered Process for Transforming Your Culture
- Change the Way You Think About Physical Therapy! Alternative Models of Care

**RESEARCH**
- The Value of Postprofessional Residency, Fellowship, and PhD Training
- A Roadmap for Integrating Research(ers) in the Outpatient Orthopedic and Sports Physical Therapy Clinic
- What’s Your Point? Writing and Reviewing With Precision for Impact and Clarity

**SPORTS**
- Interprofessional Care of the Injured Athlete: Intercollegiate Models
- Think to Perform: Training the Brain to Optimize Sports Rehabilitation and Performance
- Bridging the Gap Between Rehabilitation and Performance in the Overhead Athlete

**WOMEN’S HEALTH**
- Dry Needling for Pelvic Pain: An Orthopedic and Women’s Health Perspective
- Optimizing Rehabilitation Management for Gender Affirming Care and the Transgender Patient: A Multidisciplinary Approach
- Evaluation, Differential Diagnosis, and Treatment of Powerlifting Urinary Incontinence (PUI) in the Female Powerlifter

**WHY CSM 2020?**
APTA and its 18 sections invite you to join over 13,000 attendees and get inspired to reach a higher peak in Denver. With specialty-focused programming, networking with peers and friends from more than 35 countries, and 450+ exhibiting companies, you do not want to miss this empowering conference.
DENVER DELIVERS!

Welcome to a town bursting with art, comedy, music, and a fine appreciation of quality living. With clear skies and snow on the mountains in the distance, you will fall in love with the Mile High City!

CULTURE: Many key attractions are free, including the Colorado State Capitol and the United States Mint. The iconic Blue Bear sculpture at the convention center is worth a hug!

NEARBY: A short bus ride away, visit famous Red Rocks Amphitheatre, spectacular any time of year. Or visit the iconic Coors Brewery in Golden, Colorado. Pike’s Peak and the snowy mountains are only 1.5 hours away.

CUISINE: Denver is growing as a center for award-winning cuisine. Visit the Denver Central Market or ride the free shuttle down the 16th Street Mall to access shops, restaurants, and bakeries. Imbibe tasty cocktails like Cowboy Coffee and the Corpse Reviver, or sip on craft beers as you follow the Denver beer trail.

APTA STEP CHALLENGE: Look for details of our new step challenge for charity.

CSM REGISTRATION

<table>
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<tr>
<th>Registration Fees</th>
<th>Early Bird Registration Deadline: November 13</th>
<th>Advance Registration Deadline: December 18</th>
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* Additional discounts may apply.
** Per person, minimum 3 employees from the same location, registering together.
*** Not eligible for APTA membership.
† Guest rate: Guests must register with conference attendee. Those eligible for APTA membership are not able to register as guests.

Note: Children under 18 years of age are not permitted in the exhibit hall.

HOUSING

APTA’s exclusive and official housing provider for CSM is MCI, USA. APTA does not endorse booking hotel reservations via any other sources. Book by January 15, 2020, to take advantage of the special APTA rates offered to all attendees.

View rates, locations, and availability, and make secure housing reservations in one of the following ways:

Email: aptacsm@mcievents.com
Online: APTA.org/CSM/HousingTravel
Phone: APTA housing center at: 800/809-9565 (local) or 972/349-5841 (international) Hours: Monday-Friday, 8:00 am–5:30 pm ET

Hospitality Suite Requests:
All suite requests must receive APTA approval before the reservation is confirmed. Contact a suite specialist at 972/349-5841 or suites@mcievents.com.

TRAVEL

Good news: Discounted rates are available for CSM 2020 attendees! Reference the codes below when making your reservations.

Delta Airlines
Phone: 800/328-1111, use meeting event code NY2XH

United Airlines
Phone: 800/426-1122, use Z Code ZH3Y and Agreement Code 626214

Valid dates: February 7 to February 16, 2020, for travel through (DEN) Denver, Colorado

For rail, taxi, car rental discounts, and other travel resources visit APTA.org/CSM/HousingTravel.
All preconference courses will start at 8:00 am on Tuesday, February 11, and Wednesday, February 12. Visit APTA.org/CSM for complete course descriptions, times, and CEU information.

ACUTE CARE
- Acute, Anticipatory and Urgent: Re-Educating the Foundations of Postural Control in the Acute Care Setting
  AC-2249 | 1A
- Muscle and Diaphragm Ultrasound: Training Course for the Acute and Cardiopulmonary Physical Therapist
  AC -2124 | 1A

AQUATIC PHYSICAL THERAPY
- Aquatic Interventions for the Lower Extremity - Justifications and Applications
  AQ- 2268 | 1B

CARDIOVASCULAR AND PULMONARY
- Advanced Clinical Practice in Cardiopulmonary Physical Therapy: Are You Practicing Best Practice?
  CP- 1544 | 1A

CLINICAL ELECTROPHYSIOLOGY AND WOUND MANAGEMENT
- Show Me the Value: Evidence Base for Biophysical Agents in Postacute Practice
  CE- 2583 | 1B

EDUCATION
- Welcome to the Academy: A Workshop for New or Aspiring Faculty Members
  ED- 4195 | 1A
- Teaching Students to Learn: Facilitating Success and Developing Lifelong Learning Skills for the PTA Student
  ED- 1885 | 1A
- MERC: Measuring Educational Outcomes With Reliability and Validity and Program Evaluation and Evaluation Research
  ED- 4059 | 1A

FEDERAL PHYSICAL THERAPY
- Returning to Running: From the Clinic to the Track
  FD-1784 | 1A
- How to TREAT a Tactical Athlete Like a Traditional Athlete
  FD-2221 | 1A
- Roll With It! Wheelchair Skills Assessment and Training
  FD-2778 | 1A

GERIATRICS
- Tai Chi Fundamentals Adapted Program: Basic Moves Training (Course 1)
  GR-1426 | 2A
- Tai Chi Fundamentals Adapted Program Short Form Training (Course 2)
  GR-1427 | 2A

HEALTH POLICY AND ADMINISTRATION
- Health System Current Topics, Strategies, and Innovations
  HP-2793 | 1B
- LGBTQ+ Brave Space Training: Encouraging Difficult Dialogues in Physical Therapist Practice
  HP-2900 | 1B
- LAMP Management Essentials
  HP-1643 | 2B
- Leadership 101 - Personal Leadership Development: The Catalyst for Leading Within
  HP-2190 | 2B
- Leadership 201 - Advanced Leadership Development: The Catalyst for Leading Others
  HP-2518 | 2B

HOME HEALTH
- Advanced Competency in Home Health Certification Live Course for PT and PTA (This course has a prerequisite)
  HH-1441 | 2B

NEUROLOGY
- The Academy of Neurologic Physical Therapy (ANPT) Online Education Summit (This course is handled through ANPT)
  NE- 1552 | N/A
- ANPT Knowledge Translation Summit
  NE-2462 | 2A

ORCOPHOPAEDICS
- Clinical Pathways for the Outpatient Oncology Clinician: A Case Study Approach Implementing Clinical Reasoning
  ON- 2594 | 2A

ORTHOPAEDICS
- Physical Activity Analysis: Bridging the Gap to Improve Outcomes and Practice Opportunities
  OR-1776 | 1A
- Beyond the Basics: Design and Implementation of Best Practice in Residency and Fellowship Clinical Education
  OR-2543 | 1A

ONCOLOGY
- Subacromial Pain Syndrome Management: Evidence and Lab-Intensive Upper Quarter Evaluation, Manual Therapy, Dry Needling, and Exercise
  OR-1445 | 2A
- Translating Science Into Clinical Practice: A Pain Systems Approach to Treating Those in Pain
  OR-1975 | 2A

PEDIATRICS
- Yoga for Children With Special Health and Mobility Needs: Practical Adaptation and Clinical Application
  PD-1615 | 1B
- Concussion-Related Vision Problems in Children: Assessment and Treatment
  PD-3112 | 1B

PRIVATE PRACTICE
- Getting Paid for Physical Therapist Services: Documentation, CPT Coding, Billing, and Payment
  PP-2491 | 1A
- Eight Free, Easy Online Tools to Supercharge Social Media Posts: The Lab
  PP-1523 | 1A
- Kick-Starting Your Private Practice: A Day of Interactive Consulting
  PP-1678 | 1A

SPORTS
- Neuropathic Adaptation for Prevention, Acute Management, and Rehabilitation of Lower Extremity Sports Injuries
  SP-1833 | 1A
- US Paralympic Sports Movement: Classification, Competition, and PT Involvement
  SP-3730 | 1A

WOMEN’S HEALTH
- Work Smarter, Not Harder: Strategically Build and Market a Profitable Women’s Health and Wellness Practice
  WH-1988 | 1B
- Men’s Health: A Clinician and Researcher’s Perspective
  WH-4489 | 1B
- Pelvic Floor Surgical Techniques: A Physician’s Perspective
  WH-4490 | 1B

COLORADO CHAPTER**
- Assessment and Management of Whiplash-Associated Disorder: A Comprehensive Approach
  HC-2248 | 2A

PRECONFERENCE PRICING

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*Membership pricing is based on the individual being a member of the section sponsoring the preconference course.
**APTA members receive the section member price for the American Physical Therapy Association - Colorado Chapter’s preconference course.

#APTACSM | APTA.org/CSM
### CONTINUING EDUCATION SEMINARS

**MANUAL THERAPY SEMINAR SERIES DEVELOPED BY FOUNDER STANLEY V. PARIS, PT, PHD, FAPTA**

#### S1 - Spinal Evaluation & Manipulation: Impairment Based, Evidence Informed Approach
- 20 Hours, 2.0 CEUs (Prerequisite: Intro S1 Webinar Included)
  - **Baltimore, MD** Smith  
    - Nov 9-10, 2020
  - **St. Augustine, FL** Smith  
    - Feb 8-9
  - **Dallas, TX** Fortu  
    - Mar 7-8

#### S2 - Advanced Evaluation & Manipulation of Pelvis, Lumbar & Thoracic Spine Including Thrust
- 20 Hours, 2.0 CEUs (Prerequisite: S1; Intro S2 Webinar Included)
  - **Philadelphia, PA** Yack  
    - Oct 12-13
  - **Phoenix, AZ** Yack  
    - Oct 26-27
  - **Miami, FL** Bourgeois  
    - Dec 7-8
  - **Charleston, SC** Irwin  
    - Dec 14-15
  - **Austin, TX** Irwin  
    - Dec 16-17
  - **Miami, FL** Yack  
    - Dec 16-17

#### S3 - Advanced Evaluation & Manipulation of the Cranio-Facial, Cervical & Upper Thoracic Spine
- 20 Hours, 2.0 CEUs (Prerequisite: S1; Intro S3 Webinar Included)
  - **Phoenix, AZ** Smith  
    - Oct 5-6
  - **Austin, TX** Irwin  
    - Oct 19-20
  - **Denver, CO** Smith  
    - Nov 16-17
  - **Philadelphia, PA** Irwin  
    - Dec 7-8
  - **St. Augustine, FL** Smith  
    - Dec 7-8

#### S4 - Functional Analysis & Management of Lumbo-Pelvic-Hip Complex
- 16 Hours, 1.6 CEUs (Prerequisite: S1; Intro S4 Webinar Included)
  - **San Marcos, CA** Grant  
    - Dec 7-8
  - **Chicago, IL** Nyberg  
    - Dec 7-8
  - **Phoenix, AZ** Grant  
    - Dec 14-15
  - **St. Augustine, FL** Grant  
    - Dec 16-17, 2020
  - **San Marcos, CA** Grant  
    - Apr 18-19

#### MF1 - Myofascial Manipulation
- 18 Hours, 1.8 CEUs (Prerequisite: Intro MF1 Webinar Included)
  - **Atlanta, GA** Cantu  
    - Jan 25-26, 2020
  - **Philadelphia, PA** Stannborough  
    - Feb 8-9

#### E1 - Upper Extremity Evaluation & Manipulation
- 15 Hours, 1.5 CEUs (Prerequisite: Intro E1 Webinar Included)
  - **Philadelphia, PA** Naas  
    - Dec 7-8, 2020
  - **Chicago, IL** Busby  
    - Jan 25-26

#### E1 - Lower Extremity Evaluation & Manipulation
- 15 Hours, 1.5 CEUs (Prerequisite: Intro E1 Webinar Included)
  - **Idaho Falls, ID** Turner  
    - Oct 19-20
  - **Chicago, IL** Busby  
    - Nov 2-3
  - **Birmingham, AL** Naas  
    - Nov 9-10
  - **Charleston, SC** Busby  
    - Nov 9-10, 2020
  - **Atlanta, GA** Busby  
    - Mar 14-15

#### E2 - Extremity Integration
- 21 Hours, 2.1 CEUs (Prerequisite: E1)
  - **Austin, TX** Mandel  
    - Dec 6-8, 2020
  - **San Marcos, CA** Patla  
    - Dec 16-18
  - **Austin, TX** Patla  
    - Jan 17-19

#### Thrust - Advanced Manipulation of the Spine & Extremities
- 15 Hours, 1.5 CEUs (Prerequisite: Any Earned Manual Therapy Certification and S1 USAHS seminar attendance or Fellow of AAOMPT)
  - **Washington, DC** Yack  
    - Nov 16-17, 2020
  - **St. Augustine, FL** Irwin  
    - Mar 28-29

#### Craniocervical Symmetry Certification
- 23 Hours, 2.3 CEUs (Prerequisites: S1, S3, CF1, CF2, CF3, CF4)
  - **St. Augustine, FL** Irwin  
    - Nov 3-9, 2020

#### Manual Therapy Certification Preparation and Examination
- 24 Hours, 2.4 CEUs (Prerequisites: S1, S2, S3, S4, S5, Upper Extremity, E1 Lower Extremity, E2, MF1)
  - **St. Augustine, FL**  
    - Oct 10-12, 2020
  - **St. Augustine, FL**  
    - Jan 23-25

#### Spinal Boot Camp
- 15 Hours, 1.5 CEUs (Prerequisites: S1, S2, S3, S4)
  - **New York, NY** Irwin  
    - Nov 9-10

#### Exercise Strategies and Progression for Musculoskeletal Dysfunction
- 15 Hours, 1.5 CEUs (No Prerequisite)
  - **Milwaukee, WI** Daugherty  
    - Feb 22-23, 2020
  - **Phoenix, AZ** Strickland  
    - Jan 11-12

#### CF2 - Intermediate CranioFacial
- 15 Hours, 1.5 CEUs (Prerequisite: Basic CF1 Online)
  - **Milwaukee, WI** Hobson  
    - Nov 9-10, 2020
  - **Indianapolis, IN** Hobson  
    - Feb 22-23

#### CF3 - Advanced CranioFacial
- 15 Hours, 1.5 CEUs (Prerequisite: CF2)
  - **Beaverton, OR** Strickland  
    - Nov 2-3, 2020
  - **Phoenix, AZ** Strickland  
    - Jan 11-12

#### CF4 - State of the Art CranioFacial
- 15 Hours, 1.5 CEUs (Prerequisite: CF3)
  - **St. Augustine, FL** Strickland  
    - Oct 12-13, 2020
  - **Birmingham, AL** Strickland  
    - Nov 16-17, 2020
  - **Austin, TX** Strickland  
    - Dec 7-8, 2020
  - **Beaverton, OR** Strickland  
    - Feb 8-9, 2021

### ADDITIONAL SEMINAR OFFERINGS

- **Dry Needling I** Intramuscular Dry Needling of the Cervical, Sacro-iliac, Craniofacial Region and Upper Extremity 25 Hours, 2.5 CEUs (Prerequisite: None)
  - **Charleston, SC** Krell  
    - Oct 4-6, 2020
  - **York, ME** Krell  
    - Oct 18-20, 2020

- **Running Rehabilitation:** An Integrative Approach to the Examination and Treatment of the At Risk Runner 14 Hours, 1.4 CEUs (No Prerequisite)
  - **Boston, MA** Vighetti  
    - Mar 28-29, 2020
  - **Milwaukee, WI** Vighetti  
    - May 9-10, 2020

- **CF2 - Intermediate CranioFacial** 15 Hours, 1.5 CEUs (Prerequisite: Basic CF1 Online)
  - **Milwaukee, WI** Hobson  
    - Nov 9-10, 2020
  - **Indianapolis, IN** Hobson  
    - Feb 22-23

- **CF3 - Advanced CranioFacial** 15 Hours, 1.5 CEUs (Prerequisite: CF2)
  - **Beaverton, OR** Strickland  
    - Nov 2-3, 2020
  - **Phoenix, AZ** Strickland  
    - Jan 11-12

- **CF4 - State of the Art CranioFacial** 15 Hours, 1.5 CEUs (Prerequisite: CF3)
  - **St. Augustine, FL** Strickland  
    - Oct 12-13, 2020
  - **Birmingham, AL** Strickland  
    - Nov 16-17, 2020
  - **Austin, TX** Strickland  
    - Dec 7-8, 2020
  - **Beaverton, OR** Strickland  
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This is a story about pain. Physical, psychological, emotional—and, ultimately, transformative—pain.

Today, as I type this condensed account of my professional and personal journey, I feel that my life is in a very good place. I’m involved in a variety of activities as a physical therapist (PT) that help empower people to live their best life. I’m in no physical pain, and I’m at peace with who I am.

Just a few years, ago, however, I found myself at a professional and personal nadir. Something happened to me that I hadn’t seen coming. It was incredibly painful. It made me, at least for a time, relive all of my insecurities. It made me feel like an imposter masquerading as the expert in body science I’d held myself out to be.

But this dark time also, as it turned out, was the best thing that could have happened to me. It propelled me toward the life I’m living now.

I grew up in India. My father wanted me to be a homemaker and got me admitted to a college for home economics. But I wanted a career. When my father left to work abroad, I took advantage of his absence to reroute myself to a college for physical therapy. It was an occupation about which I knew very little, but it seemed to be populated by good people who liked what they did.

In 1988 I moved to New York City. I worked at an acute care hospital and in 3 years rose from staff PT to an acting director role. I also pursued a master’s degree in physical therapy at New York University.

I completed all the coursework but never wrote my thesis. My life was busy, and I’d already gained all that extra knowledge. What did I need with an advanced degree?

I got married, lived in Charlotte, North Carolina, for a time, then moved to Oregon. I worked in a variety of practice settings over the next quarter-century—inpatient rehab, skilled nursing, outpatient, home health, pelvic floor therapy. I had a happy, fulfilled, and balanced work and personal life.
By about 2013, however, I was starting to experience significant low back pain. It wasn’t the first time in my adult life that I’d been plagued by pain. In my early years in New York, I had severe neck pain, was diagnosed with a disc herniation, and was told by a physician that I risked being paralyzed if I didn’t get surgery. I’d instead trained with the McKenzie Method. I was able to eliminate my symptoms with the exercises taught to me. It helped me tremendously. I thought, “This is the way to treat all my patients.”

When it came to my back situation a few years ago, however, the pain persisted. None of my McKenzie techniques helped. I spoke with Kevin Cucarro, a physician and pain specialist. I respected him, but I frankly thought that some of his ideas about what pain is and how best to address it were a little “out there.” They ran contrary to my training and what I thought I knew. Also he was not a PT!

But then, at APTA’s Combined Sections (CSM) meeting in 2016, I heard those same concepts being persuasively presented by a PT. Adriaan Louw, PT, PhD, talked about pain being protective rather than manifesting damage. He spoke of the need to address fear and to avoid catastrophizing. He associated psychosocial factors, such as stress and anxiety in one’s life, with poor clinical outcomes in pain management. Something clicked in me. It all made perfect sense.

I’d been having a lot of issues at home with my 3 teenaged kids. Because I felt unable to control my own pain, I’d started to wonder how much I really was helping my patients. Professional burnout was setting in. If everything I’d heard from Kevin Cucarro and Adriaan Louw was right, no wonder my pain was persisting!

I decided to put this new understanding to work in my clinical practice by making a point of asking patients questions that...
might unearth stressors in their lives. And I would listen closely to what they said. As it happened, my very first patient after CSM—a woman I would see just once, while subbing for another PT—answered my simple request “Tell me your story” with a tearful account of her son’s suicide 20 years earlier. It turned out that the next day was his birthday. She and I hugged goodbye that day.

Over the next 6 months, I spent as much time as I could immersing myself in neuroscience articles on pain and devouring books such as Lorimer Moseley’s Explain Pain. While I didn’t feel that I was fundamentally altering my clinical approach, I was listening more and talking less, and sharing with patients some of the mindfulness messages I’d starting incorporating into my own life. Enthusiasm and energy returned to my work. I’d put burnout behind me.

But then came a fateful staff meeting. I was accused by my peers of acting more like a psychologist than a PT and working outside my scope of practice. They said I was spending too much time engaging patients in conversation, “making them cry,” and giving short shrift to exercise instruction.

In sum, they made me sound more like Dr Phil than Dr Prasad! But wait—I wasn’t Dr Prasad! In fact, I’d never even completed my master’s degree. This rebuke from my colleagues hit me hard. It brought up self-doubts I’d been trying to suppress for years. Not only did I have only a bachelor’s degree, but I was a foreign-trained therapist. Maybe I wasn’t quite as good as were these native-born PTs. I was pretty new to pain science research, too. Had I been practicing appropriately? Might these colleagues be right?

Soon after, I learned that the patient whose son had committed suicide had complained about me to her regular PT, saying that she’d come to physical therapy for help with her back pain and not with her mental health. That made me feel even worse.

For a time, feelings of inadequacy consumed me. But gradually I began to take a wider view. I might not always have incorporated my new ideas perfectly, I was willing to concede. And I still had many things to learn. Learning is a lifelong process, after all. But I was confident that I was on the right track.

I ended up leaving that job and moving to a hospital that was much more in line with my views on the biopsychosocial nature of pain. I’m still there. I now teach a group class for patients that’s called Movement, Mindfulness, and Pain Science—MMAPS. It incorporates movement elements that are meaningful yet playful—including dance, tai chi, and yoga. We include meditation and share pain science insights. It’s presented at a fifth-grade level to ensure that these important health literacy concepts are lost on no one.

I’m deeply involved with the Oregon Pain Science Alliance, which brings together providers and community members for pain awareness. I’ve helped organize 2 statewide pain summits that convene local PTs, physicians, occupational therapists, and other medical professionals. I secured a grant from Medicaid to train local high school teachers about opioid abuse, pain science, and self-care skills. The Oregon Physical Therapy Association presented me with a regional excellence award for my work on persistent pain education.

Something else happened a few months ago: I completed my doctor of physical therapy degree. So, now I really am Dr Prasad. I’ve also become certified as a therapeutic pain specialist by Evidence in Motion.

If I can offer my colleagues just 1 piece of advice, it’s this: First, be sure that you understand how your own pain is constructed. Only then can you best treat your patients’ pain. Gaining that understanding changed my life.
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If you had Congress’s undivided attention for 10 minutes to educate lawmakers on something related to physical therapy, what would you say?

**α:** I would reference the literature that shows how physical therapists are equipped to treat patients with orthopedic impairments as well as or better than a primary care physician. This would lead into my plea to advocate for allowing PTs to order imaging. We would be able to help more patients get answers sooner and start treatment earlier if we could order orthopedic imaging.

— JENNIFER SMITH, PT, DPT, BOARD-CERTIFIED ORTHOPAEDIC CLINICAL SPECIALIST

**α:** The military model of direct access to physical therapists has proven to decrease cost and cause no harm to the patient. Why isn’t a national model to change Medicare direct access to physical therapists in discussion? What further evidence would you need to convince you that physical therapists can appropriately screen patients for safe medical practice?

— LAURA COVILL, PT, DPT, BOARD-CERTIFIED ORTHOPAEDIC CLINICAL SPECIALIST

**α:** I would educate them on all the research about preventive care and wellness to convince them to reimburse [physical therapists] more for these kinds of services, which can mitigate health care costs in the long term.

— NATALIE ANZURES, PT, DPT, MS

What trait, quality, or skill do you most look for when hiring a PT or PTA?

**α:** Willingness to learn.

— JOHNNIE BURNETT, PT, DPT

**α:** Decisiveness.

— MOHAMED HASSAN, PT

**α:** Having dedicated volunteer work outside of therapy. When people see value in helping others without receiving monetary benefit, they make better teammates and coworkers.

— JENNIFER NOVAK, PTA, MBA

APTA encourages diverse voices. To give members a chance to share their insights and wisdom with colleagues, PT in Motion poses questions that any member is invited to address, and publishes selected answers. To participate in “PT in Motion Asks…,” log in to the APTA Engage volunteer platform at https://engage.apta.org and create a profile. Find the “APTA National–PT in Motion Magazine Member Input” opportunity, review the rules for submitting, and click the Apply Today! button. You’ll see a list of the questions and can respond to as many or as few as you wish in the space provided. We look forward to hearing from you and sharing your comments in future issues.

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