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TREATING PATIENTS WITH AUTOIMMUNE CONDITIONS

Multiple sclerosis. Guillain-Barré syndrome. Lupus. Rheumatoid arthritis. Addison disease. These are just a few of more than 100 autoimmune disorders that cause the body’s immune system to attack and destroy healthy body tissue by mistake. What should PTs know about managing treatment for people who have them?

A MISSION-FIRST BRAND IN THE MAKING

APTA will officially roll out its new brand in 2020. Here’s what to expect.

NEW TECHNOLOGY: KEEPING IT ETHICAL, KEEPING IT LEGAL

Advances in health care technology present both legal and ethical issues. Here are some situations that you soon may encounter, if you haven’t already. How should you respond?

COLUMNS

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“I asked my rheumatologist if he refers people to occupational and physical therapy right after giving them a rheumatoid arthritis diagnosis, and he said, ‘I’d love to, but I can’t, because insurance won’t cover it.’”

Kimberly Steinbarger, PT, MHS, in “Treating Patients With Autoimmune Conditions” (page 20)
Rehab Therapy EMR
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Virtual Meetings: 10% Technology, 90% Psychology

The world of rehabilitation is experiencing a digital revolution. Cloud-based technology has empowered PTs to interact and communicate with peers, colleagues, and patients in a digital world. This has led us into uncharted waters.

A growing number of organizations and their leadership teams are embracing a virtual meeting and engagement model in which team members remotely share ideas and insights using apps such as Zoom Video, GoToMeeting, Skype, and Google Hangouts.

Team members find themselves part of an expanding business that’s opening new clinics in different locations. PTs are making home visits. Interprofessional collaboration is taking place inside of larger organizations to ensure good patient outcomes.

The real challenge in conducting virtual meetings is not the enabling technology but the underpinning team dynamics that must be acknowledged and addressed. For example, there are some generally accepted communication barriers associated with both intraprofessional and interprofessional communication in rehab, such as:

- Perceived hierarchy related to positions in an organization.
- Gender and generational differences.
- Jargon.
- Differences in qualifications.
- Historical professional rivalries.

Creating a successful atmosphere to address these kinds of challenges in a bricks-and-mortar meeting room is hard enough. These same challenges are exacerbated when using devices to connect and communicate with colleagues within a virtual meeting room. For example, body language is often missing in a virtual meeting. By necessity, this requires people to interpret the meaning behind conversations using only the words and the tone in which they’re delivered. This can lead to miscommunication.

One paradigm that thought leaders can use to enhance meeting interactions and outcomes is “psychological safety.” This involves a shared belief that the team is safe for interpersonal risk-taking. It’s having a sense of confidence that the team will not embarrass, reject, or punish a member for speaking up, asking a question, offering a new idea, or admitting a mistake. Psychological safety underscores and supports the need for mutual respect—especially for the knowledge and skills held by peers and colleagues from other disciplines and professions.

There’s increased interest in psychological safety among health care professionals in general, as people become more aware of the role it plays in team effectiveness. Research suggests that psychological safety is a critical element in high-performing teams. In health care, it not only contributes to the well-being of health care providers, but it also is crucial to organizational efforts to reduce medical errors, enhance care coordination, and increase cost-effectiveness.

Here are some core, shared beliefs related to the concept of psychological safety:

- The setting is safe for interpersonal risk-taking.
- Participants feel accepted and respected.
- There’s mutual respect and trust among participants.
- Team members respect each other’s competencies.
- Members have positive intentions.

Have you ever been in a meeting where you’re reluctant to speak up because of the potential threat associated with bringing up a point or taking a stand on an issue? People tend to withdraw and keep their ideas to themselves in any meeting where there’s a perceived risk of negative consequences related to interacting with other participants. The result? Team members will be reluctant to share information or ideas if the repercussions are (in their minds) not worth the risk.

Creating an organizational culture that supports the principles behind psychological safety is often a long-term effort. However, embracing and promoting psychological safety in the context of virtual meetings is something that can begin with your very next meeting.

For example:

- Model the behavior you want to encourage.
- Acknowledge and appreciate a team member who takes a risk, offers a new idea, admits an error, or asks a question. It’s a powerful tactic for inspiring others to follow.
- Demonstrate engagement. Be an information seeker, giver, and encourager.
- Ask questions with the intention of learning from your teammates.
- Offer input, be interactive, and show that you’re listening.
- Express gratitude for contributions from the team or individuals.
Defining Moment: Community Service
May 2019

[The author described her efforts to establish the first bilingual and bicultural physical therapy outpatient clinic in Milwaukee and the 4 keys she found to thrive in today’s competitive marketplace.]

Inspiring!

Mark Sala

Defining Moment: Community Service
May 2019

We’ve seen the rise of a number of trends in the 2010s: frozen yogurt, urgent care facilities, and now—in the physical therapy world—"mentorship." I hear students of all levels and career focuses saying "I want a mentor," "I’m looking for strong mentorship," and "I want a place that can support me in a long-term mentorship program."

I have seen great successes, with new graduates being afforded mentorships that guide them in many domains of life—spanning personal, home, relationship, and clinical goals. To counteract the risk of burnout, supporting our newest colleagues in all facets has a way of creating long-term sustainable employees. Not merely for their retention, but for improved patient outcomes and consistent providers to the same patients and families for decades to come.

Matt Calendrillo PT, DPT

Online Comments

One of the most effective phrases you can use to help you interact in a meeting and take care of your own psychological safety is to ask “What if...?” The phrase will enable you to engage with others to provide you with a sense of safety. It’s easy to remember, extremely powerful, and creates a zone of psychological safety within which you can operate. Here are the key words:

- What if I do…?
- What if you do…?
- What if we do…?

These phrases signal that ideas are still open for discussion, and they indicate that you simply are making a suggestion. They open the dialogue for safe collaboration.

These phrases also can provide you with a subtle, nondictatorial way to solicit agreement. They are much more collaborative in nature than, for example, “Why don’t you do this…?”—which almost begs for disagreement.

The technology related to conducting a virtual meeting is simply a conduit or vehicle for facilitating communication. It’s the 10% factor. On the other hand, the 90% factor is the psychological safety associated with that communication, and its power to foster the free exchange of ideas on which best practice thrives.

John Spencer
Rehab Village

REFERENCE
Touch is a 2-way street that goes from physical therapist (PT) to patient and from patient to therapist. Physical therapy is a “hands-on” profession, and when we are palpating, feeling, assessing, and treating, we receive touch back from our patients physically and psychologically. This element in the patient-care arena is not unique to our profession; it is essential to other medical professions, such as nursing and medicine. Communication with contact is biological; most animals, and even plants, respond to touch.  

Palpation skills are requisite to our work as PTs. As students, we studied and hopefully mastered the neuroanatomy of the sensory system. We learned about skin and the various sensory receptors, as well as the importance of thermal perception, nociception, proprioception, and kinesthesia. Free nerve endings, Merkel’s discs, as well as Pacinian and Meissner’s corpuscles, are components of the important somatosensory system.  

The senses of sight, hearing, smell, and equilibrium (vestibular) are crucial to patient care, and they complement our palpation skills. Seeing a swollen joint, smelling a wound, and hearing bone-on-bone crepitus help in our decision-making. A patient with disequilibrium can been seen and felt with touch assist, or more, as required to guard against falls.  

Although we all have learned the professional necessity of avoiding the emotional side of touch in patient care, touching someone brings a psychological component to the treatment setting and can be beneficial. Anderson and associates reported that a hands-on approach helps patients with dementia experience less pain and agitation. Also, patients may feel increased rewards from PTs who shake a hand or extend an arm around the shoulder and back after a patient has achieved a goal. Touch also helps therapists gain the trust of patients of all ages, from healthy newborns to older persons who are dying.  

Feeling tone is important in many of our patients, from neonates to those with neurological conditions such as cerebral palsy, multiple sclerosis, Parkinson disease, and stroke. Assessing tone changes in sports or orthopedic conditions such as postoperative cases, injuries, and immobilization is another key component of the evaluation. Manual therapists use their hands to determine joint laxity, mobility, and end feel, and to grade their own efforts to regain normal soft tissue extensibility and joint movement.  

Lack of touch also comes into play. All of us have heard a patient complain about a previous therapist: “He/she never even touched me.” That should never happen in physical therapy.  

What I have described is mostly a 1-way street, with us touching our patients for evaluation and treatment. But part of the joy of physical therapy is that we get to know our patients and their families. And they get to know us. We are touched, in return, when a patient shakes our hand, hugs us, or bakes the clinic a cake to say thanks for the care we gave. As Kelly et al state, “Every time a professional touches a patient, they are themselves touched.”  

I remember a 6-year-old boy with a diagnosis of Male Turner’s syndrome, now called Noonan’s syndrome. At the start of care—44 years ago—he was mildly tactile defensive, which made touch more complicated. But within 6 months, we achieved some catch-up development in gross motor skills, from approximately 18 months initially to 36 months (stair climbing). We started an aquatic program, and his fine motor and psychosocial skills improved. He even tried downhill skiing. Due to his significant syndrome-related medical problems, he eventually was hospitalized and died. I felt his loss immensely. He and his parents touched me.  

The gift of touch, both giving and receiving, is not always perceptible, but it is inherent in what we do. Patient care requires it, and what we feel is more than the neuroanatomy that we learned. I have treated tens of thousands of patients over the decades. I have been enriched by this wonderful profession because we are hands-on, and I know that the vast majority of my patients felt improved quality of life—physically and emotionally—because of it.  

Timothy L. Kauffman, PT, PhD, FAPTA  

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Serving Veterans Through Community Programs

Here’s what PTs need to know about recent changes and how to sign up.

Our nation’s veterans deserve access to the care they need, within or outside Veterans Administration (VA) facilities. It is imperative, therefore, that they have timely access to comprehensive, high-quality community health care services, including physical therapy.

The VA Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act was enacted in 2018 to improve veterans’ access to health care services. It is important that physical therapists (PTs) in private practice and other outpatient settings who treat veterans in the community—or are interested in becoming a community provider—understand how, where, and when care can be delivered.

First, though, it’s important to note the difference between VA health care and TRICARE. The Veterans Health Administration (VHA) under VA covers veterans—those who once served in the military but have retired or are now separated from service due to a service-connected illness or injury. TRICARE is a civilian network, administered by the US Department of Defense, that provides health care benefits to active-duty service members, National Guard/reserve members, and their families when services cannot be provided at a military treatment facility.

When service members leave active duty, they may be eligible for benefits offered by either VA or TRICARE, depending on whether they have retired and/or how they separated from the military. Military retirees are eligible for TRICARE and also may be eligible for certain VA health care benefits. Service members who left the military because of a service-connected disease or injury may be eligible for VA health care benefits and for certain TRICARE benefits.

(TRICARE rules and regulations will be the subject of an upcoming Compliance Matters column, but you can see a snapshot of the program on the facing page.)

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

By Kara Gainer, JD
Eligibility for Community Care

Generally, a veteran eligible for community care under VA may either schedule an appointment with a VA health care provider or seek VA’s authorization to receive hospital care, medical services (including rehabilitation), or extended care services from an eligible entity or provider—as long as VA has determined the care or services are clinically necessary.

Veterans may be eligible for care through a non-VA medical facility or provider in their local community depending on their health care needs or circumstances, and if they meet specific eligibility criteria. A veteran needs to meet only 1 of the following criteria to be eligible:

1. The veteran requires a service that is not available at a VA medical facility.
2. The veteran lives in state or territory that lacks a full-service VA medical facility.
3. The veteran qualifies under a “grandfather” provision related to distance eligibility under the discontinued Veterans Choice Program that preceded the current community care program.

TRICARE Facts

Medically retired veterans who receive care for their service-connected disability at VA may be eligible to receive all of their other care through TRICARE. Under TRICARE, furthermore, veterans may choose among TRICARE Prime, Standard, and Extra plans. Their eligible family members have the same options.

Current TRICARE contractors are Humana Military (TRICARE East Region) and Health Net Federal Services (TRICARE West Region).

Learn more on APTA’s website: www.apta.org/TRICAREVA.
4. The veteran would incur too far a drive or too long a wait for an appointment if he or she were to be treated at a specific VA medical facility.

5. The veteran and the referring clinician agree that it is in the veteran’s best medical interest to receive community care based on established criteria including the nature, frequency, and quality of care required.

6. VA has determined that the VA medical service line that should provide the care the veteran needs is not providing care that complies with the VA’s standards for quality.

Even if veterans are eligible for community care, in general they still can choose to receive care from a VA medical facility. In most instances, veterans must get approval from VA before receiving care from a community provider to avoid being billed for that care. VA staff members generally make all eligibility determinations for community care.

When a veteran arrives for the appointment with the community provider—we’ll assume it’s a PT for our purposes—the PT should have on file a record of the appointment, the VA referral or order for physical therapy, and all medical documentation. If a veteran needs a follow-up appointment, the PT should check to make sure that VA has authorized additional care before scheduling the appointment.

VA offers 3 types of community care programs—Patient-Centered Community Care (PC3), the Community Care Network (CCN), and Veterans Care Agreements (VCA).

PC3. Under the VA MISSION Act, VA modified a community care contract that had provided coverage under the Veterans Choice Program in order to use the same third-party administrator (TPA)—TriWest—to provide expanded nationwide community care coverage until CCN is up and running with a full network of providers. TriWest provides this coverage through PC3.

PC3 is a nationwide network of community providers the VA uses to refer veterans to community care under specific circumstances. PC3 is intended to provide eligible veterans with access to medical care when services are not readily available or accessible at their local VA medical facility.

TriWest performs certain functions on behalf of VA, such as scheduling appointments and paying claims. It will continue to manage PC3 through at least September 30, 2020.

Scheduling. For a veteran to receive care from a community provider participating in PC3, TriWest or VA contacts that individual and coordinates the appointment between the provider and the veteran. After the appointment, the provider must submit medical documentation to the TPA.

Claim submission. Once the TPA receives medical documentation, it is uploaded to the TPA portal for VA facility staff. VA staff then downloads the medical documents and places them in the veteran’s electronic health record. After this process is complete, the TPA reimburses the provider for medical care provided.

Reimbursement rates. PC3 community providers must accept Medicare reimbursement rates.

Coverage and billing. Here are answers to commonly asked questions:

- TriWest covers services provided by physical therapist assistants (PTAs).
- TriWest requires that all state- and Medicare-related supervision requirements for use of PTAs (and occupational therapy assistants) be followed.
- As APTA staff experts understand it, TriWest follows Medicare’s 8-minute billing rule, but we suggest that providers verify with the contractor.

CCN. To provide more choices and robust care coordination for veterans,
At this writing, Optum Public Sector Solutions Inc has been announced as TPA for CCN regions 1 (mainly East Coast states), 2 (Midwest), and 3 (South). TriWest has been named TPA for Region 4 (West)—with announcements pending of contractors for regions 5 (Alaska and Hawaii) and 6 (Pacific territories). For updated information, visit the CCN webpage referenced in the Resources box on page 14. You also can request updates at this address: https://public.govdelivery.com/accounts/USVHA/subscriber/new?topic_id=USVHA_124.

Until the transition from PC3 to CCN is complete, community providers should continue to partner with TriWest. Once CCN contractors for all 6 regions have been named, those contractors will reach out to providers regarding enrollment.

Scheduling. Under CCN, VA staff will refer veterans directly to community providers and will schedule community care appointments for veterans through the local VA medical center. Veterans also can choose to schedule their own appointment with support from local VA staff.

Third-Party Administrators

To learn more about contracting with TriWest and Patient-Centered Community Care, go to www.va.gov/COMMUNITYCARE/providers/info_PC3.asp.

To learn more about contracting with the Community Care Network, go to www.va.gov/COMMUNITYCARE/providers/Community_Care_Network.asp.

To learn more about entering into a Veterans Care Agreement, contact your closest VA medical facility. To find the nearest one, use VA’s provider locator at www.va.gov/find-locations.
Compliance Matters

**Claim submission.** TPAs will pay claims submitted by community providers within their network and send invoices directly to VA for reimbursement.

**Reimbursement rates.** The contract will set forth terms of payment, but generally payment will not exceed the applicable Medicare fee schedule or prospective payment system amount.

**VCA.** Under the VA MISSION Act, VA may enter into agreements with certain community providers who are not part of VA’s contracted CCN. VCAs are intended to be used in limited situations in which VA either does not provide contracted services that veterans need through a VA facility, contractor, or sharing agreement; or in which contracted services may be available but are insufficient.

Under this authority, VA can enter into agreements with community providers to provide hospital care, medical services—including medical examination, treatment, and rehabilitative services—or extended care services to individuals who are eligible to receive such care from a non-VA provider.

Either a community provider or a local VA medical facility may initiate the process of establishing a VCA. (A VA medical facility may urge a community provider to enter into a VCA to fill a gap in contracted services.) Providers seeking to enter into a VCA must apply for certification. VA has 120 days from receipt of the application to approve or deny the request. Once a VCA is signed, it is active for 3 years and must be recertified every 12 months.

**Scheduling.** As soon as a VCA is signed, the community provider can begin receiving referrals and authorizations from VA to provide care.

**Claim submission.** Community providers submit claims directly to VA using electronic data interchange, or by mailing claims to the address contained in the referral.

**Reimbursement.** The rates paid by VA for hospital care, medical services, and extended care services furnished pursuant to a VCA will be the rates set forth in the agreement. Generally, payments will not exceed the applicable Medicare fee schedule or prospective payment system amount. VA is responsible for any payment or fee arising from care authorized through VCAs. Community providers cannot collect or seek to collect payments from any entity for VA-authorized care, including from a veteran or a veteran’s other health insurance.
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Ethics in Practice

By Nancy R. Kirsch, PT, DPT, PhD, FAPTA

Powerful Connection
A patient’s request both flatters and concerns a PT.

If you were to ask physical therapists (PTs) and/or physical therapist assistants (PTAs) which aspects of their job they find the most gratifying, most if not all likely would mention the connection they make with patients while helping them address and meet their goals.

But what are the ethical implications when a patient proposes extending that connection beyond the bounds of the typical provider-patient relationship? Consider the following scenario.

A Big Ask
Lou has been a PT at a rural hospital for the past 15 years. He especially likes his job’s variety and the continuity that the hospital offers to those it serves. Lou typically sees current patients in the morning and discharged patients in their homes in the afternoon through the facility’s home care program. Thus, it’s not unusual for Lou to see a patient in the hospital’s postsurgical unit, work with that person on his or her discharge plan, then follow up with that individual at his or her home the very next day.

This often has been the case for Lou with Harvey and Dawn Lalley, who are in their mid-80s. The PT has provided care to them many times over the years at the hospital and at their nearby ranch-style home as they’ve undergone rehabilitation following injuries and other health issues. This time, Harvey has just returned home from hospitalization for a fall and needs Lou’s help with conditioning and strength. The Lalleys have a home health aide through the hospital who comes in a few hours a week to help with bathing and general care, but Dawn, who remains cheerful and active, has mild dementia and requires her husband’s close attention.

Lou arrives at the Lalley residence and is greeted warmly by the couple, who have no children and often tell Lou he’s “like the kid we never had.” In fact, every so often since Lou postprofessionally earned his doctor of physical therapy degree 6 years ago, they’ve jokingly called him “Our son the doctor.” Until Harvey gave up driving about 2 years ago (Dawn never learned to drive), the Lalleys loved to...
go fishing—sometimes planning entire vacations around angling adventures. The Lalleys love to retell stories about “the ones that got away,” and Lou always acts as if he’s hearing those tales for the first time. Dawn used to bake quite often, and she would insist that Lou take home of few slices of her “famous” cherry cobbler “before Harvey finishes it off—he doesn’t need any extra padding!”

As always, Harvey is a model patient as Lou leads him through his exercises, but clearly with each new round of physical therapy he’s getting not only a little older, but also a little weaker and slightly more unsteady. Lou silently wonders how much longer the Lalleys will be able to remain in the home where they’ve lived for 48 of their 61 married years, and the thought makes him sad. He is pulled back from his reverie, though, by Harvey, who out of the blue says, “I was just thinking about my 2005 Lincoln Town Car. Wasn’t she a beaut?”

“Sure was,” Lou replies. “Not that I have any regrets about selling her when I did,” Harvey adds. “You were right. It’d gotten to the point where it was time. I needed to turn over my license after those fender-benders and that near-collision. It took me a while to come around, but I’ll always appreciate the way that you heard me out and let come to my own conclusion.”

“Don’t mention it,” Lou says. Although the PT had considered it his duty at the time—as a health care provider (not to mention a fellow motorist sharing the road)—to coax Harvey into giving up his car keys, he is touched by the older man’s thanks. Lou well remembers the sadness in Harvey’s eyes the day, shortly after he’d made the decision,
Considerations and Ethical Decision-Making

Should Lou respond affirmatively to Harvey’s request, he’ll have enormous potential power over both the course of the Lalleys’ medical care and their finances. How likely is this to pass the “smell test” with relatives of the couple? Is it appropriate for Lou to assess his own motivations and potential for gain?

**Realm.** The ethical realm is *individual.* This is between Lou and Harvey. There are societal implications, as well, however. Is it appropriate for health care providers to play the types of roles that Harvey is asking Lou to assume?

**Individual process.** *Moral judgment* is required of Lou, who must reflect on why he is even considering this request. Is he responding to flattery? Moved by compassion? Or might some other motivation be in play, consciously or not?

**Ethical situation.** This scenario presents a *moral temptation* for Lou, given the status he would assume and the potential for personal benefit, however pure he may deem his motives.

**Ethical principles.** The following principles of the Code of Ethics for the Physical Therapist provide guidance to Lou:

- **Principle 2A.** Physical therapists shall adhere to the core values of the profession and shall act in the best interests of patients/clients over the interests of the physical therapist.

- **Principle 3D.** Physical therapists shall not engage in conflicts of interest that interfere with professional judgment.

- **Principle 7F.** Physical therapists shall refrain from employment arrangements, or other arrangements that prevent physical therapists from fulfilling professional obligations to patients/clients.

“Not a problem,” Lou responds. He’s about to ask “What’s on your mind?” but just then Dawn, who’d been napping in the bedroom, enters the room with a pre-wrapped biscotti and says, “Take a snack with you.”

At the end of Friday’s therapy session, Harvey gets right to business. “Lou,” he says, “we’ve been together a long time now, you and Dawn and me. I know you’re not really blood to us, but you’ve seen us through a lot over the years, and your friendship and counsel—in addition to your therapy skills—have meant everything to us. We’ve got no kids, or even any siblings in this state, so Dawn and I have been talking about something. Well, on any given day she might not remember that we’ve talked about it, but we have. And every time time”—he adds with a slight laugh—“she has agreed with me. We’d like to designate you to assume medical and financial power of attorney for both of us should I become incapacitated.”

Lou is stunned. He certainly didn’t see that coming. He doesn’t know what to say.

“I know it’s a lot to ask,” Harvey acknowledges. “Give it as much thought as you need. No pressure, but it’d be a huge relief to know that you’ll be there to backstop us if and when the time comes.”

It’s all Lou can do to stifle a nervous laugh over the juxtaposition of the words “no pressure” and “huge relief.” This sure sounds like pressure to him.

“Just think about it, okay?” Harvey repeats.

Lou always has been fond of Harvey and Dawn—as indeed he is of the vast majority of his patients. And he’s always prided himself on “going
the extra mile” for his patients. But might this be a step too far?

“Our son the doctor” is just an affectionate joke, after all. Yes, Lou’s relationship with the couple is very friendly—and it has been for a long time. But are they really even his friends? They both are longtime patients. Committing to such an important legal role in Harvey and Dawn’s lives doesn’t feel quite right to him. But Lou’s acutely aware that Harvey is awaiting his answer.

“I’ll think about it,” the PT manages. Harvey smiles. Lou hears the words “Thank you” as he shuts the door.

**For Reflection**

Lou is moved by Harvey’s request because he knows it bespeaks a high level of esteem and trust. He’s made uneasy, however, by the fact that his patient regards him as more than a health care provider—if not as a son, at least as a close friend who the older man feels comfortable asking to play a role most typically assigned to a family member. Lou wonders whether it would be appropriate to assume such a role. What are the implications?

Have you, as a PT or PTA, faced a situation in which you felt you were being asked to cross a boundary between playing a professional and a personal role in a patient’s life? Looking back, do you think you handled the situation appropriately?

---

**Medical Fraud. Are You Concerned?**

The government is cracking down on RUG rate and PDPM 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.

**For Followup**

If you are reading the print version of this column, go online to www.apta.org/PTinMotion/2019/11/EthicsinPractice/ for a selection of reader responses to the scenario, as well as my views on how the situation might be addressed. 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.
TREATING PATIENTS WITH Autoimmune Conditions

By Greg Gargiulo
Multiple sclerosis. Guillain-Barré syndrome. Lupus. Rheumatoid arthritis. Addison disease. There are more than 100 autoimmune diseases that cause the body’s immune system to attack and destroy healthy body tissue by mistake. What should PTs know about managing treatment for people who have them?

In 1991, Kimberly Steinbarger, PT, MHS, had a minor injury that did not heal as expected. She had jammed her finger in a door and, 2 weeks later, found it odd that the swelling had not subsided. Making matters more alarming, one morning she noticed that the same finger on her other hand had swelled up.

“I was 24, so I was too old for juvenile rheumatoid arthritis and too young for adult rheumatoid arthritis, and I had no family history of arthritis,” she explains.

Steinbarger, who had been a physical therapist (PT) for just 2 years, was shocked when a rheumatologist eventually diagnosed her with rheumatoid arthritis (RA).

“It was a huge blow, and it took me a long time to get over it,” Steinbarger says. “At the time, there weren’t many resources available to help me. Maybe there was an Arthritis Foundation pamphlet in the physician’s office, but my course of treatment was more based on what drugs to try next. There really was no mention of exercise or physical activity back then. If you wanted to figure out how to manage your life, you had to seek outside resources on your own.”

RA is the most common of more than 100 autoimmune diseases. While each is unique, they all essentially result from an immune disorder—faulty recognition by the immune system. Instead of differentiating between foreign and native cells, as the body usually does, the immune system perceives parts of the body such as joints, skin, or
other organs to be dangerous outsiders and attacks healthy cells by releasing autoantibodies.³

Autoimmune diseases—which include multiple sclerosis (MS), type 1 diabetes, lupus, Guillain-Barré syndrome (GBS), vasculitis, autoimmune thyroid disease, psoriasis, and celiac disease—affect more than 23.5 million Americans.⁴ Symptoms vary widely, depending on which tissue(s) and organ(s) are affected, but several features are universal. Most patients experience inflammation, fatigue, swelling, and muscle and/or joint pain, all of which follow a pattern of remissions and flareups.¹⁵

Treatment Advances

Treatment for autoimmune diseases has come a long way since Steinbarger first was diagnosed with RA 28 years ago. While medications remain the mainstay of most treatment plans, physical activity and exercise increasingly have become recognized as safe, effective measures for reducing symptoms and improving quality of life.⁶ Not surprisingly, physical therapy has come to play a more significant role in management of these conditions, in part because of its focus on improving and enhancing movement.

“Physical therapists have a unique opportunity to help patients vastly improve their health status by helping them understand that exercise and activity are medicine,” says Ben Shatto, PT, DPT, owner of The Medical Fitness Center in Eagle, Idaho. He specializes in orthopedic conditions and frequently works with patients with various autoimmune conditions, including fibromyalgia, RA, Crohn’s disease/ulcerative colitis, and lupus. Shatto is a board-certified clinical specialist in orthopaedic physical therapy and a certified strength and conditioning specialist.

In most cases, seeing a PT may not be a top priority for either the patients themselves or their care team. Consequently, those patients may not be referred to physical therapy immediately—or at all, unless another health issue springs up. “As physical therapists, we typically are not working with the condition directly. We more often are seeing patients for other issues and they just happen to also have an autoimmune disease,” Shatto says. “But that person’s autoimmune disease typically is a significant comorbidity that will affect his or her care.”

Is Physical Therapy Appropriate?

Determining whether the patient is a good candidate for physical therapy depends largely on the initial evaluation, which may occur with another specialist or in a hospital setting.

For Kristin Parlman, PT, DPT, a board-certified neurologic clinical specialist at Massachusetts General Hospital in Boston, several variables must be considered during the evaluation process. Individuals recently diagnosed with MS, GBS, and myasthenia gravis account for a substantial portion of her patient population with neurologic autoimmune conditions. Each requires special attention. “Our role at the inpatient stage is to develop a treatment plan to maximize function that’s individual for that patient for their life role. We do this by impairment-level and functional testing and monitoring their response through such measures as hemodynamics, rating of perceived exertion, and fatigue,” she says. “We’re seeing them within the first couple days of their diagnosis, when their clinical status is still pretty dynamic. For someone with Guillain-Barré, for example, their condition may still be progressing and their strength and sensation may be declining. We need to continuously monitor this in order to develop a safe and effective treatment plan. Education is a big component of our intervention in each of these diagnoses. It’s very individual in terms of the readiness of the patient as to how much we educate now, versus referring them to a PT in the future to address exercise when they’re ready.”
Physical therapy and makes the appropriate referral, individualizing patient care remains crucial in treatment decisions. “Performing a complete and thorough evaluation is extremely important to provide an individualized treatment program for each patient,” says Maria Rundell, PT, DPT. Rundell, the outpatient physical therapy lead at Encompass Health Rehabilitation Hospital in Colorado Springs, Colorado, has extensive experience treating patients with MS and other autoimmune diseases, including chronic inflammatory demyelinating polyneuropathy, Graves’ disease, and RA. She is a board-certified clinical specialist in neurologic physical therapy and also is a multiple sclerosis certified specialist.

“During the subjective portion of the evaluation, fatigue, heat sensitivity, pain, and bowel and bladder issues are addressed, and we also identify patient needs for services from other health care providers.” Rundell says.

After obtaining a clear picture of the patient’s impairments, capabilities, and goals, patient education is the next step. While this applies to all physical therapy patients, the PTs interviewed for this article agree that it is especially vital for those with autoimmune conditions because of how severely affected some will be.

“For the setting I was in, the most important intervention was education—education about the disease, the disease process, patient self-advocacy, and how patients can learn more about their condition from appropriate sources,” says Kerri Sowers PT, DPT, PhD. “It’s also important,” she adds, “to teach patients about...”
the value of mobility, movement, and exercise, and how to appropriately start those activities.” Sowers is a board-certified clinical specialist in neurologic physical therapy.

Sowers was working at a level II trauma hospital and comprehensive stroke center, where she often saw patients with MS, RA, dermatomyositis, lupus, transverse myelitis, and other autoimmune diseases. (While she still does per diem and pro bono work, she now is an associate professor in the School of Health Sciences at Stockton University in Galloway, New Jersey.)

Sowers also has relevant research experience, having completed her dissertation at Nova Southeastern University on “The Impact of an Exercise Program on Stress, Fatigue, and Quality of Life for Individuals Living With Primary Immunodeficiency Disease.”

Part of what drove her to investigate exercise for patients with compromised immune systems was her personal connection to the topic as a clinician and a patient. For the past 7 years, Sowers has dealt with a primary immunodeficiency (PID) called common variable immunodeficiency (CVID).

PIDs comprise more than 350 rare, chronic disorders—CVID is the most common—that are characterized by part of the body’s immune system being absent or malfunctioning. PIDS are not autoimmune disorders themselves, but since they feature a dysfunctional immune system, many PIDs patients also will have autoimmune conditions and complications, Sowers explains.

Since learning of her CVID diagnosis—which took 2 years and a battery of tests to reach—Sowers has discovered that she needs to keep moving regularly in order to cope with the complicated course of her condition.

“For me, exercise is absolutely necessary, both physically and mentally, so I do lots of farm chores multiple times a day, and I ride horses 5 or 6 days a week,” she says. “I may feel more physically tired when I exercise, but it’s a ‘good’ tired. If I don’t exercise, I actually feel stiffer and more emotionally tired.”

Sowers’ own positive response to exercise, as well as her dissatisfaction with the available data on CVID, spurred her dissertation. Since completing the study, she’s come closer to establishing an effective formula for patients with PIDs and autoimmune disorders.

“My exercise prescription—which is influenced by my research findings—is to start with a lower-intensity, low-duration, high-frequency exercise program,” she says. “It’s also critical to find exercises that patients are interested in, so that they can engage without seeing it as exercise. Physical therapists also

“Keeping moving is an important component of arthritis self-management. Given the autoimmune response associated with RA, joint involvement, and cardiovascular and pulmonary complications of the disease, patients will benefit from a combination of joint range-of-motion exercises, aerobic conditioning, and strengthening exercises.”

– Maura Iversen
can work with patients to build up mobility throughout their usual day—by, say, taking the stairs instead of the elevator, or parking farther away from their building.”

Maura Iversen, PT, DPT, SD, MPH, FAPTA, also has dedicated much of her professional career to studying and promoting exercise in this population. She’s been working in rheumatology for more than 25 years and obtained a doctor of science degree from Harvard University so that she could design clinical trials to test nonpharmacological interventions for patients with RA and other related conditions. She is the associate dean of clinical education, rehabilitation, and new initiatives at Bouvé College of Health Sciences at Northeastern University, and a behavioral scientist in rheumatology at Brigham & Women’s Hospital. (Both are in Boston.)

“Keeping moving is an important component of arthritis self-management,” she says. “Given the autoimmune response associated with RA, joint involvement, and cardiovascular and pulmonary complications of the disease, patients will benefit from a combination of joint range-of-motion exercises, aerobic conditioning, and strengthening exercises.”

**Overcoming Barriers to Interventions**

Evidence to support exercise and physical activity for RA and other immune-mediated conditions is substantial, with multiple studies showing that specific exercises and general activity recommendations can lead to a variety of physical and psychological benefits. But because of the complex and multifaceted nature of these conditions, PTs must take into account numerous considerations when prescribing exercise.

Among these, fatigue is a leading obstacle.

“I don’t think I’ve met a patient—clinically or in my research—with an autoimmune or immune issue who didn’t have some degree of fatigue,” Sowers says. “When your body is in a constant ‘fight’ state or is constantly attacking itself, systemic inflammation can be a big contributor to fatigue in these patients.”

Research helps quantify the scope of this issue. According to an online...
survey of 7,838 patients with autoimmune diseases conducted by the American Autoimmune Disease Related Diseases Association (AARDA), 98% reported experiencing fatigue—with 89% calling it a “major issue” and 59% saying it is “probably the most debilitating symptom of having an autoimmune disorder.”

Steinbarger can attest to this burden. “Fatigue has been my biggest issue, and it’s a factor that PTs and physicians often don’t address,” she says. “I have joint pain most days, and I can deal with that. But it’s not the same with fatigue. If you’re tired and you can barely get your head off the pillow, that’s a totally different thing to manage.”

Steinbarger is the director of clinical education of the School of Physical Therapy at Husson University in Bangor, Maine. She made the transition into education after realizing she wasn’t going to be able to perform all the manual techniques and heavy lifting she needed to as a PT, although she still runs the pro bono clinic at Husson. In her academic position, she guides students and newer PTs through how to handle fatigue and other challenges that are likely to arise in patients with compromised immune systems.

“I often tell my students, ‘If you want to give patients with autoimmune conditions an exercise but they have problems with fatigue, it had better be a damn good exercise, because you can’t give them 15 exercises,’” she says. “You need to pick the 2 best tricks in your bag, because if they’re going to expend energy on it, it needs to be worth their time.”

But fatigue certainly isn’t the only commonly encountered hurdle to providing care to this patient population. “We also need to teach patients about their condition and what to do if they have flare-ups, because even if their medication is working well, they’re still going to have flares,” Steinbarger says.

For Iversen, it’s about knowing how to respond appropriately. “In the case of a flare, joints are painful and swollen, and patients often experience malaise. So the exercise prescription needs to be adapted to reduce repetitions, frequency, intensity, and duration. Once the disease is under control, patient can be directed to increase exercise parameters based on their current physical condition,” she says.

Between fatigue, flare-ups, and other potential problems that immune-mediated disorders can bring about, most patients’ symptoms extend beyond the physical realm. PTs should be prepared to handle these issues, too.

“There is a huge emotional component when treating patients with autoimmune and immune disorders,” Sowers says. “Many patients have ‘invisible illnesses,’ which are known to have a stigma associated with them. They also live with the anticipation that they may go into a flare or develop a complication or associated condition at any time, which can contribute to higher levels of stress and, in effect, make autoimmune issues worse.”

Both Iversen and Steinbarger recommend screening for depression because of how frequently it occurs in these patients. If a patient is depressed, they advise, the PT needs to help that individual recognize that exercise can help lessen depression as well as produce physical changes needed to manage the disease. It also is paramount that PTs make referrals, when appropriate, to a mental health professional or, if a patient is more comfortable there, a support group.

“Part of my job as physical therapist is knowing what’s available in my community and what’s most appropriate for each patient, and telling them where to get questions answered and how to find other people like them,” Steinbarger says.

Since PTs often are just one element of the health management needed, some go beyond the referral alone and work with other health care professionals as part of a more holistic and comprehensive model that covers multiple aspects of their patients’ care.

Rundell, for example, is a member of a team at her hospital. “It has been found that a multi-dimensional team approach is the most effective and efficient way of treating people with MS, and it empowers the patient to become

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– Kimberly Steinbarger
an integral part of the team,” she says. “We have physical, occupational, and speech therapy services in our clinic, and we’ve also developed relationships with other health care providers in our community who are familiar with the MS population.”

This team also could include rheumatologists, neurologists, mental health professionals, dietitians, nutritionists, and others. Diet is vitally important for most patients with autoimmune diseases, and some evidence suggests that certain foods—especially high-sugar, high-salt, and processed items—may contribute to the development of autoimmune conditions. But, says Sowers, “I leave specific diet advice to those who are trained in that area.”

In an ideal world, the referral process would flow in the opposite direction as well, with health care providers directing appropriate patients to physical therapy. But whether it’s because of insurance restrictions, providers not realizing the benefits of therapy, or for other reasons, this flow of patients often doesn’t happen.

“I asked my rheumatologist if he refers people to occupational and physical therapy right after giving them an RA diagnosis, and he said, ‘I’d love to, but I can’t, because insurance won’t cover it because nothing appears wrong at that moment,’” Steinbarger explains. “But there is something wrong even if they aren’t having a flare. These patients should be referred to physical and occupational therapists right away.”

Failure to properly refer deserving patients to physical therapy is a barrier to care that, to Steinbarger, shows that...
while the medical field has come a long way, “we're still not where we should be.”

Even when physical therapy can be incorporated into the treatment plan, another obstacle PTs may face is appropriately managing patients’ expectations. Since cures have yet to be discovered for many autoimmune diseases, most patients must manage their condition and all of its implications for life—which can be daunting. PTs can help by teaching patients “separate out exactly why they are having physical therapy and what it can accomplish,” Shatto says.

Parlman says, “It’s helping people to prognosticate what their potential is. Identifying each patient’s individual outcome is about understanding the trajectory of the illness as it pertains to that person.”

Navigating a “Bumpy Road”

For Rundell and her team, the goal of comprehensive MS care is to improve patients’ functional independence and enhance their participation in life, with an emphasis on education and self-management. They also encourage patients to engage in personal and social activities, and to work toward maintaining a good quality of life and independence.

Shatto has found that the patients who best cope with their condition tend to be very motivated but also realistic about the bumpiness of the road ahead.

“They seem to have a strong psychological resilience, and will get right back at it as soon as their body will allow,” he says. “I’m not sure if this was something they were born with or just developed over time, but they cope well and are not easily discouraged.”

It appears that Sowers and Steinbarger could readily be placed into this category, as they continue to remain active in their educational, research, and clinical duties—as well as their social life and family commitments—despite their physical limitations.

“I am very active and tend to overdo it, which occasionally my body reminds me of,” Sowers says. “But I try not let CVID and fears of getting sick interfere with my life—that is a purposeful effort.”

Steinbarger thinks that to be successful, patients need to be able to modify their activities so they can still do what they need to do in work, play, and family life.

“I can’t play softball anymore, but I am able to ride my bike, and I like to cook,” she says. “So, I have electric mixers and all kinds of other specialized tools in my kitchen. I would tell people: If there’s something you like to do, that’s what you want to try to achieve with appropriate modifications, because it could be a big loss if you can’t do those things.”

Through her many roles, Steinbarger seeks to provide the guidance to patients that was missing when she first was diagnosed with RA, so that they can understand the value of a path that includes physical therapy and a more active lifestyle.

“These patients need someone to walk through their lives with them to see where they can make those changes, because the path is different for everybody,” she says.

Greg Gargiulo is a freelance medical writer based in the Annapolis, Maryland, area.

REFERENCES


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NEW TECHNOLOGY

KEEPING IT ETHICAL, KEEPING IT LEGAL
Technology is constantly advancing. Just a single generation ago, smartphones, social media, and voice assistant devices didn’t exist. Now they are part of everyday life. But with new technology comes new ethical challenges and legal considerations.

“Often, technology outpaces ethical concerns,” says Bruce Greenfield, PT, PhD, FAPTA, who chairs APTA’s Ethics and Judicial Committee and is a professor of rehabilitation medicine and senior fellow of the Center of Ethics at Emory University in Atlanta. “And simply because you can do something,” he adds, “doesn’t mean that you should.”
The Perils of Online Advice

While many of us lived without social media for much of our life, in the past decade it’s become a big presence in work, school, and home. Although social media can be a benefit, Nancy R. Kirsch, PT, DPT, PhD, FAPTA, offers a cautionary tale. (Note that the scenarios presented in this article are based on actual events. Certain specifics have been modified to ensure the privacy of those involved.)

“A physical therapist (PT) shared some stretching exercise advice for skiers before ski season began. He put it on his website and said these were good things to do before you start skiing,” says Kirsch, a professor and DPT program director within the School of Health Professions at Rutgers University in New Jersey. “A guy in another state did the exercises, injured himself, and had to cancel his skiing trip. He blamed the PT.”

The injured skier filed a complaint with the licensing board in his home state. Board members questioned why the PT was practicing in the state, as he wasn’t licensed there. The board took action.

“They believed he was practicing without a license in their jurisdiction, based on the way that telehealth is defined by the American Telemedicine Association, as well as on how this state defined it in their law,” says Kirsch.

Mary Ann Wharton, PT, MS, advises, “You should put a disclaimer on your website that the material there is general information and that individual advice should be obtained with an evaluation or assessment by an appropriate physical therapist.” Wharton is a physical therapy consultant in

the areas of ethics and geriatrics. She adds, “The idea of having a disclaimer is a safeguard.”

Remember, though: A disclaimer isn’t foolproof. “Anybody can be sued for anything,” says Kirsch.

“Before blogging or posting any sort of medical advice on his website, the PT should have consulted an attorney about a legal disclaimer and made the disclaimer prominent on the website,” says Kara R. Gainer, JD, APTA’s director of regulatory affairs. “The PT also should check state law before giving out any sort of health practice advice over the internet, to see if any regulations restrict him from making medical recommendations to individuals in that setting—or in any other forum that is not face-to-face. He also should check APTA’s Code of Ethics for the Physical Therapist [the Code] to assess whether there is any guidance to help PTs navigate proper patient interaction.”

Although the Code does not make specific reference to the use of social media, it does provide guidelines related to the profession’s obligation to patients and clients that should be considered when making a decision to use social media.
In addition, Gainer says, the blog post should have made clear that the PT was offering general guidance and education rather than specific advice for patients with certain conditions.

**Posting Photos Online**

Kirsch gives another example: “A PT posted photos on her social media page of a patient who she was incorrectly instructing in yoga,” says Kirsch. “The patient was clearly identified in the photo. She had not given permission to use the photos and was embarrassed to be identified as doing yoga poses incorrectly.”

The patient reported the incident to the PT licensing board, recounts Kirsch. “The PT responded that she wasn’t acting as a physical therapist at the time, but rather as a yoga instructor. The licensing board responded that she was a PT 24/7, even though she also was a yoga instructor.

“The fact is, we sometimes think what we’re doing isn’t related to being PTs because we’re doing it after hours and on our own time,” Kirsch continues. “But when you’re licensed, you’re considered a PT all the time.”

She notes that a variety of disciplinary actions could have occurred. The PT could have received a private letter from the board, a public reprimand, or public action. The latter would have included a fine and been reported to the National Practitioner Data Bank. “Every time you apply for an insurance panel, renew your license, or obtain a practice privilege through the licensure compact, it’s going to have implications. It can affect the PT’s practice forever,” says Kirsch.

“I understand that people want to be involved in social media,” she adds. “But first you have to think it through. If you’re going to do it, make sure your privacy settings are actually set to private.”

“PTs have to be aware of patient privacy,” says Wharton. “For example, in guidelines for HIPAA [the Health Insurance Portability and Accountability Act], you can post a photo as long as you have the patient’s permission. If you are ever in doubt, you can read the HIPAA guidelines.” (See “Health Technology Resources” on page 34.)

PTs also need to consider the Code whenever they work with technology, says Wharton. “Principle 1, especially 1A, talks about being respectful of the patient regardless of age, gender, or other traits. Also, look at Principle 2,” she advises, “which covers being trustworthy and compassionate. And then, specifically, look at principles 2A and 2E. Principle 2A discusses adhering to the core values of the profession, and 2E talks about protecting confidential patient-client information. Principle 3,” Wharton adds, “is about exercising sound judgment, and 3D talks about not engaging in conflicts of interest. Inappropriately using social media can be seen as a conflict of interest.

“Finally,” Wharton continues, “Principle 4 of the Code addresses integrity in your relationships, and Principle 5 covers fulfilling legal and professional obligations. So, you really have to think about how you’re dealing with HIPAA and other regulations when you're disclosing information.”

“A good rule of thumb,” she says, “is don’t post anything on social media that you wouldn’t say on an elevator or in a coffee shop.”

**Voice Assistant Devices**

Voice assistant devices (VADs) such as Alexa, Google Assistant, Siri, and Cortana have made many people’s lives easier. The user can give a command to turn on lights, listen to music, get answers to questions, and much more. Microphones that are embedded in computer chips in smartphones or standalone devices listen and capture commands or questions. A Wi-Fi

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- NANCY R. KIRSCH
The PTs interviewed for this article suggest that PTs consult these references for further guidance on HIPAA and health information technology.

**APTA**

- **HIPAA Webpage**
  www.apta.org/HPAA/

- **Health Information Technology Webpage**
  www.apta.org/FederalIssues/HIT/

- **Privacy, HIPAA Compliance, and Social Media Policy E-Learning Course**
  learningcenter.apta.org/ (Search for course by title name above)

- **HIPAA and Telehealth E-Learning Course**
  learningcenter.apta.org/ (Search for course by title name above)

- **Social Media for Physical Therapy Practices E-Learning Course**
  learningcenter.apta.org/ (Search for course by title name above)

**US Department of Health & Human Services**

- **HIPAA for Professionals**
  www.hhs.gov/hipaa/for-professionals/index.html

- **Summary of the HIPAA Privacy Rule**
  www.hhs.gov/hipaa/for-professionals/privacy/laws-regulations/index.html

- **Summary of the HIPAA Security Rule**
  www.hhs.gov/hipaa/for-professionals/security/laws-regulations/index.html

- **Cyber Security Guidance Material**
  www.hhs.gov/hipaa/for-professionals/security/guidance/cybersecurity/index.html

- **Health Information Technology And HIPAA**
  www.hhs.gov/hipaa/for-professionals/special-topics/health-information-technology/index.html

- **Guidance on HIPAA and Cloud Computing**
  www.hhs.gov/hipaa/for-professionals/special-topics/cloud-computing/index.html

- **HIPAA for Individuals**
  www.hhs.gov/hipaa/for-individuals/index.html

**HealthIT.gov**

- **Your Mobile Device and Health Information Privacy and Security**
  archive.healthit.gov/providers-professionals/your-mobile-device-and-health-information-privacy-and-security
connection relays questions to a nearby computer that transmits them to “the cloud” and receives responses. A speaker provides answers, asks follow-up questions, and even can play music and podcasts.

But recent news stories have revealed that VADs do more than listen and respond. They also record questions and conversations, sometimes relaying them to locations unknown.

Suppose that a home health care PT goes into a home and the patient has one of these devices turned on. What should the PT do? What are the PT’s ethical and legal responsibilities?

“Because we know that these devices are recording information, we must be aware of the ethical and legal risks,” says Robert Latz, PT, DPT, the APTA Section on Health Policy and Administration’s representative to the association’s Frontiers in Rehabilitation, Science, and Technology (FiRST) Council. “Device manufacturers claim that they are only recording so that they can listen for commands, but from media reports we know that they have recorded at other times as well. So if you’re talking with the patient, it’s getting recorded.”

Latz advises PTs in the first scenario to just recognize that the device is there—because it’s awkward to ask the patient to turn it off. After all, it’s their home and their device. But in your own home, he notes, you have control over the device. If you’re talking with physicians or anyone else about a patient and sharing their confidential information, make sure the VAD is turned off, unplugged, and doesn’t have a battery backup. “Or just don’t do your work around the device,” says Latz. “You can’t take that risk.”

Always review the employer policy, Gainer adds. “Check if your employer has a policy that says that you agree to go into the patient’s home knowing the machine might be on, and that you cannot—or can—request that it be turned off.”

Gainer echoes Latz’s comments, stating: “You shouldn’t use these devices when sharing protected health information—for example, using Alexa to order a prescription for your patient.” However, an acceptable use may be getting your patient to use his or her smart home device to set a reminder to take medications at a certain time.

“A GOOD RULE OF THUMB IS DON’T POST ANYTHING ON SOCIAL MEDIA THAT YOU WOULDN’T SAY ON AN ELEVATOR OR IN A COFFEE SHOP.”

– MARY ANN WHARTON
Wearable Technology And Remote Monitoring

Suppose a PT is working with patients using wearable technology—perhaps an activity tracker or a smartwatch. She is contacted by one patient’s employer, who wants the PT to begin monitoring that patient and recording the data in the electronic health record (EHR). What does she do?

“Principle 4A in our Code of Ethics gives solid advice on that,” says Kirsch. “We have an obligation to the patient foremost—regardless of who the payer is—to be honest and truthful, and to have integrity. It also says that we’re going to provide truthful, accurate, and relevant information and not make misleading representations. So if I’m going to give somebody wearable technology, I’m going to explain that it’s subject to report in the EHR, that it’s recorded, and that it’s an integral part of their treatment with us to know what’s happening and what they’re doing. The patient needs to realize that it’s all discoverable.”

She adds, “If wearable technology is not the right treatment or intervention for the patient, I’m not giving it to them. I’m certainly not going to do it so that I can report them to somebody.”

Principle 2 of the Code of Ethics, Kirsch explains, says that PTs are collaborators with their patients. “We make decisions with patients about their health care. I wouldn’t report the information to the employer unless the patient was onboard with it.”

Kirsch also points out the risk that the patient isn’t providing correct information. For example, she cites a situation in which the PTs were getting “amazing” feedback from a patient’s wearable device, indicating that the patient was doing better than should be possible based on his condition.

The patient admitted that he had put his activity tracker on his dog’s paw.

“A problem with voice assistant devices is that they’re not yet in compliance with HIPAA,” says Greenfield. “You also have to wonder which companies have access to the information that’s being recorded.”

“A problem with voice assistant devices is that they’re not yet in compliance with HIPAA,” says Greenfield. “You also have to wonder which companies have access to the information that’s being recorded.”

“Only a select group of health care organizations can currently use Alexa to communicate protected health information without violating HIPAA rules,” says Gainer, who raises another concern: “Also keep in mind that Alexa or Google Home generally runs over a Wi-Fi network. If there are security breaches in the network, those vulnerabilities extend to the voice assistant device.”

“A PROBLEM WITH VOICE ASSISTANT DEVICES IS THAT THEY’RE NOT YET IN COMPLIANCE WITH HIPAA. YOU ALSO HAVE TO WONDER WHICH COMPANIES HAVE ACCESS TO THE INFORMATION THAT’S BEING RECORDED.”

– BRUCE GREENFIELD
“The issue with the wearable being on the dog is not only that the patient is being dishonest with the PT. Some insurance companies are giving premium discounts if people use step counters and are taking X number of steps a month. If a dog’s running around with it on, that’s giving false information to insurance companies, too,” says Latz.

“As for monitoring for an employer—we can only do that if the employee—our patient—knows it, and the employer has something in writing showing that the employee has agreed to it,” says Latz.

Cameras in the Clinic
If a PT installs cameras in the clinic to monitor employees’ job performance, is this a problem?

“Many cases about PTs installing cameras are going to licensing boards—primarily because of confidentiality,” says Kirsch. She says that PTs need to decide why they’re installing cameras. Is it to protect staff or patients from being inappropriately treated? Is it because they want everything documented so that there is a record of all treatments?

“If you’re going to have cameras, you have to disclose everywhere—all over the place in the clinic—that cameras are there and recording,” says Kirsch. “The problem arises because the most logical place to install them is in treatment rooms. But sometimes patients get undressed there.”

“Installing cameras is probably not a great idea. Even if you have disclosures, there still can be problems. Confidentiality and privacy are key,” says Kirsch.

“Employers using video cameras to monitor employees are required to have a legitimate business reason for doing so,” adds Gainer. “State privacy laws determine what is considered legitimate, so it is important to be informed about your state’s specific limitations and allowances. Courts have generally upheld an employer’s right to monitor its employees with security cameras so long as the monitoring is not particularly invasive. But note that cameras in bathrooms or dressing areas usually are not allowed.”

“Including information about video surveillance in the employee handbook can help employers direct employees to written language concerning their company’s policies,” suggests Gainer. “Making your employees aware of the video surveillance ahead of time also may disperse any negative feelings of being ‘spied on.’”

Overall, she says, “Know the laws and legal ramifications regarding video surveillance.”

Keeping Electronic Health Records Private
Because PTs often are moving from one location to treat patients to another area where the records are stored, they sometimes leave an EHR open on their computer, Kirsch notes.

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“This is becoming a huge problem. People have been fired because they allowed access to protected health
information by unauthorized people. They’ve walked away from a monitor and left the record open because they’re trying to document while they’re also treating,” she says.

An even bigger problem can occur when PTs access EHRs remotely. Hospitals often have sufficient security measures to protect patient information. But if you’re accessing the records to do work while in an airport on Wi-Fi, on the bleachers while your kid plays in a baseball game, or in a coffee shop, you’re putting yourself at risk due to the lack of encryption.

“Lack of encryption or the possibility of personalized information leaking out can result in both a legal and an ethical problem due to compromise of privacy and confidentiality,” says Greenfield.

“You have to make sure your electronic devices are appropriate to transmit patient information. Your devices must be sealed, secured, and HIPAA-compliant,” says Wharton. That means, she adds, that PTs should not use personal devices unless they meet those standards.

Latz identifies another risk: PTs who access EHR under someone else’s name. For example, if a PRN therapist is coming in on a Saturday, another PT there may try to “help” by allowing access to the records under the PT’s name. “If you’re going in under someone else’s name, you’re putting them at risk and you’re putting yourself at risk as well,” says Latz. “Don’t do it.”

Telehealth/Telemedicine

According to the Health Resources and Services Administration of the US Department of Health and Human Services (HHS), telehealth is “the use of electronic information and telecommunications technologies to support...
and promote long-distance clinical health care, patient and professional health-related education, public health, and health administration. Technologies include videoconferencing, the internet, store-and-forward imaging, streaming media, and terrestrial and wireless communications.”

Telehealth can be highly beneficial. With it, PTs can treat patients in rural areas, check in with those who can’t easily make it to a clinic, and monitor patients’ conditions. That said, there are risks of which PTs must be aware, says Greenfield.

“Telehealth changes the traditional role between the PT and patient as a 1-on-1 experience. The concern among ethicists and health care professionals regarding telehealth is that it can eliminate the personalized, traditional caring relationship between patient and provider,” explains Greenfield.

“Telehealth also can be dicey if the patient only wants to be seen online or through streaming and doesn’t want to come in for an appointment. It also can be problematic if the PT only wants to provide treatment via telehealth,” says Alan Lee, PT, PhD, DPT. “Consumers need to be aware that telehealth is a digital form of care—with no hands-on treatment. They also need to be offered the opportunity to come in and receive that hands-on care.”

PTs need to know that various states are starting to develop language regarding telehealth in their practice acts, says Lee, and be aware of the ways states are addressing it. “PTs need to be mindful of where they’re licensed and what the state is doing, because how states perceive telehealth is evolving. There isn’t one set of rules regarding telehealth for each state,” says Lee, a professor at Mount Saint Mary’s University in Los Angeles and a PT at Scripps Mercy Hospital in San Diego.

Greenfield suggests that PTs who aren’t sure what they can and can’t do should—in addition to reviewing their state practice act—consult federal entities such as HHS or the Centers for Medicare and Medicaid Services. They also can check into the American Telemedicine Association—a great resource.”

At the very least, “any clinical entity that plans to use telehealth has to have adequate encryption or security measures to protect information that’s being conveyed,” says Greenfield.

What to Keep in Mind
Technology is undoubtedly beneficial in physical therapy. “There are risks out there, there are things that make us nervous,” Latz admits. But, he adds, “If we don’t innovate and use technology, somebody else is going to, and we’re going to lose that piece in our profession. So, be as aware as you can, have policies and procedures in place, and be transparent with patients. Doing these things will decrease ethical issues.”

“PTs need to know what their employer allows or forbids them to do,” Wharton says. “They need to know what’s in their employer’s policy and procedures manual. If they’re the employer, they must know what’s in their own manual. Knowing and following the proper procedures help eliminate risk.”

Greenfield says that because technologies will continue to evolve, improve, and become more complex, and because PTs will be expected to implement them into patient care, they should ask themselves if they are educated enough to do it properly—ethically and with liability risk in mind. If they aren’t, they must figure out how to get the information and training they need. “An important ethical consideration is to know that the obligations of a PT are based on the rights of the patient as well as certain standards of care,” says Greenfield.

“PTs must be aware of what they do and don’t know about our increasingly technological world, and err on the side of caution,” says Kirsch. “Know that this technology is part of the world we’re going to continue to practice in, so we need to have a better understanding of how it all works—for the good of our patients and of our profession.”

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

Note: The comments and suggestions in this article are not offered or intended, nor should be relied upon, as legal advice.

REFERENCES
A Mission-First Brand in the Making
APTA will officially roll out its new brand in 2020. Here’s what to expect.

BY ALICIA HOSMER

I learned about the power of branding at a young age. Like most pre-teens, I didn’t think consciously about it, but I was willing to take extra babysitting jobs to pay for jeans with a Guess label. Wearing these jeans helped me feel part of my middle school tribe, fitting in while also standing out. The Guess logo—that unmistakable inverted triangle with the bold “GUESS” and iconic question mark—was the most visible part of the brand on the jeans, but it was the surrounding brand narrative that made Guess so compelling to my teenage sensibilities. Ads commonly featured beautiful models in black-and-white photos that contrasted with a bright red Guess logo.

Without ever saying the words, the brand communicated effortless cool with a dash of edginess. I didn’t want to wear anything else.

While the practice of branding continues to evolve, the basic principles remain true to its roots. Branding is a centuries-old practice created by cattle herders marking their livestock to identify and claim their property. Organizations use this practice today by creating logos to mark their products and services. But branding isn’t just about company ownership anymore. Organizations large and small, for-profit and non-profit, use branding to define and deliver on the unique value they provide their customers. Brands don’t just mark what an organization has created; they shape what organizations create.

Branding is a complex process in the 21st century. Previously, marketing departments did the majority of the talking on behalf of their company’s offerings, as consumers encountered brands through limited access points. Then, 2 major shifts occurred. First, the internet boom made it easy for consumers to research and evaluate different brands, creating a flatter, more level playing field for organizations to reach an audience. Second, smartphones and social media created not only new engagement points but also new behaviors. A teenage girl today isn’t limited to buying or not buying a certain brand of jeans. She now can shape a brand’s reputation, positively or negatively, by liking, commenting, or sharing via social media. Consumers don’t just “consume” anymore.

Living the Vision and Mission

In a world in which consumers are a more active part of the brand experience, individual-member associations such as APTA have an advantage that many organizations don’t. APTA’s very existence is the result of people forming a community to support one another and pursue shared aspirations—and community is what brands strive for. Without shared values and a common passion for progress, an organization may change its logo and update its messages, but it will struggle to inspire unbridled brand loyalty.

Thus, APTA’s brand must work in concert with the association’s vision statement for the physical therapy profession, “Transforming society by optimizing movement to improve the human experience,” and its mission statement, “Building a community that advances the profession of physical therapy to improve the health of society.” If the vision, mission, and brand are aligned, the brand experience will be authentic and relevant to its audience. If not, even the most cutting-edge designs won’t create a feeling of belonging.

Building a Unified Brand

The vision and mission provided a solid foundation for development of APTA’s new brand. But the branding initiative was built on something else, as well: data.

As APTA’s Board of Directors (Board) developed the 2019-2021 strategic plan, the association conducted extensive quantitative and qualitative research on existing and potential members to take the pulse of their needs and learn where the association needed to improve its value. One theme that emerged is that APTA is seen as a highly trusted but overly complex organization.
Data showed that the physical therapy community sometimes consumes APTA products, services, and events without realizing that APTA has provided them. They trust that APTA can support them in their careers, but they often don’t know where to get the information they need. They see value at the national, chapter, and section levels, but they find the connection among those elements confusing. (Data also drove APTA’s decision to reconsider the brand of the association’s consumer-facing website, MoveForwardPT.com, and to adopt ChoosePT.com for the site. See “A Refreshed Consumer Brand” on page 46 for more about the decision and the tie-in between ChoosePT.com and the new APTA brand.)

The reasons for this complexity were not difficult to diagnose. At the national level, APTA has maintained a “house of brands” approach, with dozens of individually branded products, services, and events. This approach extended to APTA’s chapters and sections, which used their own distinct names and often abbreviated them. The result was branding gumbo and alphabet soup, with no meaningful connections between brands. Some components even unintentionally shared brand names: For example, 2 chapters use OPTA and 3 chapters use IPTA as their primary brand.

“To look at our vast landscape of uniquely branded products, events, services, and even components is to behold an association that is fragmented and complex,” said APTA President Sharon Dunn, PT, PhD, in her address to the House of Delegates in June. “It suggests to our community,” she quipped, “that association membership should come with a tour guide and a translator.”

The solution was to develop a connected and coordinated brand—a “branded house” approach—that would make it easier for the physical therapy community to engage with the association, and vice versa. A unified brand would strengthen APTA’s role as the leading voice for the physical therapy profession and enhance the association’s ability to live its mission of building one community while pursuing a transformative vision. (Read more about these 2 approaches in “Branded House Versus House of Brands” on the facing page.)

The APTA Board prioritized implementation of an integrated brand strategy across the association by making it an objective in the association’s updated strategic plan for 2019-2021. To achieve that goal, APTA wouldn’t just rename various national products, services, and events. We’d also create opportunities for APTA chapters and sections to align within the brand—a process that is expected to take several years to implement.

“Aligning our dozens of brands won’t be easy,” Dunn said, “but the result will be a more accessible association. A unified brand strategy makes it easier for our community to engage, and it strengthens our collective voice. It’s yet another chance for us to be better together.”

Her message, to be clear, was one of evolution—not revolution. Rebranding was not about reinventing ourselves. It was about maturing as an organization
Branded House vs House of Brands

Organizations employ different brand strategies depending on their product offerings, audiences, and overall business goals. Two popular methods of branding are a branded house and a house of brands.

A branded house strategy makes the organization the brand. All sublevel brands support the main brand by consistently incorporating verbal and visual elements from the parent organization. This approach helps build strong brand recognition and makes the brand easily recognizable and memorable. Amazon is one example of a branded house.

Amazon Prime, Amazon Music, and Amazon Fresh all are examples of Amazon’s sublevel brands. Each brand extension clearly puts Amazon first, as demonstrated by their logos. Amazon always is in the same font, with the sublevel brand following it.

In a branded house strategy, all resources are committed to the same brand, rather than split between multiple teams for multiple brands. This helps create strong brand recognition and makes it easier to go to market with new offerings. A branded house strategy requires significant buy-in and willingness from everyone within the organization to embrace 1 brand.

A house of brands, meanwhile, uses the opposite concept: Each product line is branded and marketed independently. Each brand works on its own terms and serves different customers, creating numerous independent brands. Procter & Gamble is an example of a house of brands: From Crest toothpaste to Charmin toilet paper to Tide laundry detergent, the parents company’s offerings vary, and serve customers in different ways. In addition to catering to diverse constituents, this approach requires significantly more resources than does a branded house.
and maximizing our potential. APTA had been producing meaningful results for decades. A new brand would strengthen APTA’s reputation as the trusted leader of the profession while making the association more inclusive to empower members to thrive.

APTA’s Future Logo

In April 2018, the brand team leveraged member data and insights to begin developing the association’s brand platform—a guiding document that outlines APTA’s brand promise, personality traits, and impact. The platform would be the foundation of the brand—helping to define the way the world sees us and serving as a blueprint for aligning our products, services, events, and components.

In November 2018, the brand platform was finalized, and APTA began collaborating with Tenet Partners, a nationally respected brand agency, to develop the unified brand. Our work did not start with logo development. Instead, it focused on our brand architecture—how products, services, events, and components would connect with one another in a cohesive system. This process included constant engagement with chapter and section leaders.

By February 2019, blueprints of the brand were done, and it was time to move to design. Over the course of this phase, APTA explored more than 2 dozen logo concepts before selecting the concept that—after multiple thoughtful revisions—was selected to be the association’s new national mark.

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While an entity’s logo is only part of its brand, it is an essential cornerstone of any brand platform and arguably is the most visible element. APTA’s new logo evokes our brand attributes in a number of ways. First, the design of the logo symbol honors APTA’s rich history by carrying forward a triangle shape that has been consistent throughout a century of APTA logos. Second, it retains the color teal, which traditionally has been tied to APTA and enables us to build on our brand equity. Third, the new logo successfully captures the progressive spirit of our organization and the essential role movement plays in our profession.

Visually, the symbol helps communicate a sense of forward movement—changing, lifting, aspiring, and reflecting APTA’s continuous journey toward improvement. The clean and simple design helps make the logo clearly recognizable while holding the same professional stature as those of other highly regarded medical associations. (See “Anatomy of APTA’s New Logo” on the facing page.)

“The brand project is about ensuring that our collective value is greater than the sum of our parts,” APTA Chief Executive Officer Justin Moore, PT, DPT, said when he announced the new logo in June. “It’s also about committing to a higher level of excellence across all of our programs, products, and member experiences.” The new logo helps APTA tell this story.

But the logo is just 1 of many brand assets developed to help more clearly communicate what APTA is and the value we provide. In addition to the logo, we will communicate our brand through consistent use of typography, color, imagery, graphics, and messaging. We will rename our national products and services to align with our branded house strategy. While some of APTA’s offerings already lead with APTA—such as the APTA Learning Center—many do not. One example is this magazine (spoiler alert: PT in Motion will be renamed next year to make it more easily identifiable as an APTA publication). We are evaluating APTA’s 40-plus brands to determine whether we will keep, update, or sunset each one depending on how it fits within the new brand strategy. We then will rewrite and redesign our marketing and communications accordingly.
Anatomy of APTA’s New Logo

The APTA logo comprises the arc symbol, the APTA American Physical Therapy Association wordmark, and the SM mark, as shown. The arc symbol is inspired by a triangle shape that has been used consistently throughout a century of APTA logos. The teal color is uniquely APTA and is being carried forward from the old to the new brand to help build on its brand equity. The clean typography of the “APTA” acronym, along with its neutral grey, pairs it easily with the sublevel brands within APTA’s branded house model.
In 2016, APTA launched its national opioid awareness campaign by encouraging consumers to “choose physical therapy” for the management of most chronic pain, consistent with guidelines from the Centers for Disease Control and Prevention.

Since then, the #ChoosePT campaign has won multiple national awards and has inspired unprecedented involvement with APTA’s public awareness efforts. APTA members have brought the “choose physical therapy” message to Capitol Hill, community health fairs, minor league baseball games, and even license plates.

That engagement is a top reason that APTA recently retired its “Move Forward” brand, which launched in 2009, and made “ChoosePT” its overarching consumer brand message. As part of that transition, APTA switched its official consumer information website URL from “MoveForwardPT.com” to “ChoosePT.com,” transitioned related social media accounts, and released a new ChoosePT logo that is consistent with the new APTA brand architecture and visual identity.

“When we launched our opioid awareness campaign we knew that our #ChoosePT message was dynamic enough to extend beyond the safe management of chronic pain,” says Jason Bellamy, APTA’s executive vice president of strategic communications. “With the association’s centennial approaching in 2021, and the public awareness opportunities that will provide, this was the perfect time to make “ChoosePT” our primary call to action.”

Additionally, APTA launched an enhanced Find a PT directory at ChoosePT.com that makes it easier for consumers and health care providers to filter results by practice focus or specialization. Profiles in Find a PT are an exclusive benefit of physical therapist (PT) APTA membership that PTs should maximize.

“More than 4 million people will have visited ChoosePT.com this year,” Bellamy says. “One of their most common destinations is Find a PT. I encourage APTA members to ensure that their profiles are up-to-date, and to add a headshot to make their profile more appealing. Do everything you can to help consumers choose you.”
Over the next 6 to 12 months, we will begin to roll out the brand through our communications channels, officially launching the first round of rebranding with the debut of the new APTA.org website in summer 2020. APTA’s website will be one of the main representations of the new brand. It will have a new, modern interface that will be easier to navigate. It will reflect the work being done over the next 6 months to bring our disparate brands into a branded house concept, and will help elevate our brand story and member benefits.

Chapters aligning with the unified brand will eliminate confusing abbreviations and move to an APTA-leading name—for example, APTA North Dakota, APTA Mississippi, and APTA Virginia. Chapters will share the same arc symbol as APTA and a slightly darker shade of blue that complements the APTA teal. Through the APTA-leading naming convention, color, typography, and messaging, the new brand elements will help to strongly connect yet still effectively distinguish APTA national from its chapters.

Better Together

So, what does a new brand strategy mean for APTA members and their experience with the association?

A unified brand symbolizes our ability to work together by providing a platform that connects our national products and services, specialty sections, and chapters while still recognizing and respecting the uniqueness of each entity. We’re making improvements that will help us communicate more clearly nationwide and at the local level, so that all of APTA can do a better job of representing and empowering members.

While chapters and sections will continue to operate autonomously to support the specialized needs and interests of their members, across our component organizations members already have started to experience the new brand. APTA chapters and sections are in full swing toward adopting the unified brand, with several already launching the new look and new names as these innovations work best for them. APTA is helping components make the transition to the new unified brand by providing resources through a component support program that was approved by the Board earlier this year.

These changes are not just about new graphics and product names. The new brand is designed to prepare APTA for its centennial by celebrating our accomplishments and embracing our progressive spirit. Much like the association’s mission and vision, over time the brand will help inform the opportunities APTA provides members and shape the impression members have of the association.

When APTA’s new brand launches nationally in 2020, it will better reflect our accomplishments, the dynamic nature of the organization, and our leadership in the health care industry. We will never stop evolving. We will ensure that our brand helps us deliver on our mission and reach toward our vision to transform society by optimizing movement to improve the human experience.

Alicia Hosmer is APTA’s senior director of brand strategy.
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HEALTH CARE HEADLINES

We’ve compiled highlights of stories published by PT in Motion News for a recap of reports on the physical therapy profession.

CMS Has New Authority to Deny Enrollment to Providers Who Are or Were “Affiliated” With Sanctioned Entities

In a problematic rule that is effective November 4, the Centers for Medicare and Medicaid Services has granted itself the power to deny or revoke enrollment in Medicare, Medicaid, and the Children’s Health Insurance Program (CHIP) to providers who do not disclose an “affiliation” with a previously sanctioned organization—even if that organization was not enrolled in Medicare, Medicaid, or CHIP at the time of the relationship. The definition for affiliation is extremely broad, including relationships in which the provider has as little as a 5% direct or indirect ownership of the affiliate, as well as any reassignment relationship. APTA believes the rule is overly burdensome and puts patient access at risk.

www.apta.org/PTinMotion/News/2019/09/09/CMSAffiliationRule/

A Connection Between Knee/Hip OA and Increased Risk of Heart-Related Death?

Researchers from Sweden found that among individuals studied, those with hip or knee osteoarthritis (OA) died from chronic ischemic heart diseases and heart failure at a greater rate than did both the non-OA population and those with OA in other peripheral joints. No other significant correlations were found between the presence of OA and other causes of death, including diabetes, dementia, neoplasms, or diseases of the digestive system. The authors believe the findings further underscore the importance of emphasizing physical activity in the treatment of OA. The study was published in Osteoarthritis and Cartilage.

www.apta.org/PTinMotion/News/2019/08/16/KneeHipOAAndCauseOfDeath/

Physical Therapy’s Social Media Reach Could Be Better

A study published in PTJ (Physical Therapy) that analyzed physical therapy-related tweets found that, for the most part, Twitter discussions about the profession are occurring in an “echo chamber”—if they even rise to the level of a discussion in the first place. Researchers found that many messages didn’t make it past a tight cluster of users, with large numbers of messages resulting in “no interaction with anyone other than the tweet’s original author.”

www.apta.org/PTinMotion/News/2019/08/05/PTsReachSocialMediaStudy/

Mothers Who Exercise During Pregnancy May Give Their Infants a Motor Skills Boost

In a study that analyzed data from 60 healthy mothers and their infants, researchers found that infants of mothers who engaged in aerobic exercise during pregnancy tended to show better motor development at 1 month compared with infants of nonexercising mothers. And in what authors describe as an “intriguing” finding, female infants in the exercise group erased the motor skills edge that male infants tend to have at that age. The authors believe that the motor skills boost so early on could be a hedge against overweight and obesity in later childhood. The study appeared in Medicine and Science in Sports and Exercise.

www.apta.org/PTinMotion/News/2019/08/20/AerobicExerciseDuringPregnancy/

Physical Therapy Education Leader Rosemary Scully Dies

Rosemary Scully, PT, EdD, FAPTA, the author of several influential books, reports, and studies, had a tireless passion for learning that left a lasting imprint on physical therapist clinical education. Her presence also was felt at APTA: Scully was vice speaker of the APTA House of Delegates from 1977 to 1983 and received the association’s Lucy Blair Service Award in 1989. In 1992, Scully was named a Catherine Worthingham Fellow. She was 83.

www.apta.org/PTinMotion/News/2019/08/26/ScullyObit/
APTA LEADING THE WAY

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

New Clinical Guidelines Say There’s Strong Evidence to Support Exercise Therapy for Patellofemoral Pain

In its first-ever comprehensive clinical practice guideline (CPG) on patellofemoral pain, APTA’s Academy of Orthopaedic Physical Therapy lays out a set of recommendations stressing exercise therapy as the best approach to improve functional performance in the short, medium, and long term. The guidelines, published in the *Journal of Orthopaedic and Sports Physical Therapy*, also include recommendations on diagnosis, classification, and examination. APTA provided funding and technical support during development of the CPG as part of its ongoing initiative to work with sections to produce a range of guidelines that highlight the evidence base for physical therapy in treatment of a variety of conditions.

APTA Pushes for PTs to Be Included In Proposed FCC Pilot Program to Subsidize Telehealth Delivery to Rural and Low-Income Americans

The Federal Communications Commission (FCC) has proposed a pilot project intended to increase delivery of telehealth to rural and low-income Americans by way of a $100 million, 3-year funding initiative. Details remain to be worked out, including which providers would qualify for the subsidies, whether the funding would be limited to telehealth services for a limited list of patient conditions, and how compliance with the program would be monitored. APTA provided FCC with its take on the proposal, emphasizing the need to include physical therapists as qualified providers and urging FCC to think more expansively about the range of conditions that would be appropriate for telehealth services.

www.apta.org/PTinMotion/News/2019/08/21/CommentsToFCTelehealth/
Here’s recent research of note and more from PTJ (Physical Therapy, APTA’s scientific journal), as selected by Editor-in-Chief Alan Jette, PT, PhD, FAPTA.

**Highlights From the November Issue:**

Have you had any experience with virtual clinical trials? If so, Alan Jette wants you! This month, he calls for a “next generation” of clinical trials that fully incorporate new digital technologies, arguing that traditional randomized controlled trials are becoming more costly, inefficient, and inaccessible. “Given the types of patients served by the rehabilitation community and the large and talented cadre of clinical rehabilitation scientists,” he sees virtual clinical trials as a way to expand the capacity to conduct trials—with increased generalizability—in important areas of physical therapist practice.

When it comes to hot topics, the sacroiliac joint (SIJ) is a perennial. Just look at the social media activity related to November’s “Changing the Narrative in Diagnosis and Management of Pain in the Sacroiliac Joint Area”: even in its publish-ahead-of-issue version, it had more than 240 mentions, with tweets from Russia, Saudi Arabia, Australia, Nigeria, France, and the Sudan. In this Perspective, Palsson et al review the evidence on clinical detection and diagnosis of SIJ movement dysfunction and question the continued use of movement dysfunction assessment despite growing evidence that “undermines the biological plausibility and treatment paradigms based on such diagnoses.” The call is for clinicians to improve patient outcomes by aligning “assessment methods and explanatory models to contemporary science.” Look for Editor-in-Chief Alan Jette’s author interview with Thorvaldur Palsson.

Let this sink in: 25% of patients with acute stroke did not receive a physical therapist consultation or intervention. That’s what Capo-Lugo et al found in their longitudinal study of more than 1,300 patients with ischemic or hemorrhagic stroke in an acute stroke center (“Patients With Greater Stroke Severity and Premorbid Disability Are Less Likely to Receive Therapist Consultations and Intervention During Acute Care Hospitalization”). The authors suggest strategies to help ensure delivery of acute care therapy services for these patients, including real-time updates to consultation requests and rosters to show patients’ current status and availability or suitability for physical therapy.

Watch some fascinating videos and animations with “Creative Yoga Intervention Improves Motor and Imitation Skills of Children With Autism Spectrum Disorder.” Evidence is mounting that motor impairments—such as poor gross and fine motor control and poor balance—accompany autism spectrum disorder (ASD) in children, but evidence on the effects of motor interventions in this population is limited. In this promising study, Kaur and Bhat found that a physical therapist intervention using creative yoga resulted in improvements in 24 children with ASD. Look for Jette’s author interview with Anjana Bhat.

**Other topics covered this month:**

- Pain and disability outcome measures in pregnancy-related low back and pelvic girdle pain.
- Functional strength integration techniques to improve functional performance for veterans after total hip arthroplasty.
- Blinding strategies in dry needling trials.
- Physical fitness and health-related quality of life in women with fibromyalgia.
- Home-based exercise with blood flow restriction to improve quadriceps muscle and physical function after total knee arthroplasty.
- Perceptions of balance in Parkinson disease.
- Multidimensional developments and free-play movement tracking in toddlers with ASD.
- Treatment effect of low-intensity pulsed ultrasound on benzene- and cyclophosphamide-induced aplastic anemia in rabbits.
- Suggested modifications to the Brief-BESTest.

November articles are posted at academic.oup.com/ptj/issue/99/711.

APTA members have unlimited free online access to current and past PTJ articles.
I Don’t Care About My Grades

I find that my grades rarely measure what I expect.

How many times have you gotten back a poor grade even though you had studied for a week straight? Or—conversely—you ace that quiz that you completely forgot was even scheduled?

Recently, I failed a pretty important class assignment. I was graded by my peers on my ability to perform an evaluation and give a differential diagnosis. I was nervous. Not only was I being judged by a group of 4 student observers acting as clinical instructors, but I also was going to be graded by my “patient.” The interesting aspect of the assignment was that the patient was, in turn, being graded by me and the clinical instructors on her performance playing an authentic patient. Talk about pressure—am I right?

At the end of our role-play I breathed a sigh of relief. While I missed a component of the overall diagnosis, I left feeling pretty satisfied with my performance. Maybe I wouldn’t get an A+, but definitely I would get nothing below a B.

A few days later my grade was posted. I nonchalantly logged into the grading portal to find a 65%.

Was I seriously that bad at this whole physical therapist thing? Am I just walking through life overly confident in my abilities?

After speaking to my professor about the disparity, I learned that I was not the failure that I made myself out to be. Whew! My student “clinical instructors” had actually scored me the same way I would have graded myself; however, my “patient” scored me fairly low. Because all the grades counted equally, my final grade suffered.

In the end, aggregate patient outcomes are going to be the most important grade, and although there will be always some outliers, this is arguably the most valuable item to structure my practice around.

So maybe it’s not that I don’t care about my grades but that I realize their fallibility.

Grades are just trying their best to keep us energized and motivated. Acknowledging the feedback is always a smart idea, but I also get to choose what to accept and place value upon. In this case, I chose to place the value back on me.
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Defining Moment

By Katie Borgelt, PT, DPT

A Message of Hope at A Critical Time
Thoughts on a presidential address.

Katie Borgelt, PT, DPT, is a travel physical therapist employed by CompHealth.

It had been an unexceptional day in the clinic in small-town Virginia. Despite a pleasant work environment at my newest travel site, I couldn’t shake the familiar “funk” that had been present, in varying degrees, since my first job after graduation with my doctor of physical therapy (DPT) degree in 2016.

Settling on the couch of my new rental unit that June evening, I spotted an email from APTA in my inbox. Perhaps subconsciously desperate for inspiration, I clicked on a video of APTA President Sharon Dunn’s recent address to the 2019 House of Delegates. I am glad I did, as Dr Dunn’s message left me with a refreshed sense of hope and encouragement regarding the profession of physical therapy and my role in it—as opposed to an overall building disenchantment with the profession I had experienced over the previous 3 years.

Dr Dunn was addressing the House, but it was as if she had been speaking directly to me. She sugar-coated nothing—zeroing in on 3 serious issues facing physical therapy. The first was the cost of our education, which she described as “a crisis that is plaguing our present and threatening our future.” The second was employer productivity models that endanger, as she put it, “what makes our profession special for the provider and the consumer: a human connection that cares for the person in front of us, not just the condition.”

The third issue was insufficient diversity, equity, and inclusion within physical therapy—a failure, she conceded, that starts at the top. “For a long time,” acknowledged Dr Dunn—a white, middle-aged academic—“our association leadership has looked a lot like me: same general age, same skin color, often hailing from the halls of education, as I do.”

I was impressed by her frankness in both acknowledging the serious problems that physical therapy faces and presenting potential solutions to each challenge. With resolve, she stated, “We can do better.” (I encourage all physical therapists, physical therapist assistants and students of physical therapy to check out the video of her address at www.apta.org/Blogs/PTTransforms/2019/6/11/Dunn/)

Defining Moment spotlights a particular moment, incident, or case that either led the writer to a career in physical therapy or confirmed why he or she chose to become a physical therapist or physical therapist assistant. To submit an essay or find out more, contact Associate Editor Eric Ries at ericries@apta.org.
What I most appreciated was Dr Dunn’s rallying cry to unity and accountability for the sake of long-term advancement. “We are in this together, and we must be accountable to each other and to the generations that will shape our next 100 years,” she said, adding, “Let’s put our self-interests aside and do the right thing, even when it’s the hard thing.”

Dr Dunn’s address was exactly what I had needed to hear at that moment. For context, I would like to share a brief account of my personal journey in the profession—which in some ways may parallel yours.

I found PT school to be difficult. Despite excellent and supportive faculty and classmates, the rigorous coursework and schedule took a mental and emotional toll. In the back of my mind, I also felt the growing weight of student debt that, even assuming gainful employment upon graduation, would take me a decade or more to repay. Still, my desire to improve people’s lives as a physical therapist drove me forward. I looked to the future with optimism, despite moments of self-doubt and financial worry.

With a fresh degree and license in hand, I entered my first job ready to change lives—only to end up leaving the position 7 months later with a sense of mistrust, heightened insecurity, and discouragement.

Another early job at a large outpatient clinic left me most days feeling physically, mentally, and emotionally drained. Unreliable patient attendance, a flood of required meetings (often over lunch hour), limited mentoring, and management-encouraged overbooking to meet productivity standards resulted in high stress and decreased personal wellness. I could not provide the quality of care I desired in this setting.

My immediate supervisor was sympathetic. She supported my idea to seek counseling—which proved helpful. But I still felt burned out. It was again time to make a change.

Hence, my current role as a travel therapist.

I am certainly happy with aspects of my current position. Increased control over my schedule, including vacation time, gives me greater freedom to prioritize time with my family and friends. A higher salary enables me to pay down my student debt more quickly. I also have enjoyed the diversity of practice settings, geographic locations, and, yes, people. (Although, as Dr Dunn pointed out, our profession still has a long way to go to mirror the diversity of American society.)

That being said, I still feel uncertainty regarding my future career. The issues that Dr Dunn presented in her address are real and continue to weigh on me. Providing quality patient-centered care as a physical therapist is extremely difficult in a system of excessive documentation requirements and
insufficient reimbursement for our services. I continue to feel worn down at the end of many work days spent in a flurry of balancing patient care, administrative tasks, and documentation.

Recently I found myself Googling “best second careers”—specifically, in view of my debt burden, “best second careers that do not require additional education.” Three years out of grad school—despite a love of helping patients and my belief in physical therapy’s potential to transform society—I contemplate eventually leaving the profession that has taken a toll on my wellness.

I do not, however, plan to leave the PT world anytime soon. I am grateful for an excellent education, a useful and relevant skillset, and the opportunity to positively affect each patient I am entrusted to treat. When I consider my long-term work life, the largest doubt is the sustainability of my own personal well-being.

Although Dr Dunn’s address alone has not reversed my consideration of an eventual career change, her words did instill hope that some of the factors affecting quality of life and job satisfaction among therapists such as me could change for the better. However, as Dr Dunn communicated in her speech, “Each one of us has a leadership role to play in creating change.” In the address, she notes, “History is...defined by the actions we take, and, just as significantly, it’s defined by the actions we don’t take.” As is the case with most things in life, it is easy to complain, but much more constructive to pursue solutions. This is, admittedly, easy to proclaim and harder to live.

Soon after watching Dr Dunn’s address, I sent her an email of thanks. I shared the link to the video on my DPT class’s Facebook page. I sought out the dates of next year’s Combined Sections Meeting in Denver. And then I began considering how I personally might go about “doing the right thing”—to help strengthen our profession and fulfill its promise.

I thought about reaching out to the DPT faculty at my alma mater to ask about the school’s current credit-hour requirement—and to see whether it might decrease, without a drop in program quality, to lessen the cost burden on current and future students. I resolved to have conversations with colleagues, administrators, legislators, and even patients about barriers to care to brainstorm potential solutions. I considered taking a more active role in APTA’s Health Policy & Administration Section (HPA The Catalyst), and—in keeping with Dr Dunn’s vision—to advocate for greater inclusion of traditionally underrepresented groups within our profession.

In my email to Dr. Dunn, I wrote that her speech reassured me that I am not alone or unfounded in some of my feelings. I told her that it gave me hope to hear APTA leadership addressing the hard questions and seeking collaborative, long-term solutions to the barriers faced by our profession.

One of my favorite quotes about leadership is by Dolly Parton, who said, “If your actions create a legacy that inspires others to dream more, learn more, do more, and become more, then you are an excellent leader.” I thanked Dr Dunn for her leadership, because I recognized myself wanting to “do something” after hearing her address—a response indicative of true leadership.

Ultimately, our collective success lies in each one of us—physical therapists, physical therapist assistants, and students—asking ourselves what we can do now to improve factors that are hindering therapists from thriving. Thoughtful answers put into action are our hope for improving the sustainability of our wonderful profession—benefiting both patients and providers for generations to come.
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α: We have more access to information today. Every answer we need is at the tips of our fingers. We also carry a lot more debt, tend to work more hours to pay this debt, and take jobs that are less desirable but come with a higher salary.

– KAITLIN NAUGHTON, SPTA

What’s the best way you’ve found to get patients to buy into their home exercise program?

α: Engagement and communication. Patients seek verbal and written directions on how to complete their exercises, in adjunct to tactile cues. Patients who understand their diagnosis and how this exercise will help their prognosis will be compliant. Also, empathize with your patients regarding their time; give only 2-3 exercises at a time. Finally, let your patients know they are accountable for doing their home exercises. Their follow-up visits will be to answer questions regarding their program and to introduce new progressive exercises—not to repeat their previous home exercises in the clinic.

– ALISA DRAPEAUX, PT, DPT

α: Shared decision-making.

– JUDITH DEUTSCH, PT, PHD, FAPTA

What advice do you have to avoid burnout?

α: Maintain healthy habits outside of work. Make sure you get plenty of rest, exercise, and proper nutrition so that you have a positive outlook and plenty of energy for work.

– MATTHEW SPILSBURY, PT, DPT

α: Take time to take care of yourself—you need to move (and not just rush around at work) as much as any of your patients do.

– MICHELE STANLEY, PT, DPT

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