Healthy Growth in Wellness Services

Twelve Months of Health Care Awareness

Highlights from CSM
LOOKING AT THE FEET?

If you’re not:

• You’re not getting the full picture of patients’ biomechanical dysfunction
• You may not be providing the best tool for postural stability and balance
• You’re missing out on a solution - Custom Orthotics
• An additional revenue stream is walking out your door

Foot Levelers custom orthotics - experience the benefits yourself.

FootLevelers.com 888.966.0970
L300 Go is a functional electrical stimulation [FES] system that provides low-level electrical stimulation which activates the nerves and muscles that lift the foot.

**SUPERIOR STANDARD OF CARE**
- Facilitates muscle re-education
- Prevents/retard disuse atrophy
- Maintains or increased joint range of motion
- Increases local blood flow

**RECLAIM YOUR FREEDOM**

L300Go.com | 844.669.2653

Individual results may vary. Patients are advised to consult with a qualified physician to determine if this product is right for them.

Important Safety Information and Risks: For indications for use, contraindications, warnings, adverse reactions, precautions, and other safety information please refer to www.bioness.com/Safety_and_Risk_Information.php (also available in the L300 Go Clinician’s Guide).
What you need to know about offering health and wellness services at gyms and public pools.

The need for teamwork to best serve a patient.

The journey of a PT/anthropologist.
Neo G is proud to be an official worldwide partner of The Chartered Society of Physiotherapy, the UK equivalent of the American Physical Therapy Association (APTA). Medical Grade orthopedic supports, designed by professionals and registered as Class 1 Medical Devices with the FDA – now available at Walgreens and leading retailers across America. For further information visit get.neo-g.com

Now Available At

Walgreens

Trusted since 1901™
People shell out vast sums of money for personal training, nutritional consultations, and mail-order diets. People also understand the importance of an annual check-up with their primary care physician, eye doctor, or dentist, but somehow physical therapy is generally perceived as that thing you do only if you get sick or are injured.

James Gallegro, PT, DScPT, MSPT,
in “Healthy Growth in Wellness Services”
(page 16)
Intensive Gait Therapy at it’s Best

Meet Indego Therapy, the most versatile exoskeleton for intensive overground gait training—featuring special software programs for patients post CVA and SCI.

- Efficient training thanks to quick setup time
- Covers the full continuum of care
- Based on motor learning principles
- High patient satisfaction

Call us to schedule a product demonstration or to learn more about our attractive lease to own program: 844-846-3346
On March 20, as the severity and spread of the COVID-19 pandemic was all too apparent, APTA’s president reached out to members with this open letter that we’ve excerpted for PT in Motion. Since then, certain guidance related to practice and safety considerations, and to broader telehealth options, has been released by entities such as CMS and the CDC. The most current information is on APTA’s continually updated COVID-19 webpage: apta.org/coronavirus/.

To the physical therapy community,

This is far from the world’s first pandemic, but it’s the first of this scale of our lifetimes. It’s not often that we are aware we’re in a historical moment as it’s happening, but this is one of those times – and the story is still being written.

None of us knows how this will end. It’s hard to predict when it will even feel “over.” At some point confirmed cases of COVID-19 will wane and go away, but left in the outbreak’s wake will be collateral damage that, on a personal level, will affect many of us far more than the virus itself.

[In March], APTA released a statement encouraging physical therapists to “use their professional judgment to determine when, where, and how to provide care, with the understanding this is not the optimal environment for care, for anyone involved.”

I’ve heard from some members of our physical therapy community who feel that this statement didn’t go far enough, that we should have called for all outpatient clinics to temporarily shut down. I understand those concerns.

This is a challenging time to be in health care. I commend all those who are putting their own health at risk to treat their patients and clients who have immediate health needs. I also applaud those who are selflessly closing the doors to their practices because they have determined the risk of spreading COVID-19 outweighs the benefits of providing care that is not urgent. Both actions are heroic.

That’s why the APTA Board of Directors felt that the best approach is to rely on the professional judgment of physical therapists – because care decisions should be based on a specific person’s needs and a risk/benefit analysis for the individual, not simply by the setting in which the care is provided. The COVID-19 outbreak changes the factors we must consider in our professional evaluation, but it does not change our basic responsibility to do what is best for our patients. As licensees, physical therapists are empowered and obligated to make those decisions.

We are going through this together, day by day, doing our best to make a positive impact on society in a moment in time when there are no easy solutions.

Some people in our physical therapy community will have their lives affected by the coronavirus. Others will be harmed by our country’s very necessary efforts to stop its spread. Jobs will be lost. Some clinics that close may struggle to reopen. And students will graduate into what could be an unstable economy.

My heart hurts when imagining what might be. But I also have hope.

I hope that this disruption to our health care system will prove once and for all the necessity of broad-based access to our services, including telehealth, and that the primitive barriers APTA has spent years advocating to remove will finally start to fall.

I hope that this uncertain time brings us together – as a nation, as a community, as an association – by showing us how connected we are, and how much we depend on each other.

And I hope that our profession will do what it does best: help our society move on from a period of suffering, by restoring function, independence, and dignity to survivors.

Just as we rose to the occasion during the polio epidemic, I believe we have another watershed moment at our doorstep to help rehabilitate a world challenged by COVID-19.

Based on some of the forecasts, our fellow health care providers could soon be inundated by an influx of patients with needs specific to COVID-19, which will lead to an increased demand for physical therapists in critical care units, emergency departments, and triage. We will need to pivot quickly in order to respond to our calling.

Take care of yourselves and your community. We need each other.

Sharon L. Dunn, PT, PhD
Board-Certified Orthopaedic Clinical Specialist
APTA President
Compliance Matters: How to Apply the New CQ Modifier

March 2020

There is zero chance that this policy can be effectively implemented short of having a video of the treatment session ... but then there’s HIPAA. There is no way to refute what is billed. For example, submitting claims in the absence of services being billed, or billing when a PT was not present. This brings up the question of how onsite supervision can be mandatory, yet reimbursement is reduced. How is that fair or reasonable?

William Bieker

Rewiring the Brain to Ease Chronic Pain

May 2019

Excellent, informative article, I agree that lifestyle, sleep pattern, stress factors, and vitamin D levels have to be considered.

Ram Saroop

Defining Moment: Making a Wheel Difference

February 2020

Thank you for allowing my grandson Reid Fracchia to get involved in such a worthy project. My hope is that many more states become involved in your Come Roll With Me program.

Marvin Reid

Excellent article. I have been so impressed with your energy and passion over the past few years to grow this program! Thank you for sharing the steppingstones for others to develop a Come Roll With Me program.

Barbara Crume

Well To Do: Adopt the Rule of 7

March 2020

I would love a follow-up on this article. I’m a DPT student, and obviously the opportunities to rank the engagement up to a “7” are very limited with the mundane and time-consuming tasks that are required of us. Thank you!

Jessica Smith

Actors With Disabilities and the PTs Who Treat Them

March 2020

I often have commented that Hollywood does not use PTs as consultants when it portrays characters with disabilities. For example, Dr. House used his cane incorrectly. So did Frazier’s dad. Why not start there?

Nataly Pluta, PT
Providing Offsite Wellness Services

What you need to know about offering health and wellness services at gyms and public pools.

Physical therapy is about so much more than recovery from injury. While PTs are experts in rehabilitation and habilitation, they have the skillset to help improve overall health and prevent the need for avoidable health care services and costs. It’s no wonder, then, that so many PTs are incorporating health and wellness activities into their practice. The Regulatory Affairs team at APTA receives many queries about what PTs and PTAs can and can’t do in this field, particularly with regard to providing physical therapy to Medicare beneficiaries in a fitness facility, gym, or public pool. So, let’s answer a few of the most frequently asked questions.

Can I meet my Medicare patient in a local gym to conduct a physical therapy session? The answer depends on the type of provider you are.

The Centers for Medicare and Medicaid Services has a clear answer for PTs who are in private practice: Medicare Part B covers physical therapy services furnished by PTs in private practice when those services are offered in the PT’s office space or in the patient’s home. “Office” is defined as the location in which the practice operates, in the state in which the PT (and the practice, if applicable) is legally authorized to provide services, during the hours in which the PT engages in practice at that location. A PT’s private practice office space must be owned, leased, or rented by the practice and used solely for operating the practice. Also, the PT must be enrolled in Medicare in a solo practice, a partnership, or a group practice, or be employed by one of those types of practice.

So, if you are a private practice PT, it’s possible to use a gym to provide therapy services to Medicare beneficiaries, but you must lease or rent the gym for the time spent and restrict your use of the gym during that time to physical therapy services to your patients.

PTs with other outpatient rehabilitation providers, such as rehabilitation agencies or comprehensive outpatient rehabilitation facilities, must comply with conditions of participation and accompanying guidance outlined in the Medicare State Operations Manual.

For instance, the publication states that providers of outpatient therapy and speech-language pathology
services must provide the required services at their primary Medicare-approved site. While the manual provides guidance on permissible off-premises activities at other locations, such guidance must be closely examined.

What is acceptable to Medicare Advantage plans or commercial payers is less clear. When dealing with commercial insurance providers, check your contract and the provider manual for guidance on which settings are eligible, and what requirements the payer places on services delivered in a gym or a fitness facility setting.

**Can I provide aquatic therapy to Medicare patients in a public pool?**

Again, the first question to be answered is: What type of provider are you?

If you’re a PT in a private practice, physician office, outpatient hospital, or outpatient skilled nursing facility, you may furnish aquatic therapy services in a community pool, but, similar to using a gym, the pool or specific part of it must be rented or leased for the time spent, and you must restrict your use of the pool during that time to providing therapy services to patients of your practice or facility.

When you rent or lease part of the pool, the written agreement must describe which part of the pool you will use and at which times. The agreement must be available for review on request.

Other providers, including rehabilitation agencies (previously referred to as outpatient physical therapy and outpatient rehabilitation facilities) and CORFs, are subject to requirements outlined in the Medicare State Operations Manual with regard to rented or leased community pools. The manual states: “...[An] organization may want to use a community pool to provide aquatic therapy. The SA [state agency] or AO [accreditation organization] shall verify that the community pool meets all applicable state laws (i.e., health and safety, infection control requirements, etc.) governing the use of the community facility. Also the SA or AO shall review the organization’s policies and procedures regarding the type of therapy being provided, training for staff, supervision, etc.”

The passage continues, “The pool must be closed to public use during the time the organization is providing therapy to protect the privacy and safety of the patients being treated. The hours of operation and days of the week during which the facility will be used for therapy services, supervision, etc., must be clearly stated in the organization’s policies and procedures as well as the contractual agreement between the community pool and the organization. Verify that the organization has a carefully detailed policy regarding specific arrangements for emergency services in the event of a medical emergency at the community location (i.e., Is a telephone in close proximity to the qualified professional providing the service? Is there a second organization staff person on site? etc.).”

**Can I allow my Medicare patients to use my practice’s gym by purchasing a gym membership pass?**

What if you are a private practitioner with a gym, and you would like to offer a monthly gym membership to Medicare patients who want to exercise in a safe facility with PTs on site?
Compliance Matters

Lots of PTs like this option, especially for patients who have been discharged but could benefit from some supervision while they work out. If you already have the equipment, why not let people use it?

The main issue here goes back to Medicare’s exclusivity requirement. If you allow the public—including former patients—to use your gym while you are treating Medicare patients, you aren’t using that space exclusively for your practice. A possible solution is to treat Medicare beneficiaries during hours that the gym is not open to the public. You also might be able to treat patients with commercial insurance while the gym is open, but be certain the insurance doesn’t have its own exclusivity requirement.

Another major issue to consider when offering access to your gym is that of “incentives.” Gifts to beneficiaries of federal health care programs trigger the anti-kickback statute if one purpose or perceived purpose is to induce the patient to receive services. The federal Civil Monetary Penalties Law prohibits you from offering or transferring remuneration to Medicare or Medicaid beneficiaries if the remuneration is likely to influence the beneficiary to order or receive items or services payable by federal or state programs, unless certain conditions are satisfied.

Accordingly, you must not charge an unrealistic amount for membership to Medicare or Medicaid beneficiaries who are current, past, or potentially future patients.

Resources

APTA
Cash Practice: Considerations for Physical Therapists
www.apta.org/Payment/Billing/CashPractice/

Council on Prevention, Health Promotion, and Wellness
www.apta.org/PHPW/

CMS
Medicare Advance Written Notices of Noncoverage

Medicare Benefit Policy Manual Chapter 15: Covered Medical and Other Health Services
www.cms.gov/media/125221

Medicare State Operations Manual Chapter 2: The Certification Process

Memorandum: Clarification of Requirements for Off-Premises Activities and Approval of Extension Locations for Providers of Outpatient Physical Therapy and Speech-Language Pathology Services and Off-Premises Activities

Outpatient Therapy Services and Advance Beneficiary Notice of Noncoverage FAQ
By the same token, though, free or discounted gym memberships to these individuals are not allowed.

These laws do not apply to patients who have private insurance. Your state may have its own laws on inducements, however, that you should research.

How do I charge for fitness and wellness services?

Wellness and fitness services usually aren’t covered by public or private health programs. Check your patient’s plan, then follow the rules for cash practice if those services are not covered. (See the resources box on the facing page.)

For Medicare, as stated in Chapter 15 of the Medicare Benefits Policy Manual:

“Services that do not meet the requirements for covered therapy services in Medicare manuals are not payable using codes and descriptions as therapy services. For example, services related to activities for the general good and welfare of patients, e.g., general exercises to promote overall fitness and flexibility and activities to provide diversion or general motivation, do not constitute therapy services for Medicare purposes. Also, services not provided under a therapy plan of care, or provided by staff who are not qualified or appropriately supervised, are not payable therapy services.”

Before accepting cash payment, ensure that the services you are providing are not covered by Medicare for one of the following three reasons:

- Services are never covered because they are not defined as a Medicare benefit under the statute.
- Services are not covered, even though they may be defined as a Medicare benefit, because they are not considered “reasonable and necessary.”
- Services are not covered, even though they may be a defined Medicare benefit, because coverage requirements are not met and would result in a technical denial.

Wellness and fitness services typically fall under the first reason, while physical therapist treatment that is no longer medically necessary typically falls under the second reason.

When a service is never covered by Medicare, you do not need to require your patient to sign an Advance Beneficiary Notice, although doing so is advisable so that the patient is clear about being responsible for paying out of pocket. However, an ABN must be signed when Medicare is expected to deny payment for all or part of the cost of an item or service because of reason two — that item or service is deemed not reasonable and necessary under Medicare program standards.

Keep in mind that you should not ask every patient to sign an ABN form. ABNs should be used only when you believe there is a reason that Medicare will not pay a specific service. For additional information on when furnishing an ABN is mandatory versus voluntary, check out CMS’ booklet “Medicare Advance Written Notices of Noncoverage.”

APTA has created a Council on Prevention, Health Promotion, and Wellness for PTs, PTAs, and students who are interested in incorporating prevention, health promotion, and wellness into their practice. Its purpose is to facilitate the physical therapy profession’s role in transforming society and physical therapist practice by connecting people and knowledge to develop and disseminate best practices in prevention, health promotion, and wellness for all individuals and populations.

Membership in the council is free. The webpage includes the link to a signup form. Members are automatically subscribed to email alerts from the council’s online community and can tailor notifications to their needs.

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.

240-553-1207
bmarkovitz@jglaw.com
jglaw.com

PTinMOTIONmag.org / May 2020
Spinal Integrity
The need for teamwork to best serve a patient.

The expertise of physical therapists and other members of the health care team combine to ensure that decisions are made in the patient’s best interest. What’s to be done when a key team member is not on board and may be motivated by a competing interest? Consider the following scenario.

More To Achieve
Physical therapist Emily and occupational therapist Christopher are colleagues at Sunnyside Rehabilitation Hospital, a facility whose patient population is highly diverse in age and conditions, and which has a reputation for outstanding interdisciplinary communication and collaboration. This is the first job out of school for both Emily and Christopher. They feel fortunate to have spent the past five years not only growing in their own profession but also learning a lot about their colleagues’ fields and how everyone can best contribute to the care of patients.

The young PT and OT are part of a team treating patients who have sustained spinal cord injuries. The pair’s newest patient is Rich, a newlywed similar in age to them who dove off a waterfall on his Hawaii honeymoon into shallow-than-anticipated water. In an instant Rich went from being a new husband and newly minted certified public accountant — having recently passed his CPA exam — whose passion was training for and competing in triathlons to a person with quadriplegia, dependent on hospital staff and his new wife for help with the simplest of tasks.

Initially, Rich spoke defiantly of “beating the odds” and vowed not only to walk again, but also to one day participate in athletic competitions. After six weeks at Sunnyside, however, his confidence has faded, as the enormousness of the challenges facing him has sunk in. His focus and effort in therapy have lagged, although he has made expected progress. When his wife Lisa urges him on, he shakes his head and says things such as “I feel like I have no control over my life” and “I’ll bet you wish you never married me.”

Cara, the psychologist on the spinal cord team, notes that depression is typical in cases such as Rich’s, but she
adds that providing the patient with the right motivation sometimes works wonders. That gives Emily an idea.

“What if we were to extend Rich’s therapy and recharge his competitive spirit by drawing parallels between going all-out in rehab and training for a triathlon?” she asks Christopher. “There are all kinds of websites out there detailing what these athletes put their bodies through and how they prepare themselves. We can read up on all that. Rich is facing a much greater challenge simply to reclaim his activities of daily living. I’m sure that we can draw parallels to triathlon training and tap his strong sense of determination.”

“I love that idea!” Christopher responds. “Rich initially insisted that he was going to become a competitive athlete again. That’s probably not realistic, but it suggests a drive in him that we can try to tap.”

Cara likes the idea, too. But Liz, a nurse on the spinal care team, has some words of caution.

“I’ve heard troubling things about Nick,” she says. She’s referring to the physician who’s new to the spinal cord team and has authority over this decision. “A nurse friend of mine who’s familiar with him from University Hospital says he’s very interested in the economic bottom line and that he’s a ‘my way or the highway’ kind of guy.”

This surprises Emily and Christopher, the latter noting, “If that’s true, he sounds like a bad fit for the way we do things at Sunnyside.”

“I agree,” Liz says, “but the scuttlebutt is that he’s got impressive credentials, that some board members considered it a coup to have poached him from University, and that he’s been brought in partly to help rein in spending.”

“Well,” Emily says, “I guess we’ll find out whether he’s going to be a problem. For our plan for Rich to succeed, we’ll need Nick’s buy-in.”

Two days later, the spinal cord team meets for the first time with Nick. By that point the team members have met him, but just for a handshake and

resources

At www.apta.org/EthicsProfessionalism/

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

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

- “Ethical Decision Making: Terminology and Context”
Considerations and Ethical Decision-Making

While it’s debatable whether stronger preparation on the parts of Emily and her colleagues might have swayed Nick’s thinking, there was nothing to be lost by it and everything potentially to be gained. At any rate, is Nick’s verdict final? Do Emily and the other team members have any recourse in lobbying for Rich to receive additional rehabilitation services?

**Realm.** This scenario touches on all three realms of ethical decision-making. The relationship between Nick and each member of the spinal cord team is individual. Nick’s focus on the economic bottom line, and the suggestion that he’s been hired in part to enforce fiscal restraint, bespeak institutional/organizational factors. Finally, should Nick’s stance in this instance prevail, the implications for the team dynamic and for future care decisions will have societal implications.

**Individual process.** Moral courage is required of Emily and other members of the spinal cord team to act ethically on their patients’ behalf despite the promise of adversity from Nick and possibly from Sunnyside’s hierarchy.

**Ethical situation.** This is a problem or issue in which important moral values are being challenged. For Emily and her teammates to simply acquiesce would constitute moral silence.

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

- **Principle 1.** Physical therapists shall respect the inherent dignity and rights of all individuals.
- **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 3C.** Physical therapists shall make judgments within their scope of practice and level of expertise and shall communicate with, collaborate with, or refer to peers or other health care professionals when necessary.
- **Principle 7.** Physical therapists shall promote organizational behaviors and business practices that benefit patients/clients and society.

Emily, Christopher, Cara, and Liz are shocked by the insensitivity of Nick’s comments, but Emily has the presence of mind to hide her distaste and calmly respond, “Rich has completed several triathlons. Speaking as a movement expert, I believe we can make significant gains with him by drawing parallels between triathlon training and rehab. We’ll fuel his competitive fires.”

“There are studies I can show you that back up the power of providing patients with spinal cord injuries with the right kind of motivation,” Cara affirms.

“Is that so?” Nick asks. “And that will make this gentleman a triple threat — if you’ll pardon the expression — to do ... what, exactly?”

Christopher jumps in, his voice betraying irritation with Nick’s condescension. “We all very feel strongly that Rich has hit an understandable rough spot in his rehab, but that with our help he still can make considerable progress. Rich can leave here with much greater independence than he has now.”
“I’m not sure I like your tone,” Nick says, “but let’s not get personal. Look, the bottom line, it seems to me, is that we’ve already put this CPA on the road to being able to resume his numbers-crunching. He’s got a new wife. He’s presumably got other family and friends who can help him out. And he can get outpatient rehab down the line if he feels he needs it. So, are we ready to move on to the next patient?”

“We most certainly are not!” Emily exclaims as Christopher, Cara, and Liz nod their heads in agreement. She’s taken aback by Nick’s stance, but she also wonders how best to convince him to see things the team’s way. It occurs to her, too late, that she and her colleagues should have entered the meeting better prepared with objective measures, study results, and outcomes data.

For Reflection
Have you been treated with disrespect by a colleague who is in a position of authority, with implications for the optimal care of a patient? If so, how did you address the situation? With the benefit of hindsight, might you address a similar scenario differently now?

For Follow-Up
If you are reading the print version of this column, go online to www.apta.org/PTinMotion/2020/5/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.
Healthy Growth in Wellness Services
A big trend recently has been the rise of PTs offering wellness services to boost business and offer their patients a “bit more.”

Paul J. Welk, PT, JD, an attorney with Tucker Arensberg, P.C., in Pittsburgh, has seen a significant increase in the number of PTs offering wellness services.

“I believe this increase is driven by a greater recognition by consumers of the value of a physical therapist in wellness and an effort by many PTs to diversify their services in light of reimbursement challenges,” he says. Welk adds that wellness services offered by PTs have evolved “to include — sometimes in partnership with other providers — services such as wellness screenings, health coaching, intervention programs targeting specifically identified risk factors, smoking cessation, and injury prevention.”

Patrick Berner, PT, DPT, RDN, a physical therapist at Fuel Physio in Taylors, South Carolina, who also is a registered dietitian nutritionist, says that offering wellness services has become more ingrained into patient care.

“There’s realization that the person in front of you has more than a shoulder injury — they have a family, kids, stress at work, poor nutritional habits, and lack of sleep, all of which affect their shoulder,” Berner says. “And there’s loads of evidence that show the effects of various social determinants of health on outcomes. The evidence is clear for wellness inclusion.”

That’s why he believes wellness services are moving away from niche status, with more clinicians and facilities emphasizing treating the whole person. So much so, Berner says, that a majority of new physical therapy clinics or mobile therapy entities that he sees opening now include the words “and Wellness” following “Physical Therapy” in their company names.

Brad Cooper, PT, MSPT, PhD, MBA, ATC, cofounder of the Catalyst Coaching Institute, which provides wellness coach certification to PTs and other health professionals, says PTs see opportunities to positively influence the lives of their patients and community by expanding into wellness services.

“Interestingly, we have more physical therapists pursuing our wellness coach certification than participants from any other profession. It’s not even close,” he says. “Some are looking to add a tool to their toolbox, while others are developing an entire new service line. And an increasing number of wellness coaches are using the certification to dip their toes into cash-pay business.”

Patrice Hazan, PT, DPT, MA, founder and CEO of GroupHab Physical Therapy and Wellness in Simpsonville, South Carolina, says that many factors are demanding a change in the way PTs provide care — both in general and in increasingly pursuing wellness services. These factors include aging demographics, an epidemic of falls among older adults, the high cost of health care, a lack of physical activity in the U.S. population despite national initiatives, and patient nonadherence to prescribed home exercise programs.

“Wellness services are evolving because the traditional medical model of short-term physical therapy interventions followed by discharge with a home exercise program is not sufficiently keeping patients healthy and well,” says Hazan, a board-certified clinical specialist in geriatric physical therapy. “In the traditional model, PTs like me have become frustrated working with patients and discharging them only to have them come back in a few months because they are not exercising at home.”

Hadiya Green Guerrero, PT, DPT, a senior practice specialist at APTA, says PTs are gravitating toward wellness programs as part of employment-based services, are providing physical therapy in a group or on a one-on-one basis, and are contracting with larger companies to provide more of a population health approach. “PTs then can recommend changes or steps to implement for the benefit of the employer and employees,” she says.

She’s also seeing a rise in annual checkups — a screening and evaluation encompassing all parts of the body, with an emphasis on the movement system. Those are provided on a cash basis. As APTA explains on its webpage “Annual Checkup by a Physical Therapist: Steps to Opening a Cash-based Business”: 

An increasing number of PTs are offering them. Continuing challenges include payment and public understanding.
“An annual physical therapist checkup is not routinely reimbursed by third-payer payers. You need to consider the policies of the approved payers when providing a noncovered service to their beneficiaries. Physical therapists with in-network or participating provider relationships with private payers should understand and comply with the policies of each individual payer.”

Defining Wellness
Jessica Lynn Berglund, PT, DPT, chair of APTA’s Council on Prevention, Health Promotion, and Wellness in Physical Therapy and a PT at Live Your Life Physical Therapy in Eden Prairie, Minnesota, notes that the glossary of the Guide to Physical Therapist Practice offers definitions of elements of “wellness services.”

For example, “health promotion” is defined as any effort taken to help an individual, group, or community achieve awareness of — and the power to pursue — prevention and wellness. “Wellness,” meanwhile, is defined as a state of being that incorporates all facets and dimensions of human existence, including physical health, emotional health, spirituality, and social connectivity.

“If we so define wellness, and we expand the question of what it comprises to include prevention, health promotion, and wellness,” Berglund says, “my sense is that as a profession we are moving in the right direction. More specifically regarding wellness, we increasingly are recognizing that we need to understand the many facets of each person we are serving, including all the facets of the individual’s wellness.”

It’s becoming clearer, she says, that the outcomes of the plan of care that PTs develop with each person are significantly affected, and should be guided, by such personal wellness factors as the individual’s physical, emotional, and mental health, and his or her spirituality, social connectivity, and support network.

“The physical therapist services we provide also must consider the whole host of social determinants of health that significantly affect each person who walks into our clinics,” Berglund adds. “We should be knowledgeable, aware, respectful, empathetic, and compassionate to the truth that there is no way we can treat two different people even with a similar diagnosis exactly the same, because those two people have significantly different facets of their human existence — both internally and externally.”

James Gallegro, PT, DScPT, MSPT, notes that PTs might say wellness is inextricably linked to their profession. But he defines wellness services offered by PTs as standing apart from traditional physical therapy. Gallegro, a board-certified clinical specialist in orthopaedic physical therapy, is clinical specialist at the Hospital for Special Surgery in New York City. He also is a certified manual physical therapist.

“We’re not talking here about someone with an orthopedic injury or a stroke who comes to a PT to be rehabilitated. What I see are boutique — often cash-based — practices that are trying to connect with patients to offer them wellness expertise to live healthier, more active, and well-rounded physical lives,” he says.

Such services typically extend well beyond what an in-network, insurance-based physical therapy practice can provide, Gallegro says, given that episodes of care often are based on functional limitations and pain as measured by outcome measures and psychometric visual analogue scales.

“Wellness services are evolving to include a focus on matching clients’ demographics, injury history, and physical ability level to their goals regarding health and activity,” he says. “Wellness is evolving into a subspecialty of physical therapy.”

Popular Services
Among the more popular wellness services that PTs offer is an annual exam to guide their patients in health promotion, prevention, and fitness. Such exams are a great way for PTs to maintain an ongoing relationship with their patients, say PTs contacted for this article.

Berglund senses that PTs increasingly are embracing and incorporating wellness services into their plan of care.

“We are starting to recognize that we need to understand more about an individual’s health and health behaviors in order to provide the most comprehensive physical therapist services,” she says. “The physical therapy annual exam seems to be gaining more traction in the profession. We are starting to recognize ourselves as experts in primary care, prevention, and providing direct access to PTs’ services in order to help individuals maintain optimal health, wellness, and fitness.”

Berner says group classes that provide both camaraderie and accountability have “really taken off.”

Take, for example, Hazan’s experience. Five years ago, she opened GroupHab to offer PT-designed and -led exercise classes to keep patients well and to provide a long-term solution to noncompliance with a home exercise program.
She has in essence expanded the application of physical therapy from exercise after injury or illness to a long-term program to improve quality of life and to keep patients healthy.

“To me, the most rewarding part of the model is the social support that members and patients give one another,” she says. “We now have a GroupHab family. Members call and check on one another. They go out to lunch after class and offer each other encouragement.” Wellness classes also are integrated into many of her patients’ individual treatment plans.

“As PTs, we are unique in that we already have trusted relationships with those we serve, and are well respected,” Cooper says. “So, wellness coaching can be a natural extension. It’s important to keep in mind,” he adds, “that the added credibility to referring physicians of being a certified wellness coach can be extremely valuable.”

Payment Issues

One challenge of providing wellness services is that there’s no clear rule on how PTs are to receive payment or reimbursement. That makes payment a topic that most providers must discuss with patients beforehand.

In a previous position, Berglund had the opportunity to offer annual exams, prevention, health promotions, and fitness and wellness services in a private pay model. But that’s not the case for everyone, she acknowledges.

“This is one topic that we as a profession need to continue to try to wrap our minds around,” Berglund says. “Prevention, health promotion, and wellness services often are thought of as a niche practice separate from skilled services — the idea being that you only can practice one or the other at one time. The truth, though, is that prevention, health promotion, and wellness interventions can be and often are provided as part of the PT’s skilled plan of care.”

“Unfortunately, our current reimbursement model, which leads to the productivity demands on PTs and PTAs, often constrains the types of services provided,” Berglund observes. “As the health care system trends toward more value-based care and payment, I sense that we will be afforded more opportunity to include prevention, health promotion, and wellness services into our plan of care.”

The private pay situation should not be seen as a challenge, Berglund argues, but rather as an opportunity for innovation. If the profession wants the public to view PTs as experts in prevention, health promotion, and fitness and wellness, then she believes the profession needs to take it upon itself to craft new models.

“With the health care system in a state of change, we have a great opportunity right now to break out of the box within which we’ve been constrained,” Berglund says. “Many PTs are developing innovative models that are disrupting the reimbursement model as we know it. Those individuals are defining the future of our profession.”

Berner says PTs need to stop relying solely on insurance reimbursement. If a PT offers a quality product that solves a problem, she maintains, people will pay.

Paul Welk notes that with employers directing significant attention to their employees’ overall health, as well as to the expense of providing health insurance, many are electing to pay PTs directly for their recognized expertise in providing wellness services.

“Our cost-benefit perspective, I am personally aware of numerous physical therapy providers who have been able to show significant employer cost savings through health and wellness interventions, and have been able to leverage that concept in broadening the scope of services they provide to employers,” he says. “Benefits to the employer may include everything from reductions in health insurance costs to reductions in the number of days employees miss work due to illness and injury.”

Gallegro notes that most PTs do not accept insurance for these episodes of care, as the purpose of the wellness services is not clearly stated as being rehabilitative.

He says that some patients have success submitting claims as “out-of-network” benefits for at least partial reimbursement, “and we provide them with whatever documentation they request, but often those submissions still are denied as not ‘medically necessary.’ This is an area in which we need to educate the public,” he says, “as third-party payers are unlikely to change their policies anytime soon. People shell out vast sums of money for personal training, nutritional consultations, and mail-order diets. People also
understand the importance of an annual check-up with their primary care physician, eye doctor, or dentist, but somehow physical therapy is stuck being generally perceived as that thing you do only if you get sick or are injured.”

For patients being provided one-on-one physical therapist interventions, Hazan says, her company bills insurers. The company does not charge those patients to attend GroupHab classes.

“From a business standpoint, giving away classes works, because more than 60% of patients join our membership program upon discharge,” she says. “After discharge, or if someone is going directly into the wellness classes, we offer a recurring monthly membership fee. We have a sponsorship program for those who cannot pay. We also have members who have donated to our sponsorship program, and I sponsor several.”

**Adding to the Practice**

For PTs who want to begin incorporating health promotion and prevention services into their current practices, Berglund recommends identifying the health behaviors they believe are most appropriate to address with the majority of the patient population they see.

“Brush up on your knowledge of those health behaviors, then take a motivational interviewing course,” she says. “Motivational interviewing offers guidance on how to approach the discussion of changing health behaviors. It’s a great approach to take with all the individuals we serve with physical therapy.”

Gallegro advises starting with current and past clients. They are going to be most amenable to considering expanding or renewing their relationship with physical therapy because trust already exists.

“Reach out to them, get to know them better, and tell them about the other services you offer,” Gallegro says. “Ultimately, they can be ambassadors for expanding public knowledge in your neighborhood. Next,” he continues, “you need credible and
experienced PTs who have a passion for health and wellness. Encourage them to pursue advanced certifications in sports or activities that they care about.”

He also recommends engagement with organizations such as the National Strength and Conditioning Association and the American College of Sports Medicine. “Such involvement can help build fitness credibility for your staff,” Gallegro says. “Once you have therapists in place who have passion, strong backgrounds, and advanced certifications, they can speak from a place of authority to help clients meet their health and wellness goals.”

Berner advises PTs to seek unique service offerings and play to their skillset. “My other professional hat is as a registered dietitian, so I play to that strength,” he says.

**The Importance of Wellness Services**

Over the past six years, Gallegro has worked with clients who are willing to invest in their health by paying out of their own pockets beyond what a third-party payer will reimburse.

“While some of these clients started out as patients recovering from injury, others sought out our expertise for the sole purpose of moving better,” he says. “In all cases, they continued to attend physical therapy sessions with a goal of improving their overall wellness through a better understanding of their bodies — identifying and correcting imbalances, improving muscle activation patterns, and moving more efficiently.”

Gallegro’s wellness evaluation starts with the same components as a typical PT examination — measuring range of motion, strength, flexibility, and so on. It continues, however, to include motor control assessment and expanded history-taking that identifies the client’s current level of fitness understanding, activity level, and goals.

“Sometimes these episodes of care run from four to six sessions over the course of a month or two. Other times, the client continues to come in once every few weeks for ongoing check-ups, with new questions or challenges based on changing activity participation,” Gallegro explains. “The overarching purpose is to help people better understand health and fitness, and better match their habits to their desired activity levels.”

As a PT who has worked primarily in home health, Berglund has found that providing prevention and health promotion screening, education, and further intervention, when appropriate, is meaningful to the people she works with — sometimes even more meaningful than the therapeutic exercise she also provides.

“Initiating conversations with individuals about their health behaviors, how those behaviors contribute to overall health, and how each health behavior contributes to the primary diagnosis for which I am treating that person often can resonate more than the home exercise program itself,” she says. “Educating someone about the benefits of regular physical activity, how important it is to have a well-rounded eating pattern, or how to improve his or her sleep hygiene; or guiding someone in taking the first steps toward tobacco cessation can eventually lead to significant changes in someone’s life and lifestyle. Patients truly value that guidance.”

One of the challenges to PTs providing wellness services is overcoming the public’s perception that working with a physical therapist is something that is only necessary following an injury.

“Educating the general public about the role physical therapists serve in health and wellness, and how these programs can reduce injuries and other related health problems, could help overcome this challenge,” Welk says. “A PT already has many of the tools needed to offer wellness services. I believe that to succeed in providing them, physical therapists need to be able to demonstrate to stakeholders — including employees, employers, and insurers — the value they can bring to the table.”

**Keith Loria** is a freelance writer.
Beyond National Physical Therapy Month in October, how many months, weeks, and days do you know that have been designated to highlight conditions that PTs and PTAs manage? There probably are more than you think!

Physical therapists and physical therapist assistants treat a wide range of patients and clients — young and old, male and female, those with disabilities (born or acquired) and those without — for a wide range of conditions.

National Physical Therapy Month, marked every October, recognizes the contributions that PTs and PTAs make to their patients and clients and to society. There are, however, dozens of days, weeks, and months designed to raise awareness of health or movement conditions and situations — ranging from brain injury and cancer to women’s health and family caregivers. Some of these programs are created and promoted by government agencies. Others originated from associations and organizations representing specific populations. Often, multiple groups jointly promote them.

APTA is a member of coalitions representing many of the conditions addressed in the calendar. These coalitions also are noted in the calendar. For more information about APTA’s coalition involvement, go to apta.org/coalitions.
We’ve created a calendar denoting a sampling of these awareness programs. It lists contact information — an organization or agency actively involved in the program and a website — if you want more information. This by no means is a comprehensive list, but it illustrates the types of conditions that PTs and PTAs manage. Most of these programs, similar to National Physical Therapy Month, offer information about the health condition, populations affected, and ways to get involved.

You’ll also see links to APTA resources that are available for some conditions. For complete information on those conditions, begin with a search of the specific condition on APTA’s websites — both apta.org and our consumer-facing site, ChoosePT.com.

Note: APTA will unveil a new website later this year. While it will greatly enhance your experience, some of the APTA links provided in this article may not work on the new site. In that case, enter the search term or description into the search box to find the updated links.

APTA’s National Physical Therapy Month webpage provides an extensive list of activities in which PTs and PTAs can engage. Many PTs and PTAs can support their patients and clients whose conditions or situations are addressed by the awareness days, weeks, and months listed here. For example, APTA advises:

› Share resources from APTA’s official consumer information website, ChoosePT.com, which will be visited by more than 4 million Americans this year. The site includes the Find a PT directory, symptoms and conditions guides, health tips, podcasts, and more.

› Explain to the public, payers, and other health care professionals the role in collaborative care played by physical therapists and physical therapist assistants.

› Participate in PT Day of Service and other community events.

PTs and PTAs may choose to inform the public about the services they can provide, using resources from both APTA and the organizations promoting the awareness programs. Because the calendar presented here is representative only of the conditions addressed by PTs and PTAs, it just scratches the surface of these types of programs and events.
Alzheimer’s Awareness Month

ALZHEIMER SOCIETY OF CANADA | ILIVEWITHDEMENTIA.CA

- Academy of Neurologic Physical Therapy: neuropt.org
- PT in Motion: Teaching the Brain to Battle Degenerative Diseases (July 2016)
- Physical Therapy Guide to Alzheimer’s Disease: choosept.com/symptomsconditionsdetail/physical-therapy-guide-to-alzheimers-disease
- Patients with a Progressive Condition and Declining Functional Status: apta.org/PatientCare/DecliningFunctionalStatus/

American Heart Month

AMERICAN HEART ASSOCIATION | HEART.ORG

- Cardiovascular & Pulmonary Section: cardiopt.org/
- Move Forward Radio: Heart Health and Cardiac Rehabilitation: choosept.com/radio
Brain Injury Awareness Month
BRAIN INJURY ASSOCIATION OF AMERICA | BIAUSA.ORG
- Academy of Neurologic Physical Therapy: neuropt.org
- Concussion and Traumatic Brain Injury: apta.org/TBI/
- PT in Motion: Beyond Rest: Physical Therapists and Concussion Management (March 2017)
- APTA is a member of the Consortium for Citizens with Disabilities: c-c-d.org/

National Nutrition Month
ACADEMY OF NUTRITION AND DIETETICS | EATRIGHTPRO.ORG
- Nutrition and Physical Therapy: apta.org/PatientCare/Nutrition/
- PT in Motion: Nutrition: A Portion of PTs’ Menu of Services (September 2017)
- E-learning course: Nutritional Screening and Intervention for the Home Health Therapist: learningcenter.apta.org
- APTA collaborates with the Academy of Nutrition and Dietetics on areas related to health promotion, prevention, and nutrition education: eatrightpro.org/

National Sleep Awareness Week
NATIONAL SLEEP FOUNDATION | SLEEPFOUNDATION.ORG
- PT in Motion: Promoting Sleep: Not a Leap (October 2018)
- PTJ: Sleep Health Promotion: Practical Information for Physical Therapists (August 2017)
National Autism Awareness Month
AUTISM SOCIETY | AUTISM-SOCIETY.ORG
› PT in Motion: Physical Therapy for People With Autism (July 2018)

National Minority Health Month
U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, OFFICE OF MINORITY HEALTH | MINORITYHEALTH.HHS.GOV
› Racial and Ethnic Health Disparities: apta.org/HealthCareDisparities/
› Addressing Health Care Disparities With Cultural Competence in the Clinic: apta.org/HealthCareDisparities/CulturalCompetence/
› PT in Motion: Battling Bias’s Distorted Image (October 2019): apta.org/PTinMotion/2019/10/Feature/Bias/
› APTA is member of the Corporate Round Table of the National Black Caucus of State Legislators: nbcsl.org/

National Public Health Week
AMERICAN PUBLIC HEALTH ASSOCIATION | NPHW.ORG
› PT in Motion: Community Health Promotion: Reaching Beyond the Clinic (May 2018)
› PT in Motion: Addressing the Social Determinants of Health (July 2019)
› PT in Motion: The Role of PTAs in Health, Wellness, and Fitness (April 2013)
› PT in Motion: Healthy Growth in Wellness Services (May 2020)
› APTA is a member of the Friends of the Health Resources and Services Administration: friendsofhrsa.org/

FIRST FULL WEEK

World Health Day
WORLD HEALTH ORGANIZATION | WHO.INT

Arthritis Awareness Month
CENTERS FOR DISEASE CONTROL AND PREVENTION | CDC.GOV
› APTA Geriatrics: An Academy of the American Physical Therapy Association: geriatricspt.org/
› Arthritis Management Through Community-Based Programs: apta.org/Arthritis/
› ChoosePT.com: Arthritis: Find a Community-Based Physical Activity Program: choosept.com/resources/detail/community-based-physical-activity-programs-arthritis
› APTA partners with the National Association of Chronic Disease Directors’ Arthritis Initiative: chronicdisease.org/
› APTA is a member of the Disability and Research Rehabilitation Coalition: atra-online.com/general/custom.asp?page=DRRC
National Osteoporosis Awareness and Prevention Month
NATIONAL OSTEOPOROSIS FOUNDATION | NOF.ORG
› APTA Geriatrics: An Academy of the American Physical Therapy Association: geriatricspt.org/index.cfm
› Academy of Pelvic Health: aptapelvichealth.org
› Online course: Nutritional Considerations and Treatment Solutions in Osteoporosis: learningcenter.apta.org
› Physical Therapy Guide to Osteoporosis: choosept.com/symptomsconditionsdetail/physical-therapy-guide-to-osteoporosis
› APTA is a founding member of the United States Bone and Joint Initiative: usbji.org/

American Stroke Month
AMERICAN STROKE ASSOCIATION | STROKE.ORG
› Academy of Neurologic Physical Therapy: neuropt.org
› Physical Therapy Guide to Stroke: choosept.com/symptomsconditionsdetail/physical-therapy-guide-to-stroke
› Online course: Physical Fitness Training After Stroke: learningcenter.apta.org

National Women’s Health Week
U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, OFFICE ON WOMEN’S HEALTH | WHR.ORG
› Academy of Pelvic Health: aptapelvichealth.org/
› PT in Motion: Making Core Connections (May 2014)
› Specialist Certification: Women’s Health: abpts.org/Certification/WomensHealth/

World Red Cross and Red Crescent Day
INTERNATIONAL COMMITTEE OF THE RED CROSS | MEDIA.IFRC.ORG
› Global Health SIG, Health Policy and Administration Section: aptahpa.org/page/GlobalHealthSIGAbout
› Supporting Charitable Organizations: apta.org/ProBono/SupportingCharitableOrganizations/
› Pro Bono Services by Setting: apta.org/ProBono/ServicesbySetting/

Chronic Immunological and Neurological Diseases
CFIDS ASSOCIATION OF AMERICA | MAY12TH.ORG
› Academy of Neurologic Physical Therapy: neuropt.org
› PT in Motion: The Real Story About Chronic Fatigue Syndrome (September 2017)
› APTA is a member of the Disability and Research Rehabilitation Coalition: atra-online.com/general/custom.asp?page=DRRC
Men’s Health Month

National Cancer Survivors Day

Alzheimer’s and Brain Awareness Month

Family Health and Fitness Day

PT in Motion: Serving Survivors (April 2019)

Physical Therapy Guide to Cancer: choosept.com/symptomsconditionsdetail/physicaltherapyguide-to-cancer

APTA Policies on Health, Wellness, and Fitness: apta.org/PreventionWellness/Policies/

PTJ: A Model to Integrate Health Promotion and Wellness in Physical Therapist Practice: Development and Validation (August 2017)

APTA is represented on the board of directors of the National Physical Activity Plan: physicalactivityplan.org/

Alzheimer’s Association: alz.org

(See January listing for Alzheimer Disease Awareness Month.)
Pain Awareness Month

AMERICAN CHRONIC PAIN ASSOCIATION | THEACPA.ORG

- Pain SIG, Academy of Orthopaedic Physical Therapy: orthopt.org/content/special-interest-groups/pain
- Beyond Opioids: Transforming Pain Management to Improve Health: apta.org/BeyondOpioids/
- PT in Motion: Rewiring the Brain to Ease Chronic Pain (May 2019)
- PT in Motion: Keeping Pain Out of the Red Zone (July 2017)
- APTA is a member of the Alliance for Balanced Pain Management: alliancebpm.org/

World Alzheimer’s Month

ALZHEIMER’S DISEASE INTERNATIONAL | WORLDALZMONTH.ORG

- (See January listing for Alzheimer Disease Awareness Month.)
- PT in Motion: Improving the Lives of People With Dementia (March 2018)

Duchenne Muscular Dystrophy Action Month

PARENT PROJECT MUSCULAR DYSTROPHY | PARENTPROJECTMD.ORG

- Patients with a Progressive Condition and Declining Functional Status: apta.org/PatientCare/DecliningFunctionalStatus/
- APTA is a member of the Disability and Research Rehabilitation Coalition: atra-online.com/general/custom.asp?page=DRRC
National Family Caregivers Month
AARP | AARP.ORG
» APTA is a member of the Eldercare Workforce Alliance: eldercareworkforce.org/

American/National Diabetes Month
AMERICAN DIABETES ASSOCIATION | DIABETES.ORG
NATIONAL INSTITUTE OF DIABETES AND DIGESTIVE AND KIDNEY DISEASES | NIDDK.NIH.GOV/HEALTH-INFORMATION/COMMUNITY-HEALTH-OUTREACH/NATIONAL-DIABETES-MONTH
» Physical Therapy Guide to Diabetes: choosept.com/symptomsconditionsdetail/physical-therapy-guide-to-diabetes

National Home Care and Hospice Month
NATIONAL ASSOCIATION FOR HOME CARE AND HOSPICE | NAHC.ORG
» Hospice and Palliative Care SIG, Academy of Oncologic Physical Therapy: oncologypt.org/
» APTA Home Health Section: homehealthsection.org/
» Hospice and Palliative Care: apta.org/PatientCare/HospicePalliativeCare/
» Podcast: The Role of Hospice and Palliative Care: Services Provided by a Physical Therapist: apta.org/Podcasts/2012/10/20/HospiceandPalliativeCare/
» APTA is a member of the Eldercare Workforce Alliance: eldercareworkforce.org/

Great American Smokeout
AMERICAN CANCER SOCIETY | CANCER.ORG
» APTA Academy of Oncologic Physical Therapy: oncologypt.org/
» Health Priorities for Populations and Individuals: apta.org/uploadedFiles/APTAorg/About_Us/Policies/Practice/HealthPrioritiesPopulationsIndividuals.pdf
» PT in Motion: Addressing the Social Determinants of Health (July 2019)
» PT in Motion: Community Health Promotion: Reaching Beyond the Clinic (May 2018)
World AIDS Day

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES | HIV.GOV

HIV SIG, Academy of Oncologic Physical Therapy: oncologypt.org/sigs/physicaltherapy-guide-to-hiv-disease-aids

International Day of Persons With Disabilities

UNITED NATIONS | UN.ORG

PT in Motion: Actors With Disabilities and the PTs Who Treat Them (March 2020)
PT in Motion: Battling Bias’s Distorted Image (October 2019)
PT in Motion: The Competitive Edge of Adaptive Sports (June 2019)
PT in Motion: The Journey of PTs With Disabilities: Challenges and Contribution (March 2019)
February seems like a lifetime ago given today’s circumstances, but that’s when the largest physical therapy conference took over the Colorado Convention Center in Denver. The APTA Combined Sections Meeting attracted record attendance – registration peaked at over 18,000 PTs, PTAs, students, and others – for educational sessions, poster and platform presentations, an exhibit hall with hundreds of vendors of products and services, numerous networking events, and a sneak peek at some of APTA’s activities surrounding the association’s centennial in 2021.

Stories are abridged from CSM 2020 News, published by APTA and produced by CustomNews Inc. To read the full articles, visit www.apta.org/CSM/News/. Contributing editors and writers are APTA staff Lois Douthitt and Donald E. Tepper; and Deb Burrows, Tim Mercer, and Jenn Waters from CustomNews. Photography is by Jonathan Bachman unless noted otherwise.
Opening Ceremony Attendees Urged to Exercise Curiosity and Practice Observation

American Board of Physical Therapy Specialties opening ceremony speaker Robert Sellin, PT, DSc, declared, “Rare is the day that goes by that any of us sees something in somebody that we’ve never seen before or defies our common knowledge. It is only through constant observation and repetition that we can see or sense the outliers that need special attention.”

Sellin is immediate past chair of ABPTS and a board-certified clinical specialist in clinical electro-physiologic physical therapy.

The theme of his remarks was “The Value of Curiosity, Observation, and Repetition in Developing Clinical Excellence,” but he said his original title was, “What Does the Study of the Tongue of a Woodpecker Have To Do With Clinical Specialization?” The latter was drawn from a biography of Leonardo Da Vinci, who made lists of things he wanted to do and learn. One of Da Vinci’s goals was to “describe the tongue of the woodpecker.”

It would seem, Sellin said, that knowing about a woodpecker’s tongue is unnecessary to draw a picture of the bird or to understand its flight. It turns out, however, that the woodpecker’s tongue acts like a shock absorber, protecting the bird’s brain while it pecks with exertion 10 times the force that could kill a human. “Da Vinci used his hours and hours of painstaking dissections of woodpecker tongues, other animals, and, especially, human corpses to learn how to produce masterpiece works of art that show amazing, while subtle, aspects of human expression,” Sellin said.

Clinical specialists do something similar, he continued. “We share a passion for clinical excellence, and we use our skills in observation and touch to apply techniques that may look mechanically the same with every application but have subtle differences. We adjust to the contour of the area treated and the response of the client to our body language, our touch, and our words. So, like Da Vinci, we use curiosity, observation, and repetition to create new experiences with every client or patient,” Sellin said.

He also had a suggestion for those receiving their certification, borrowing the idea from his son’s graduation from the Navy’s diving school. Sellin explained that at the end of the ceremony all of the instructors lined up in front of the military classroom as the graduates were called up one at a time to take a dive pin to proudly wear on their uniforms. Each new Navy diver handed the pin to the instructor who was the most valuable in their training. That instructor pinned the graduate.

Sellin suggested that the newly certified PTs do something similar: “Approach the person or persons who meant so much to you in your preparation for specialty certification, be it family or a mentor. Thank them, and ask them if they would ‘pin’ you. This could be done with your ABPTS pin or symbolically by relating this story.”

Sellin further encouraged the specialists to “play it forward,” saying, “Maybe someday a newly minted physical therapist will ask you to pin them. I believe you will find that to be even a better feeling than the terrific feeling you all have earned tonight.”
“We Can Do Better” in Practicing Geriatric Physical Therapy

“We have an image problem in geriatrics. That image is too often the perspective of decline and decay as aging,” said Dale Avers, PT, DPT, PhD, FAPTA, speaking at the Academy of Geriatric Physical Therapy’s Carole B. Lewis Distinguished Lecture. “Aging seems to be something folks let happen, without a lot of thought,” she continued, adding, “yet most of the health problems of older age are exacerbated by inactivity and deconditioning.” In fact, she said, “60%-70% of a person’s health is due to factors we can influence, if not control.”

For that reason, Avers said, “We need to adjust expectations to make sure they are reflective of the older person’s expectations...We must reset our expectations every time we see a different patient. Low expectations for the aging process and for the capacity-building of older people has no place in communicating the value of what we do and what we have to offer aging adults.”

She proposed five goals for PTs who work with older adults:

1. Possess an expertise about the aging process and geriatric physical therapy that is continually modified, reflected upon, and shared.
2. Practice person-centered care within a capacity-building paradigm.
3. Conduct a comprehensive evaluation that screens for vulnerabilities, informed by meaningful outcome measures.
4. Implement best practice and evidence-based interventions with creativity, appropriate challenge, relevance, and individuality to empower the patient.
5. Actively support and promote intentional aging.

When PTs, PTAs, and students get together, neither the presenters nor the audience sit still through a session.
“Listen to Your Heart, and Let Your Lungs Breathe”

Attendees of the Linda Crane Lecture, hosted by the Academy of Cardiovascular and Pulmonary Physical Therapy, were promised laughter, tears, dancing, singing, and inspiration. Speaker Anne K. Swisher, PT, PhD, FAPTA, delivered on every one during her talk, “Following Your Heart (and Lungs) as a Professional Development Plan.”

Swisher illustrated her theme by leading the audience through her own professional development. She spoke of her father, describing him as her inspiration to enter the medical sciences.

After college graduation, she moved to a position in the intensive care unit. “I loved the cutting-edge machines and techniques in the ICU, but I also loved being the advocate for seeing the whole person who was connected to the machines,” she said.

Her career path then led her to pursue a master’s degree in exercise physiology. “I learned that exercise is a medicine that must be prescribed, just like pills are,” she said.

Swisher later returned to her home state of West Virginia, where she joined the West Virginia University faculty and earned her PhD while raising a daughter and son with her husband.

“There were many days when I felt like I wasn’t doing anything well,” she said. “We all take on more than we can, and we need to be kind to our heart and let our lungs exhale.”

She then spoke about transitioning from being a clinician to academia. “Most of us in academics come from a clinical world,” she said. “When your patients went home, or the documentation was completed, your work was done. The biggest surprise to a clinician entering academics is that the work is never done.”

Swisher described academia as a three-legged stool consisting of teaching, research, and service.

Related to teaching, she said, “What happens in the classroom with our students is magic, but it is also hard work.” She added that she makes sure students know they also must work to learn. “Our role is to guide learning,” she said, “not to spoon-feed it to passively open mouths.”

Concerning research, she said that those in academia are expected to contribute to the profession. “If you have a question that is exciting you, others will get excited too. Keep pursuing it.”

The third leg of the stool — service — is particularly relevant to the physical therapy profession. She encouraged the audience to explore different types of community service activities, including with their professional association.

Passing around a plush heart, she asked the audience to think about things that make them excited. She then did the same with a set of plush lungs. “The lungs are your chance to take a deep breath and think about diving in.”

Also as promised, she led the room in doing the “ECG dance” — a series of dance moves created to teach electrocardiogram rhythms — as well as in a rousing chorus of “Take Me Home, Country Roads.”

Anne Swisher passed around a plush heart and asked attendees to think about something that “makes you excited.”
New CPG on Locomotor Training Describes ‘Active Ingredients’ in Interventions to Improve Walking

Walk, walk hard, and walk a lot. Interventions that adopt these main “active ingredients” under the principles of exercise physiology — specificity, intensity, and repetition — can improve walking function in patients with a six-month-or-longer history of acute-onset stroke, motor incomplete spinal cord injury, or traumatic brain injury, based on a new clinical practice guideline published in January in the Journal of Neurologic Physical Therapy.

“Implementing the Active Ingredients for Locomotor Recovery,” a session hosted by the Academy of Neurologic Physical Therapy, explored eight action statements from the CPG.

Carey Holleran, PT, MPT, DHS, was the main presenter, with fellow speakers Lisa Goodwin, PT, DPT, Allison Miller, PT, DPT, and Meredith Banhos, PT, DPT. In addition, a panel comprising Goodwin, Miller, Maghan Bretz, PT, Thomas Hornby, PT, PhD, and Irene Ward, PT, DPT, answered audience questions at the end of the presentation. Banhos, Holleran, Miller, and Ward are board-certified clinical specialists in neurologic physical therapy.

The CPG’s eight statements are divided into what clinicians should perform, what they may consider, and what they should not perform. In the “should perform” category are walking training at moderate to high aerobic intensities — 70%-80% of heart rate reserve or up to 85% maximum heart rate — and training coupled with virtual reality. Clinicians may consider strength training at 70% or more at one repetition max; circuit training, cycling, or recumbent stepping; and balance training with virtual reality. And what should be avoided? Static or dynamic low-intensity balance activities, body-weight supported treadmill training with emphasis on kinematics (a harness may be used as a safety catch but not for walking support), and robot-assisted gait training. Key to patient safety is continuous heart monitoring during interventions.

In addition to describing the CPG itself, the presenters discussed the role of CPGs in knowledge translation — applying knowledge, such as a research-based CPG, to practice for improved patient outcomes. A survey of members of the Academy of Neurologic Physical Therapy indicated that respondents agreed or strongly agreed that CPGs are important in effecting change in practice but that barriers exist to their use, such as time to develop a program based on CPG recommendations, time to read, lack of institutional support, lack of access to the CPG, lack of understanding of the recommended practices, and fear of hurting the patient with higher-intensity activity.

Thumbs Up: A Detailed Look at an Amazing Appendage

Many misunderstandings and controversies surround the thumb’s treatment and anatomy. In the session titled “Thumbs Up!” hosted by the Academy of Hand and Upper Extremity Physical Therapy, presenters Diane Coker, PT, DPT, and Janelle Freshman, PT, DPT, described some of them.

Both presenters are certified hand therapists; Freshman also is a board-certified clinical specialist in orthopaedic physical therapy. Coker said the thumb is unique in that:

- It has two axes and three planes of motion.
- It does not lie in the same plane as the hand.
- Pathways do not intersect.
- Independent control of pronation would require two additional muscles.

Discussing the impact of impairments of the thumb, Freshman said that total disability of the thumb equals loss of 22% of bodily function and nearly 40% of hand function. “Proximal phalanx and the base of the metacarpal are frequent places fractures occur. They are most common in children up to 16 years old and in adults over 65.” Metacarpal base fractures happen most commonly when the thumb is engaged in grip, she continued, such as when holding onto a steering wheel or motorcycle handle bars. While unstable fractures usually are treated surgically, she added, good outcomes are possible with immobilization.

In ligament injuries, Freshman explained that the shape of the metacarpal head determines the amount of motion of the metacarpophalangeal joint. “The flatter the head of the joint, the less motion and the more chances of ligament injuries.” She added that pain-free stability of the joint is more important in treatment than is range of motion.

A common condition of the thumb is carpo-metacarpal osteoarthritis. Freshman said that despite research, the condition’s etiology is unknown. She said theories include deterioration of the anterior oblique ligament, or AOL; ligament laxity; hormonal changes with menopause; and genetic disposition.
When Running Is Part of the Job: Implications of Running Shoe Choice

Not everyone runs for the love of it. For those in law enforcement, military, and first responder professions, running can be a required component of the job and physical fitness tests. Working with these patient populations presents unique challenges for PTs and PTAs.

During the Federal Physical Therapy Section’s session “What Is All the Hype About Running Shoes? Practical Implications for the Running Tactical Athlete,” speakers offered a deep dive into working with this population group. Nancy Henderson, PT, DPT, and Haley Worst, PT, DPT, looked at everything from the type of running they do, to the role of running shoes, to possible rehabilitation and training methods. Both presenters are board-certified clinical specialists in orthopaedic physical therapy.

“This is a unique population to work with,” said Henderson. “It requires specialized physical training strategies to improve physical performance.” In particular, understanding the core components of running shoes is critical when it comes to working with runners and tactical athletes.

As she discussed shoe anatomy, Worst offered tips on modifications that can be made for injuries or running on different surfaces.

She cautioned that selecting a pair of running shoes can be a daunting process. For tactical athletes, cost may be a factor. Service members, for example, receive a free pair of shoes in basic training, but they pay for subsequent pairs.

Henderson explained that many running injuries are related to overuse. Reasons for these injuries include running too many miles, lack of ramp-up time, and going “from 0 to 60 miles” too quickly rather than undertaking a 10% weekly mileage increase.

Treating tactical athletes requires asking a lot of questions, she explained: What do they do each day? How much do they run, and on what types of surfaces? What they are doing during circuit training? What breaks have they taken from physical training?

It’s also important that tactical athletes understand foot strike patterns, Henderson said. She learned from published research that athletes may not know their own pattern: Only 43%-69% of runners accurately describe their foot strike. She recommended using video analysis to improve that accuracy.

Another consideration when it comes to foot strike is the role of fatigue. “The research has said that the longer runners run, the more likely they are to adopt a rear foot strike pattern,” said Henderson. “This shows a potential need to introduce step rate manipulation during a fatigue state.” She suggested filming foot strike during a running episode and comparing it before and after pain starts.
Linking the Extremities to the Trunk in Acute Care

Postural control is recognized as critical for functional movement. In the preconference session “Acute, Anticipatory, and Urgent: Reeducating the Foundations of Postural Control in the Acute Care Setting,” attendees learned through lecture, lab, and video the importance of the trunk in managing functional tasks.

Susan Ryerson, PT, DSc, Elise Ruckert, PT, DPT, and Lauren Hurt, PT, DPT, provided current evidence on improving postural treatment of patients with mobility and functional limitations. Ruckert and Hurt are board-certified clinical specialists in neurologic physical therapy, and Ruckert is a board-certified geriatric specialist as well. The session was hosted by the Academy of Acute Care Physical Therapy.

Hurt began by stating that there is a gap between current acute care practice and the evidence of best practice. Giving examples of many well-known function tests, she noted, for instance, that the grading in the Berg Balance Scale has a vague description of “use of hands.” “Patients score better [than what they can really do] because they can do the skill, but we don’t really know what’s working. The movement-analysis piece is missing.”

Hurt said the focus is on the level of assistance rather than on the cause of the deficit, and scoring is not based on movement analysis. “We focus on function without considering the prerequisites.” She believes PTs can be more effective through retraining the foundational components of anticipatory postural control.

Ruckert noted, “Acute care practice must address the foundations of anticipatory postural control in order to promote recovery.” Anticipatory postural responses, or APAs, are the unconscious muscular activities designed to maintain balance prior to perturbation. “Anticipatory postural control helps us to maintain balance before we move. Our muscles start firing 80 to 100 milliseconds before focal limb movement and make functional limb activity possible,” said Ruckert. “Reestablishing trunk activation after prolonged immobility or injury requires careful assessment of missing components, using a structured process.”

Ryerson and Ruckert described a motor control framework that puts anticipatory postural control in the center and trunk-limb linkages in close relationship. “Our extremities drive the movement of the trunk,” said Ryerson. “Linking the trunk and extremities is necessary to perform functional tasks. Control of trunk movement components is a prerequisite to perform functional tasks.”

“Often as PTs we think of only [treating the] legs, but we need to treat the upper body as a prerequisite to treating the legs, and then link the legs with the trunk. Extremity movements have hierarchical levels of demand on the trunk,” said Ryerson.

She concluded, “Retraining function in the acute care setting requires an understanding of the prerequisites for anticipatory postural control. Trunk movement components form the foundation of trunk-limb linkages.”
Task Force Finds Insufficient Research on PTA Education and Practice

Although the depth and breadth of entry-level PTA curricular content has increased, as has the role of the PTA, research on PTA education and practice still is lacking. That was one of the conclusions of the PTA Education Trends Task Force of the Academy of Physical Therapy Education, which presented its findings at the session “The Current State of PTA Education: Findings of the PTA Education Trends Task Force.”

Presenters were Michele Marie Avery, PTA, Katherine Griffin, PTA, MSEd, Jennifer Jewell, PT, DPT, Rebecca McKnight, PT, MS, and Krissa Reeves, PTA, MEd.

The presenters reviewed the history of PTA education, from discussions in the 1940s regarding the possible need for a trained technician to assist PTs with treatment interventions, to the approval in 1967 of the first two PTA education programs at Miami Dade Community College in Florida and St. Mary’s Campus of the College of St. Catherine in Minnesota, to expansion to 376 accredited and 32 developing PTA programs as of July 2019.

The speakers shared some statistics related to PTA education: The average PTA program graduates 18 students annually, the ultimate NPTE pass rate is 92.3%, and the employment rate is 98%.

Despite this growth and size, the task force found a lack of up-to-date content regarding PTA education. It further found that most APTA documents and work activities are “highly focused” on PT education, with little or no mention of PTA education, and that “there is little documented evidence of work being done on the quality of PTA education or advancement of PTA education.”

The presenters reviewed the findings of a survey to which PTA program directors responded. It found that “the cognitive load within PTA educational programs is inappropriate for an associate degree, which is congruent with higher curriculum expectations placed upon programs by CAPTE and increased outcome expectations regarding the NPTE-PTA.” However, there wasn’t a clear consensus for a preferred entry-level program length. A slight majority (53%) indicated a preference for either all PTA programs being at the bachelor’s degree level or allowing institutions to determine the degree level awarded for PTA entry-level education. The greatest concern in transitioning PTA programs to a bachelor’s degree was the impact on student debt.

The task force also recommended further research into challenges associated with the number and quality of applicants, student retention and graduation rates, graduate employment opportunities, and clinical site availability and variety.
Elastic Taping Offers New Option for Edema Management

When you think of elastic taping, you may immediately think of Olympic athletes such as beach volleyball players. But as Nicolle Samuels, PT, MSPT, explained during “Stretch Your Mind and Their Skin: The Role of Elastic Taping in Wound Management,” such taping can benefit patient populations with edema, lymphedema, and scarring. Samuels is a certified lymphedema therapist, certified wound specialist, and certified kinesio taping practitioner. The session was hosted by the Academy of Clinical Electrophysiology and Wound Management.

Samuels pointed out that elastic taping is not a stand-alone replacement for other treatment methods. Rather, it can promote healing or be used when other treatments are not working.

Among the integumentary applications she discussed were managing edema as an alternative to compression bandaging, reducing mechanical stress, and scar/remodeling techniques. For example, she said that elastic taping can encourage fluid movement around a scar. The goals of taping in wound management include an increased uptake of lymphatic loads; mechanical correction of tissue position; improved mobility, pliability, and coloration; and reduced fibrosis and pain.

Samuels noted that it’s important to be familiar with potential side effects and to avoid using tape with patients who are diabetic; have fragile or irradiated skin, an infection or open wound, or deep vein thrombosis; or are sunburned.

Physical Activity: The Common Denominator in Treating Delirium, Depression, and Dementia

Delirium, depression, and dementia are distinct conditions that often affect the older adult population. What they have in common is that physical activity can help patients with those conditions. As movement experts, PTs must possess the ability to promote physical activity in any of the “3Ds,” said Christine Childers, PT, MS, PhD. She spoke at the Home Health Section’s session “D, DD, DDD: One Size Never Fits All!”

After explaining the differences between the three conditions, Childers said it’s necessary to assess a person’s cognitive level with any of the 3Ds to determine how best to manage that individual.

She provided several tips for working with this population. First: Don’t use the term “exercise.” “If you ask them if they exercise, they’ll say they don’t,” she said, even though they walk, take stairs, or bend to attend to a garden. And they may shy away from instructions to exercise but willingly will engage in dancing, walking, boxing moves, and other physical activity that’s characterized as something other than “exercise.”

Childers also recommended that clinicians “step into their world; don’t try to pull them into ours.” For example, she uses jitterbug dancing for aerobic activity. Additionally, she said, “everything takes longer because you have to engage them first.” It will get easier as they become familiar with the movements, accompanying music or props, and your instructions, “and then you can focus on specific interventions.”

On that last tip, Childers commented that some clinicians may indicate that a patient is unable to cooperate when, in fact, “what they’re really saying is that they don’t know how to teach them.” The profession needs to ensure that clinicians are trained appropriately to engage with these patients, she said.

She cited several strategies for promoting physical activity in those with dementia. These include goal setting, social support, and a credible source — or combined use of all three, which could be more effective than other behavior change attempts to increase physical activity. Another approach, self-determination theory, incorporates the themes of competence, autonomy, and relatedness or connectedness with others.

Childers interrupted her presentation often to have the audience engage in cardiovascular physical movements such as boxing moves, tossing and catching a ball, dancing, and stretching — all of which, she said, have a rationale for use with patients in this population.
How (and Why) to Include Older Adults in Clinical Trials and Research

Older adults often are excluded from clinical trials. A panel of PTs provided an array of suggestions and techniques to include more of them in that research. The Section on Research session “Including the Often-Excluded Older Adult in Clinical Research: Strategies for Recruitment, Enrollment, Retention, and Engagement” was presented by Margaret Danilovich, PT, DPT, PhD, Jennifer Sokol Brach, PT, PhD, FAPTA, Valerie Lea Shuman, PT, DPT, and Victoria Davila, PT, DPT.

The presenters acknowledged that designing studies that include older adults can be difficult. They pointed out that research often prioritizes precision, and older adults are scientifically “messy.” They pointed out, too, that funding agencies often focus on a specific disease or injury. Older adults often have multiple conditions that can make it difficult to determine how the specific condition being studied is being affected. In addition, older adults can be difficult to recruit and manage.

The National Institutes of Health’s “Inclusion Across the Lifespan Policy” is intended “to ensure that the knowledge gained from NIH-funded research is applicable to all those affected by the conditions under study.” In announcing the new policy last year, NIH noted that the population of older adults is “disproportionally absent in clinical research...resulting in insufficient data regarding treatments and interventions for this population.”

The presenters listed traits that make it more challenging to include older adults in research, then provided strategies to address those issues. For example, in dealing with people with sensory deficits — particularly hearing and vision — the panelists suggested using high-contrast and large-print materials, avoiding electronic communication, and minimizing background noise when conducting a study in person. “If you’re in a community space where they’re calling Bingo in the next room,” Brach noted, “you might need to find a quieter space.”

In working with people with mobility limitations, the panelists’ strategies included providing transportation or reimbursing travel, minimizing walking during study visits, and accounting for use of assistive devices.

The presenters had similar tips in addressing health literacy, decisional capacity, and adherence and retention.
The Future Is Now in Telehealth

Mark Milligan, PT, DPT, is excited about the possibilities in the telehealth market. A board-certified clinical specialist in orthopaedic physical therapy and a fellow of the American Academy of Manual Physical Therapists, he led the Private Practice Section session “Telehealth: How to Leverage Technology for More than Just Treatment.”

Milligan began with descriptions and definitions. “Telehealth is the application of technologies to help patients manage their own illness through improved self-care and access to education and support systems electronically. Telerehabilitation is the delivery of rehab services over telecommunication networks and the internet,” Milligan said.

He then described different models of telehealth. These include synchronous or live video, and asynchronous modes, which include prerecorded videos, emails, and photos. “Remote patient monitoring, which is reimbursable by Medicare, allows medical data collection from an individual in one location via electronic vehicle to the provider. Mobile health and public health practice education are supported by mobile devices such as cell phone or tablet and involve using an app.”

“Virtual reality in telerehabilitation is one of the newest tools available,” said Milligan. “Computer technology allows the development of three-dimensional virtual environments that make it fun and engaging for the patient.”

“Many companies provide telehealth physical therapy platforms that you can use to provide care, but whatever platform you use, make sure that it is HIPAA-compliant,” cautioned Milligan. “Know the rules,” he said. “They must sign the same papers as if you were treating them in the clinic, and a digital policy as well. It is your due diligence to maintain your patient’s privacy.” He said that HIPAA violation fines range from $100 to $4 million. “There were over 800 million attempts to break into health records in 2018. Every record is worth over $400 on the black market.”

Noting limitations in Medicare policy related to PTs’ use of telehealth, he said, “Medicare does not consider physical therapists as one of their approved telehealth providers, and many states adopt Medicare language. Legislatively we need to change this.”

How to Help Your Patients Sleep Better

For patients with pelvic pain, sleep might not be the first connection you think of, but during the Academy of Pelvic Health Physical Therapy session “Sleep Management and Persistent Pelvic Pain — Could This Be Your Missing Link?” speakers looked at the importance of sleep and provided practical suggestions for attendees to take to their patients. Presenters were Mark Shepherd, PT, DPT, Katie Siengsukon, PT, PhD, and Jennifer Stone, PT, DPT.

Stone spoke about the roles of the parasympathetic system, bowel and bladder functions, and sphincter control in working with patients who experience pelvic pain. “All of the other things we do are important, such as talking about pain management,” said Stone. “But if we don’t address sleep, we may not be giving patients all the tools they need.”

Shepherd picked up on the importance of sleep as “one of the cornerstones to a healthy well-being.” He discussed how many different body systems are related to sleep and the relationship between sleep and pain.

Siengsukon discussed social determinants of health and their impacts on sleep. These factors include race and ethnicity, social support, job opportunities, and the affordable, healthy foods. “If a patient does not have enough food to eat or can’t pay their rent, sleep may not be their priority,” she said. “Sleep can be seen as a luxury.”

She shared some ways to screen patients, stressing that there is a need to screen all patients for sleep challenges. Screening a patient includes asking questions about sleep disruption, sleep quality, and perceived sleep issues. It also may include conducting a further assessment using a questionnaire, and possibly referring a patient to a sleep specialist.

She cautioned that talking about sleep can be very personal for a patient. “They are inviting you into their bedroom, into their relationship with their partner.”
Movement Evidence in Sports

Movement analysis, assessment of key impairments, addressing errors, and clinical treatment were among the topics discussed during “Sports Medicine Secrets: Evidence-Based Lower Extremity Sports Movement Analysis: Sprinting, Cutting, and Jumping,” a session hosted by the Academy of Orthopaedic Physical Therapy. Marshall LeMoine, PT, DPT, Michael Wong, PT, DPT, Andrew Morcos, PT, DPT, ATC, Stephanie Bell, PT, and Leigh Weiss, PT, DPT, ATC, MS, presented.

LeMoine, Wong, Bell, and Weiss are board-certified orthopaedic clinical specialists. LeMoine, Marcos, and Weiss are board-certified sports clinical specialists. Morcos is also a board-certified pediatric clinical specialist. LeMoine, Wong, and Morcos are fellows of the American Academy of Orthopaedic Manual Physical Therapists, and Morcos and Bell are certified strengthening and conditioning specialists.

“When athletes are performing cutting maneuvers, I want them to have good lower limb control,” said Wong. He said that common movement errors with cutting include high center of mass, excessive knee valgus, and poor hip and core stability.

LeMoine said the top three faults associated with injury are decreased dorsal flexion, quadriceps weakness, and fatigue. He suggested giving movement corrections with both external and internal cues. “External cues might be ‘land with your knees over your toes,’ ‘land like an egg,’ ‘land quieter,’ or ‘spread the floor away with your feet from the direction you are going.’ We want a low center of mass for optimal deceleration. For optimal cutting we want good knee alignment in the frontal plane, with a lower center of mass.”

Marcos suggested filming the athlete’s movements and then reviewing them in slow motion and at multiple angles to see how each area is flexed at landing. “Some joints are meant to move and some are meant to be stable,” he said. The mobile joints are the ankle, hip, and thoracic area, and the stable joints are the knee, lumbar area, and neck. “If it’s a knee problem, the ankle or hip may not be moving enough. You must look at the whole body to find the problem,” he said.
Engaging All Cultures in Cancer Rehabilitation

We all try to be equitable in supporting patient populations, but is equity all that’s needed? “Equity is giving patient populations what they need, but justice looks at what is causing inequality and removes it,” said Ann Marie Flores, PT, MSPT, PhD. Flores joined Kristin Campbell, PT, PhD, BSc, and April Gamble, PT, DPT, in addressing vulnerable populations in oncology rehabilitation during the Academy of Oncologic Physical Therapy’s session “If You Build It Will They Come?”

Flores has conducted numerous studies involving minority populations and cancer rehabilitation. She presented one that looked at cancer survivors of Puerto Rican descent. Most participants had household incomes of less than $20,000 a year, had lower than a ninth-grade education, and lived in the Boston area. “Cancer types included breast, prostate, and colorectal, and many had surgery,” she said.

Of those in the study with one or more impairments, only around 18% actually received physical therapy. Flores said that barriers to receiving physical therapy included lack of a recommendation by their physician (28.6%) and cost (12.9%).

Gamble lives and works in the Kurdistan region of Iraq, which she described as “a very diverse region.” She told the audience that it is the therapist’s job to provide culturally responsive care. “If we don’t,” she said, “there are lower health outcomes. To make treatment plans more responsive we need to consider every level of the health care system.” She suggested examining the therapeutic relationship with the patient, using appropriate written materials, and individualizing assessment, education, and treatment. Outreach barriers must also be addressed: “Do your public awareness campaigns only feature attractive white people?” she asked.

The community being served should be involved, she said. “You need to be purposeful in giving them a voice,” said Gamble. “If you are addressing a population, they should be at the planning table with you.”
The Role of Aquatic Therapy in Spinal Cord Injury Rehabilitation

Incorporating aquatic therapy into the recovery of a patient with a spinal cord injury offers physical and mental benefits. During “Getting Back in the Pool: An Interdisciplinary Approach to Aquatic Therapy Post Spinal Cord Injury,” hosted by the Academy of Aquatic Physical Therapy, presenters Brian Maloney, PT, DPT, and Gabriel Shivers, MS, discussed the role aquatic therapy has played in patient care at the Shepherd Center in Atlanta, Georgia.

Maloney reported that even though patients with a spinal cord injury are living longer, less than 50% of them return to any form of recreation and are dying from secondary complications that are cardiovascular- or pulmonary-related.

Because patients with a spinal cord injury from a diving accident had enjoyed being around the water prior to their injury, they should be encouraged to return to it, Maloney said. “They may have some issues early on,” he added, “but it is something they can enjoy. It can promote lifelong fitness.” He stressed that the earlier a patient can start aquatic therapy, the better.

Incorporating aquatic therapy requires many different types of practitioners coming together with the patient to work for one goal. Maloney said each team should include a PT, occupational therapist, physician, psychologist, speech-language pathologist, and dietitian.

Shivers discussed ways to integrate physical therapy and occupational therapy goals into aquatic sessions. Occupational therapy goals can include, for example, getting in the shower, getting dressed, and practicing transfers.

Throughout the session, Maloney and Shivers narrated videos depicting patient experiences, best practices for helping patients into and out of the pool, and patients performing various exercises.

One area of the body that can particularly benefit from aquatic therapy is the shoulder, Maloney said, noting that up to 90% of patients experience pain there. He explained that overloading the humerus can lead to downward rotation and winging of the scapula. Therapies in the pool can offload the humerus and help the patient improve range of motion.

A dusting of snow provided authentic challenges for those in a manual wheelchair skills workshop that moved in and out of the convention center.
Children With Autism Can Benefit From Movement Interventions

Audience members packed a room and two overflow areas for “Creative Movement and Play Interventions for Children With Autism Spectrum Disorder,” a session hosted by the Academy of Pediatric Physical Therapy. Speakers Anjana Bhat, PT, and Sudha Srinivasan, PhD, discussed the benefits of movement interventions to children with autism spectrum disorder, and explained why it is necessary to evaluate patients for movement impairments even though such impairments are not considered part of the diagnostic criteria of autism.

“Studies show that 87% of autistic children aged 5 to 15 years are at risk for motor impairment,” Bhat said.

Given the increased prevalence of ASD, it is important, Srinivasan said, to develop interventions that can be used throughout the lifespan. She noted that dysfunction in several areas of movement may be observed in children with ASD, including gross, fine, and oral motor skills; balance and posture control; gait; multi-limb coordination; motor timing, imitation, and praxis skills; and physical fitness, including BMI, muscular strength, and cardiovascular endurance.

“Autistic children tend to prefer sedentary activities because movement difficulties affect their ability to participate in activities,” Srinivasan said. “We have the opportunity to impact this population by developing movement-based interventions for them.” She warned, though, that parents sometimes are less concerned about their child’s physical fitness and more about their social interaction. Working with this patient population requires knowing their interests and goals, she said, and what methods will be most successful in reaching them.

Bhat concurred, saying that when conducting patient assessments, it’s important to engage with children so that they’ll more likely adhere to the plan of care. It’s also important to know what has and has not worked, and to observe children in multiple settings: at school, on the playground, at home, and in a one-on-one setting. Bhat suggested, as well, asking the child’s teachers which communication methods work best with that individual.

Tips to incorporate into treatment strategies, Bhat and Srinivasan said, include:

- Using small spaces.
- Understanding that children want predictability and structure.
- Using picture schedules to help children understand what’s going to happen, which reduces their stress.
- Being less verbal and more visual.
- Incorporating singing, dance, and musical instruments.
Attendees Get Hands-on Learning at Technopalooza

At Technopalooza, CSM attendees were invited to step outside the classroom setting and take advantage of hands-on experiences with new technologies. The annual event, hosted by the Health Policy and Administration Section, focused on telerehabilitation and remote patient monitoring, and featured product demos and information about such areas as AI advancements at 20 different stations.

Robert Latz, PT, DPT, is a member of the Technopalooza organizing team. Now in its ninth year, the event continues to grow, he said, noting that music with a DJ was added for CSM 2020.

“Everything is hands-on,” Latz said. “It helps attendees get comfortable with technology and see what’s currently being used in practice. We look for what’s brand-new and cutting-edge, and also at how old technology is being used in new ways.”

Attendee Misti Thompson, PT, DPT, took the opportunity to wear an exoskeleton device designed to help patients with spinal cord injuries walk with robotic assistance. “Technopalooza is a nice way to stay up to date on everything,” she said, “and to get a glimpse of things I can incorporate into my practice and share with my students.”

Virtual reality demos were part of an array of 20 stations featured at Technopalooza. Photo by Jenn Waters.
Statement From the APTA Board of Directors on Patient Care and Practice Management During COVID-19 Outbreak

March 17, 2020: As actions are taken across the country to reduce the spread of COVID-19, a virus that spreads easily from close contact, APTA encourages physical therapists to use their professional judgment to determine when, where, and how to provide care, with the understanding this is not the optimal environment for care, for anyone involved.

APTA encourages PTs, PTAs, and students to flatten the curve of the COVID-19 outbreak by following CDC guidance to minimize exposure in the clinic and practice social distancing by avoiding large social gatherings. At the same time, we know that our profession plays a crucial role in the health of our society, and there are people in our communities whose health will be significantly impacted by disruptions to care.

Patient care has always been specific to the individual, with the physical therapist assessing a person’s needs relative to their goals. Thus, physical therapists have a responsibility to review CDC guidance, to understand who is at highest risk and how to best reduce exposure, and to use their professional judgment in the best interests of their patients and clients and their local communities – including rescheduling nonurgent care if that is the best approach, or making other adjustments when the risk of exposure to COVID-19 outweighs the benefits of immediate treatment.

APTA’s mission is to build a community that advances the profession of physical therapy to improve the health of society. In this challenging time, we are mindful of the effects of this outbreak on our own community as well as on the society our profession nobly serves. Striving for the optimal health of everyone must be our goal.

— APTA Board of Directors

[Editor’s note: See the online statement at apta.org/Coronavirus/Statement/ for links to CDC guidance noted in the statement. Also, APTA President Sharon Dunn, PT, PhD, issued an open letter to members on the COVID-19 pandemic that appears at the front of this issue in the “Viewpoints” section.]
IN OTHER NEWS

Exercise Remains Strongest Recommendation for Knee, Hip, or Hand OA

Although researchers weren’t able to recommend precisely what kind and how much, exercise interventions in general have once again emerged as one of the most strongly recommended approaches to treating knee, hip, or hand osteoarthritis, per an updated practice guideline issued by the American College of Rheumatology and the Arthritis Foundation. The recommendation for exercise is the result of an extensive review of physical, psychosocial, and pharmacological approaches that evaluated the evidence base for their use. Other strongly recommended approaches for all three types of OA include self-management programs and oral nonsteroidal anti-inflammatory drugs, or NSAIDs. Findings were published in Arthritis Care & Research.

www.apta.org/PTinMotion/News/2020/02/11/HipKneeWristOACPG/

TRICARE Changes Coverage for TENS and Dry Needling

The TRICARE Health program used throughout the U.S. Department of Defense health care system has disallowed transcutaneous electrical nerve stimulation – TENS – as a reimbursable treatment for low back pain. And in another recent shift, the DoD agency that oversees TRICARE has ruled that dry needling will not be covered if it’s the sole purpose of a visit. Both TENS and dry needling now are listed as “unproven” treatments in the TRICARE manual. The change is effective June 1.

www.apta.org/PTinMotion/News/2020/03/06/TRICAREDryNeedlingTENS/

CMS Confirms That PT Compact Licensure Is Valid Under Medicare

After several months of uncertainty about the reach of the system that allows PTs and PTAs licensed in one compact state to obtain practice privileges in other compact states, the Centers for Medicare and Medicaid Services made a definitive statement that privilege holders under the Physical Therapy Compact can participate in Medicare. APTA, the Federation of State Boards of Physical Therapy, and the Physical Therapy Compact Commission that oversees the program had pressed CMS for clarification since late last year, when privilege holders began reporting problems with enrolling in Medicare to serve residents of states included in the compact.

www.apta.org/PTinMotion/News/2020/02/25/CMSCompactDecision/

APTA Wants to Hear From You About COVID-19 Experiences

The COVID-19 pandemic continues to change lives in dramatic ways, with more to come even after the crisis ends. APTA wants to know how you’re doing. How are you meeting the needs of your patients under current conditions? Are you volunteering to make a difference in your community? Are you transitioning to or retraining for a new setting? What advice would you give to other PTs facing similar challenges? If you would like to share your story, you can submit via APTA Engage the association’s volunteer resource found at engage.apta.org. Responses may be published in APTA publications or on APTA’s website.

www.apta.org/PTinMotion/News/2020/04/01/COVIDExperiences/

APTA Matches Facilities in Need With Volunteers

APTA began working in March with other organizations and members to connect volunteers with facilities that need physical therapist services. Through the association’s online volunteer portal, PTs, PTAs, and students can volunteer to be available if help is needed, and facilities can outline their needs. Needs were divided into acute, response, and recovery phases; as of this writing, the first two phases were active, and all three still could be for the near future. The submission point is APTA Engage, at engage.apta.org.

www.apta.org/PTinMotion/News/2020/03/30/VolunteerMatch/

Although researchers weren’t able to recommend precisely what kind and how much, exercise interventions in general have once again emerged as one of the most strongly recommended approaches to treating knee, hip, or hand osteoarthritis, per an updated practice guideline issued by the American College of Rheumatology and the Arthritis Foundation. The recommendation for exercise is the result of an extensive review of physical, psychosocial, and pharmacological approaches that evaluated the evidence base for their use. Other strongly recommended approaches for all three types of OA include self-management programs and oral nonsteroidal anti-inflammatory drugs, or NSAIDs. Findings were published in Arthritis Care & Research.

www.apta.org/PTinMotion/News/2020/02/11/HipKneeWristOACPG/

The TRICARE Health program used throughout the U.S. Department of Defense health care system has disallowed transcutaneous electrical nerve stimulation – TENS – as a reimbursable treatment for low back pain. And in another recent shift, the DoD agency that oversees TRICARE has ruled that dry needling will not be covered if it’s the sole purpose of a visit. Both TENS and dry needling now are listed as “unproven” treatments in the TRICARE manual. The change is effective June 1.

www.apta.org/PTinMotion/News/2020/03/06/TRICAREDryNeedlingTENS/

After several months of uncertainty about the reach of the system that allows PTs and PTAs licensed in one compact state to obtain practice privileges in other compact states, the Centers for Medicare and Medicaid Services made a definitive statement that privilege holders under the Physical Therapy Compact can participate in Medicare. APTA, the Federation of State Boards of Physical Therapy, and the Physical Therapy Compact Commission that oversees the program had pressed CMS for clarification since late last year, when privilege holders began reporting problems with enrolling in Medicare to serve residents of states included in the compact.

www.apta.org/PTinMotion/News/2020/02/25/CMSCompactDecision/
Professional Pulse

PTJ’S EDITOR’S CHOICE
Here’s recent research of note from PTJ (Physical Therapy, APTA’s scientific journal), as selected by Editor-in-Chief Alan Jette, PT, PhD, FAPTA.

Highlights From Volume 100, Issue 5, May 2020:

› Have you ever thought about **fidelity measurement**? Probably not. Although it is common in psychological and health behavioral research, fidelity measurement is rare in physical therapy research. It looks at how closely a treatment plan is followed — helping to improve understanding of effectiveness, dose, frequency, and timing of intervention, as well as the implementation of research findings in practice.

› **Femoroacetabular impingement syndrome** has been getting more attention within the past decade. Even so, aspects of FAIS and its management remain unclear. Powers and colleagues organize the current understanding of FAIS and propose that its consequences and progression can be cyclical in nature.

› **Primary lower limb lymphedema** is a chronic disorder without a cure, but it can be mitigated with two phases of treatment: volume reduction and volume stabilization. Authors look at predictors for the effectiveness of the first phase of treatment.

› How do **strokes affect balance and gait** in both the acute phase and after three and 12 months? Hamre and colleagues looked specifically at patients under 70 years of age who had experienced minor ischemic strokes and found that impairments still existed a year later in a third of the participants. Find out what factors predict impaired balance after 12 months.

› Children born preterm are at risk for many things, including motor skill impairment. Surprisingly, however, not a great deal is known about the effects of interventions in the neonatal intensive care unit. This study examines the effectiveness of **parent-administered exercise programs** with the assistance of clinicians.

› **Learn about Coach2Move**, a personalized treatment strategy by physical therapists to elicit physical activity in community-dwelling older adults with mobility problems.

› People with lower limb amputation rarely reach their full potential functionality. This paper looks at the effectiveness of the Evidence-Based Amputee Rehabilitation Program for **people with unilateral transtibial amputation** who have already completed initial physical therapy and prosthetic training.

› **Pain neuroscience education and motivational interviewing** have been shown to help patients deal with chronic pain in the short term. Nijs and colleagues explain how to integrate these two programs into your own practice.

› People who have had strokes are not meeting their recommended levels of physical activity. Why? Thilarajah and team looked at patients discharged from inpatient rehabilitation and conducted a follow-up after three months. A range of factors across different domains, and not just physical capacity, were involved. **Better physical function at discharge** was associated with future increased levels of physical activity.

› Is there a better way to **evaluate upper extremity motor function**, especially for those who had hemiparetic stroke? Okuyama and colleagues look at a reachable work space assessment to determine its validity and reliability, and to see if it can be recommended in a clinical setting.
Why You Should Keep a Close Eye on Telehealth

Want to know a stunning fact? According to a new Pew Research study, 81% of Americans now own a smartphone.

Our phones clearly play a huge role in our lives — so much so that they’ve almost become extensions of our own bodies, rarely leaving our pockets or hands.

The point is that the smartphone has ushered in a new era, not just because of the device itself, but because of what it makes available: Most of the valuable services in our lives are accessed through that minicomputer.

But have you ever noticed that health care services on smartphones are seemingly absent? Why hasn’t health care reached our pockets yet? If 81% of Americans use smartphones to access their most important service providers, why aren’t health care services included?

Facebook, Spotify, Instagram, and Uber all realized early on that the smartphone enabled an entirely new opportunity but also posed a unique challenge. They had to reinvent an existing service so that it could more efficiently connect with us, the consumers.

Can you see where this is headed?

You should keep a close eye on telehealth because there is an interesting opportunity looming to reinvent how physical therapist services can be delivered and accessed.

From a conceptual perspective, telehealth could add another avenue that makes our services more accessible and valuable. And with continued cuts to payment for physical therapist services in the near future, along with health crises such as the COVID-19 pandemic, access will become increasingly important. Here are a few more facts of interest:

- More than 150 million Americans are digital natives. A digital native is someone who was born during the digital era or who grew up with technology and doesn’t find the complexity of technology to be problematic.
- Outside interest in digital therapeutics is skyrocketing. Within the past several years, there has been an influx of non-physical therapists and other outsiders entering the growing digital physical therapy space.
- APTA is strongly supporting the growing interest in telehealth. Created in 2016, the FiRST Council is dedicated to advancing technological innovations in professional practice, education, and research. Telehealth is one of its five focus areas, and APTA is beginning to roll out more valuable information about why telehealth is rising in importance, guidelines for navigating telehealth ethics and regulation, and additional resources, including research and media surrounding the topic.

We are living in the digital age, and aspects of our practice, education, and research should reflect this. If you’re interested in learning more, check out APTA’s growing telehealth resources or look into the current evidence supporting its potential efficacy.

Read the full story from January 8, 2020, in The Pulse. www.apta.org/CloseEyeonTelehealth/
APTA MEMBER VALUE

APTA is committed to providing value from membership in the association, especially during difficult times.

APTA’s Learning Center Offers Free Online Courses on Telehealth

The association’s online continuing education platform offers a collection of webinars and courses that can provide you with insight into telehealth, where some of the most significant changes are happening to the profession in response to the COVID-19 emergency. APTA also has collected self-paced courses on a variety of other topics that are perfect for when you need to give yourself time away from the current crisis. Visit the Learning Center at learningcenter.apta.org.

www.apta.org/PTinMotion/News/2020/04/03/LearningCenterFreeCourses/

Stay Up to Speed on Telehealth, Licensure Provisions, and Other State-Level Changes

Many states have made temporary changes to their laws that may provide additional opportunities for PTs and PTAs during the COVID-19 pandemic. States are the decision-makers regarding much of what PTs and PTAs can and can’t do during the health crisis – as they are during nonemergency times. To help you keep up and make fact-based practice decisions, APTA is offering access, via the link below, to the following regularly updated resources on state actions. (A caveat: Check with your state physical therapy licensing board and each of your payers for confirmation, as laws and regulations are changing frequently.)

- A weekly updated APTA chart that tracks state orders allowing PTs and PTAs to provide telehealth services.
- A weekly updated APTA chart that tracks state actions related to telehealth in Medicaid, commercial, and workers’ compensation coverage.
- A rundown of state licensure exemptions and requirements for PTs and PTAs related to the pandemic.
- Contact information for state physical therapy licensing boards, courtesy of the Federation of State Boards of Physical Therapy.

www.apta.org/PTinMotion/News/2020/04/10/StateResourcesCOVID/

Support From APTA Strategic Business Partners and Member Value Programs

Many of APTA’s Strategic Business Partners and Member Value Programs have stepped forward with special offers to assist the profession and APTA members during the health crisis that continues to disrupt our society. Among the offerings are free courses and significant discounts. See the list on our website using the link below, and check with each vendor for details such as the duration of the offer.

www.apta.org/PTinMotion/News/2020/04/08/SBPAndMVPOffers/

We Make MIPS Simple.

Enrollment now open for the 2020 reporting year.

Request a Demo:
ptoutcomes.com/lead
APTA CONNECT Telehealth brings your remote patients closer and allows you to maintain high quality rehab care in a way that still feels personal and thorough.

**Designed for healthcare.**
- HIPAA compliant video and storage
- Options to store a full 30-minute visit or just screen capture
- Less expensive than other teleconferencing tools

**Convenient for patients.**
- Automated text and email reminders

**Easy for therapists.**
- Integrated workflows and documentation in APTA CONNECT Rehab EMR
- Telehealth appointments automatically created in CONNECT Scheduler
- Dashboard shows daily appointments and notifies when patient is in the virtual waiting room
- Join telehealth visit with a single click

# Call Your Rep
Your ability to reach vulnerable communities – including children, seniors, and the 20% of Americans who live in rural areas – is at risk.

It’s time to make telehealth a permanent option for rehab care, not just a stopgap with e-Visits during COVID-19.
## MANUAL THERAPY AND ORTHOPAEDIC CONTINUING EDUCATION SEMINARS

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

#### S1 - Spinal Evaluation & Manipulation: Impairment Based, Evidence Informed Approach
- 20 Hours, 2.0 CEUs (Prerequisite: S1 Intro Webinar Included)
  - Beaverton, OR: Furto May 2-3
  - Chicago, IL: Yack May 2-3
  - Raleigh, NC: Yack May 9-10
  - Indianapolis, IN: Furto Jul 11-12
  - New York, NY: Yack Jul 11-12

#### S2 - Advanced Evaluation & Manipulation of Pelvis, Lumbar & Thoracic Spine Including Thrust
- 18 Hours, 1.8 CEUs (Prerequisite: S1 Intro S2 Webinar Included)
  - York, ME: Yack May 16-17
  - Chicago, IL: Yack Jul 18-19
  - Philadelphia, PA: Irwin Aug 9-9
  - San Marcos, CA: Yack Aug 15-16

#### S3 - Advanced Evaluation & Manipulation of the Cranio Facial, Cervical & Upper Thoracic Spine
- 20 Hours, 2.0 CEUs (Prerequisite: S1 Intro S3 Webinar Included)
  - Austin, TX: Grant Aug 15-16
  - Birmingham, AL: Irwin Jun 6-7
  - Beaverton, OR: Irwin Aug 1-2
  - St. Augustine, FL: Viti Aug 15-16

#### S4 - Functional Analysis & Management of Lumbo-Pelvic-Hip Complexes 16 Hours, 1.6 CEUs (Prerequisite: S1 Intro S4 Webinar Included)
  - Denver, CO: Stanborough Jun 20-21
  - Dallas, TX: Stanborough Jul 25-26
  - Little Rock, AR: Cantu Aug 8-9
  - St. Augustine, FL: Lommennov Sep 19-20

#### MF1 - Myofascial Manipulation 18 Hours, 1.8 CEUs (Prerequisite: Intro MF1 Webinar Included)
  - Denver, CO: Daugherty Jun 20-21
  - Dallas, TX: Stanborough Jul 25-26
  - Little Rock, AR: Cantu Aug 8-9
  - St. Augustine, FL: Lommennov Sep 19-20

#### E1 - Upper Extremity Evaluation & Manipulation 15 Hours, 1.5 CEUs (Prerequisite: Intro E1 Webinar Included)
  - Miami, FL: Naas May 2-3
  - Atlanta, GA: Busby May 16-17
  - St. Augustine, FL: Busby Jun 6-7
  - New York, NY: Naas Aug 8-9
  - Denver, CO: Turner Aug 8-9

#### E1 - Lower Extremity Evaluation & Manipulation 15 Hours, 1.5 CEUs (Prerequisite: Intro E1 Webinar Included)
  - Denver, CO: Turner May 2-3
  - San Marcos, CA: Turner May 16-17
  - St. Augustine, FL: Busby Aug 15-16
  - New York, NY: Naas Oct 17-18

#### E2 - Extremities Integration 21 Hours, 2.1 CEUs (Prerequisite: E1)
  - Charleston, SC: Mandel May 1-3
  - Atlanta, GA: Mandel Jun 26-28
  - Miami, FL: Mandel Aug 14-16
  - Denver, CO: Patla Sep 11-13

#### Thrust - Advanced Manipulation of the Spine & Extremities 15 Hours, 1.5 CEUs (Prerequisite: Any Earned Manual Therapy Certification and USUHS seminar attendance or Fellow of AADOMPT)
  - Austin, TX: Yack Sep 12-13
  - Denver, CO: Yack Nov 7-8

#### Cranio Facial Certification Preparation and Examination 23 Hours, 2.3 CEUs (Prerequisites: S1, S3, CF1, CF2, CF3, CF4)
  - Austin, TX: Aug 20-22

#### Manual Therapy Certification Preparation and Examination 24 Hours, 2.4 CEUs (Prerequisites: S1, S2, S3, S4, E1 Upper Extremity, E1 Lower Extremity, E2, MF1)
  - Austin, TX: St. Augustine, FL Oct 22-24

#### Exercise Strategies and Progression for Musculoskeletal Dysfunction 15 Hours, 1.5 CEUs (No Prerequisite)
  - New York, NY: Daugherty Jun 13-14
  - Charleston, SC: Daugherty Jul 18-19
  - Indianapolis, IN: Daugherty Aug 1-2
  - Little Rock, AR: Daugherty Oct 10-11

### ADDITIONAL SEMINAR OFFERINGS

#### Dry Needling I
- Intramuscular Dry Needling of the Cervical, Scapulo-thoracic, Craniofacial Region and Upper Extremity 25 Hours, 2.5 CEUs (Prerequisite: None)
  - Denver, CO: Krell Jun 12-14
  - Dallas, TX: Krell Oct 23-25

#### Dry Needling II
- Intramuscular Dry Needling of the Lumbo-Pelvic and Lower Extremity 25 Hours, 2.5 CEUs (Prerequisite: DN I)
  - Denver, CO: Krell Aug 14-16
  - Knoxville, TN: Krell Sep 11-13

#### Running Rehabilitation:
- An Integrative Approach to the Examination and Treatment of the At Risk Runner 14 Hours, 1.4 CEUs (No Prerequisite)
  - Open to PTs and ATs
  - Milwaukee, WI: Vighetti May 9-10
  - Dallas, TX: Vighetti Jun 6-7
  - Boston, MA: Vighetti Jun 27-28
  - Atlanta, GA: Vighetti Aug 8-9

#### CF2 - Intermediate Cranio Facial 15 Hours, 1.5 CEUs (Prerequisite: Basic CF1 Online)
  - St. Augustine, FL: Hobson May 7-8
  - Baltimore, MD: Strickland Jul 11-12

#### CF3 - Advanced Cranio Facial 15 Hours, 1.5 CEUs (Prerequisite: CF2)
  - St. Augustine, FL: Hobson May 9-10
  - Raleigh, NC: Hobson Jun 6-7
  - Indianapolis, IN: Hobson Oct 24-25

#### CF4 - State of the Art Cranio Facial 15 Hours, 1.5 CEUs (Prerequisite: CF3)
  - St. Augustine, FL: Hobson Sep 19-20

### WEBSNARS AND ONLINE OFFERINGS

**ALSO AVAILABLE - CPE.USA.EDU**

- Dissection of the Knee & Thigh (2 Hours; 2 CEU) $70
- Dissection of the Pelvis (2 Hours; 2 CEU) $70
- Dissection of the Axilla & Arm (2 Hours; 2 CEU) $70
- Dissection of the Forearm & Hand (2 Hours; 2 CEU) $70

### Registration - A $100 non-refundable deposit must accompany your registration form. A 50% non-refundable, non-transferable deposit is required for Certification. Balance is due 30 days prior to start date of the seminar. Balance can be transferred or refunded with two week written notice. Notice received after that time subject to only 50% refund. No refunds or transfers will be issued after the seminar begins.

**Team Discount**: Two (2) or more colleagues registering for the same seminar at the same time receive a 10% discount at the time of registration. (Advanced notice and full payment is required; does not apply after the first day of a seminar)

**Multiple Seminar Discount**: Register and pay in full for two or more seminars at the same time and receive a 10% discount. (May not be combined with any other discounts or previous registrations.)

**Audit Seminar Discount**: Register and pay for a seminar previously attended/completed and receive a 50% discount. (Note: You must call 904-826-0084 to verify your previous attendance and to register and pay for the seminar.)

**Webinar availability**: Also available - cpe.USA.EDU

**Call**: 800-241-1027
**Visit**: cpe.usa.edu

There are no content errors in the document.
Grow your clinical practice

Therapeutic Pilates education designed for health care professionals.

The STOTT PILATES® Rehabilitation Program and Merrithew™ equipment provide the tools you need to build your knowledge and your clinical practice. Adding Pilates can help you increase revenue and work with Cash Pay and Insurance clients.

merrithew.com/rehab

Want to learn dry needling?
No better place than Myopain Seminars!

Our current Dry Needling 1 (DN-1) courses:

- April 3-5  Bethesda, MD
- April 3-5  Appleton, WI
- May 29-31  Bethesda, MD
- June 5-7  Appleton, WI
- July 17-19  Bethesda, MD
- August 7-9  Bethesda, MD
- September 18-20  Bethesda, MD
- September 18-20  Overland Park, KS
- September 18-20  Memphis, TN
- October 9-11  Bethesda, MD
- October 9-11  Atlanta, GA

After all, dry needling in the USA started with Myopain Seminars back in 1997!

Register today at myopainseminars.com
INTERESTED IN BECOMING A CREDENTIALED CLINICAL INSTRUCTOR?

**CCIP Level 1**
Explore different aspects of the clinical learning environment, including skills and techniques, that are necessary to provide a structured and effective learning environment for students.

**CCIP Level 2**
This program is a natural progression from Level 1 and will help further develop your clinical teaching skills and in constructing a clinical curriculum.

**DID YOU KNOW?**
- Over 65,000 PTs and PTAs have been credentialed since 1996.
- More than 2,300 PTs and PTAs have received their Level 2 credential since 2008.

Learn more at [apta.org/CCIP](http://apta.org/CCIP)
At Optum360®, our partnership with APTA is important. We work together to develop unique coding solutions that meet the specific needs of physical therapists. That’s why we offer APTA members discounts on the coding resources they rely on every day.

**Simplify coding and billing with the resources developed exclusively for the physical therapist — from Optum360 and APTA.**

**ORDER YOUR 2020 EDITIONS TODAY.**
As an APTA member, enjoy a special offer — get 20% off the 2020 Coding and Payment Guide for the Physical Therapist and 40% off the 2020 ICD-10-CM Fast Finder® for Physical Therapy.

**2020 Coding and Payment Guide for the Physical Therapist**
ITEM NUMBER: SPT20 | AVAILABLE: DEC 2019
The Coding and Payment Guide for the Physical Therapist is your one-stop coding, billing and documentation guide to submitting claims with greater precision and efficiency. It provides all the information you need — organized by the way you work — to support accurate, timely reimbursements.

**2020 ICD-10-CM Fast Finder® for Physical Therapy**
ITEM NUMBER: 18928 | AVAILABLE: OCT 2019
The ICD-10-CM Fast Finder® series uses our patented Optum360 Xpress Coding Matrix™. Save time with this quick-lookup tool, putting the most specific ICD-10-CM codes for physical therapy at your fingertips.

**Act today to save up to 40% on resources that meet the unique needs of physical therapists.**

Visit: optum360coding.com and enter promo code APTAFO20 at checkout

Call: 1-800-464-3649, option 1, and mention promo code APTAFO20
Rose was just into her eighties when she became my home care patient. Both she and her daughter were confused and frustrated by her growing list of physical ailments, including pain and stiffness in her lower left leg, difficulty walking, and anxiety.

This was a woman who had travelled the world in her 70s, having been to the Taj Mahal and the Great Wall of China. She'd trekked into the African bush to encounter gorillas at age 80! Now, however, she barely was able to walk from her bedroom to her bathroom some 20 feet away.

A recent hysterectomy, emesis due to a liver cyst, interventional radiology, prolonged hospital and short-term rehabilitation stays — something or everything was causing her to stumble and fall in her home. She also had a host of comorbidities, including gastroesophageal reflux disease, chronic low back pain, and spinal stenosis.

After going over my evaluation, we immediately set out to identify her most pressing impairments in order to address her falls risk and maximize her functional mobility and safety. I suspected from the start, though, that this wasn't going to be a straightforward case. That turned out to be true. Over the course of her physical therapy, specialist after specialist gave Rose diagnosis after diagnosis — a litany of reasons why her body was changing or malfunctioning. Some simply chalked it up to old age.

Eventually, the possibilities of left knee arthritis or Parkinson disease were proposed — by an orthopedist and a neurologist, respectively — as the main cause of her walking difficulties. My responsibility as her physical therapist was to help Rose figure things out — to help alleviate her pain and to work with her to improve her balance, endurance, and strength. We went to work on the immediate goals of safe mobility and reduced falls risk in the home.

Still, I felt strongly that there was something amiss with the whole scenario. I wanted to dig deeper. As humans, we’re all complex, and factors such as disease and environment can add layers of complication to cases like Rose’s. Fortunately, I had two hats available to me as I tackled these complexities: those of the physical therapist and of the anthropologist.
All physical therapists encounter medically complex patients who force us to think harder and outside the box. This challenge is one of the reasons I joined the profession, graduating from New York University’s baccalaureate program in 1995. Our professors equipped us to see the big picture while homing in on myriad details for further investigation.

Over time, I developed the ability to tell what might be occurring among different physiological systems, and to pay close attention to such factors as the home environment and the patient’s medications. Continuing education and experience further sharpened my skills at pattern recognition.

I saw that Rose did not fit neatly into the patterns consistent with a diagnosis of knee osteoarthritis, spinal stenosis, or Parkinson disease. So, I needed to explore other possible pathologies that better fit her overall picture. I knew that I needed to consider the factor of variation — the variability of disease presentation, symptoms, and age-related issues of individuals within the geriatric population.

I’ve always enjoyed working with older adults and addressing the health challenges that accompany aging; it’s why I became a board-certified clinical specialist in geriatric physical therapy. My physical therapy knowledge and training provide me with many tools to address aging’s complications. But I have another scientific bent, as well. Might the answers to some of my questions about human variation lay in the field of anthropology?

Physical therapists are musculoskeletal experts. We treat people who come in all shapes and sizes. I was looking for the “why” behind such variation. I found it in the subfield of physical anthropology — also known as biological anthropology — at Hunter College in New York City. It’s a broad field that includes primatology (think Jane Goodall) and forensic anthropology (think television’s “Bones”). Many anthropologists teach gross anatomy at medical schools. I zeroed in on the areas of genetics, functional morphology, and comparative anatomy.

I graduated from Hunter with my master’s degree in 2008 with a thorough appreciation of the array of influences on biological variation. My thesis, for example, involved investigating thoracolumbar osteoarthritis patterns among a specific group of primates and determining what factors — vertebral position, biomechanics, living in the wild versus captivity, and others — might be associated with those patterns. The study found that spinal osteoarthritis among my sample group varied according to such factors as sex, body size, and age. Interestingly, more arthritic changes were seen in primates that weren’t just older but also were in captivity or had larger body masses. I thought about how my physical therapy patients might similarly be shaped by their genes and environment, and how their diseases or conditions might be influenced by those factors.

In Rose’s case, the physical therapist in me explored the connections between her symptoms — including ataxic gait, pain and stiffness in the lower anterior compartment of her leg, and anxiety — and the possible diagnoses. It’s the kind of detective work I enjoy as a diagnostician.

Meanwhile, the anthropologist in me was mindful of the ways in which natural variation can muddle things — producing variable responses to medications and different presentations of the same disease. One also must consider each person’s unique trajectory in life — family history, employment, culture, and lifestyle. Such factors shape all of us in different ways.

It was clear that Rose’s symptoms were not due to Parkinson disease. Nor could they be fully explained by osteoarthritis. The fact that her sister had posterior lateral sclerosis — a rare neuromuscular disease — led me to explore the possibility that Rose had inherited it.
Research revealed that PLS is not hereditary, but two other conditions are — familial amyotrophic lateral sclerosis and pure hereditary spastic paraplegia. Pertinently, both FALS and PHSP are characterized by gait ataxia, unilateral lower leg symptoms (worsened by anxiety in the case of PHSP), and late-adulthood onset.

I relayed this theory to Rose’s neurologist and her geriatrician for further consideration. With that diagnostic possibility in mind, Rose and I carried on — focusing on alleviating her pain, improving her balance and gait, and meeting her physical therapy goals. (Rose’s family members and specialists agreed not to mention FALS or PHSP to her, given her easily triggered and debilitating anxiety.)

My work with Rose illustrated why I became a physical therapist, and what motivated me to supplement those skills with knowledge and training in biological anthropology. Human beings are molded by their genes, culture, and environment. When individuals present with mysterious and confusing symptoms that cause discomfort and real risks for injury, I try to piece together that puzzle. I may not always succeed. What I can and do always provide, however, is compassion and caring. I strive to convey — straightforwardly and without medical jargon — the fact that I’m steadfastly listening, and that my patients are not alone in their struggle and their search for answers.

As a clinical scientist and anthropologist equipped with a holistic approach to rehabilitation, I continue to serve others — ever observant and always curious about the variables that make us uniquely ourselves.

Maybe, in the end, it’s all about helping people who are in pain feel human again — in all of their complexity.
Millions of Americans visit ChoosePT.com each year.

Help them find you.

Activate or update your Find a PT profile, available free to all APTA member physical therapists who are willing to be contacted by consumers seeking care.

Log in to your APTA.org profile to make changes. See it live at ChoosePT.com/FindaPT.
What’s the best way you’ve found to get patients to buy in to their home exercise program?

α: Make the program reasonable and provide ideas and opportunities to integrate it into their daily life. When family or other caregivers are involved, provide at least some exercises that individuals can perform without assistance, so their loved ones don’t have so much pressure on them.

– KAITLYN BATCHELDER, PT

β: First, establish their goals and relate the importance of the home exercise program to those goals. Second, initially keep the number of exercises or activities low to ensure tolerance, especially when they are starting a new routine.

– MICHAEL BRENEMAN, PT, DPT

γ: Motivational interviewing increases their confidence and helps identify their excuses.

– SUSANNE ORTIZ, PT, DPT

What advice do you have to avoid burnout?

α: Take your lunch break daily and use your vacation and personal days; you need that time for yourself. Exercise regularly. Make time for leisure activities, family, friends. Work a flexible schedule, if possible, and talk with your supervisor if you’re starting to feel burned out.

– MELANIE WELLS, PT

What do you believe is different about today’s students from when you were in school?

α: I think newer clinicians are more inclined to think along evidenced-based practice lines, as they were taught this early on in school, and, although small, there is a growing body of literature. The paucity of research when more-experienced clinicians went to school did not lend itself to teaching evidenced-based practice. New and seasoned clinicians have a lot to learn from each other!

– NATALIE ANZURES, PT, DPT, MS

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

Responses may be edited for clarity, style, and space, and do not necessarily reflect the positions or opinions of PT in Motion or the American Physical Therapy Association.
Made to exacting standards, the NormaTec PULSE 2.0 Series Recovery System is designed to work for you and your patients. Improve clinical outcomes, increase patient satisfaction, promote retention rates, and grow your practice with NormaTec’s patented compression technology.

(Clinical references available at www.normatecrecovery.com/science)

Email today to request a demo: ptchiro@normatecrecovery.com
Patient ACHES and PAINS?
Here’s a cool app for that.

Introducing:
Helix™
Professional Pain Relief

Helix Professional Pain Relief is an exciting innovation in topical analgesia that delivers cooling pain relief from our optimized formula of menthol (7.4%), while its smooth consistency allows for easy application. It also contains arnica, ilex, and aloe... plus tangerine oil for a fresh citrus fragrance.

Helix is fast-acting, aesthetically pleasing, and provides temporary relief from:

- Sore Muscles • Joint Pain
- Arthritis • Backache

Visit helix4pain.com

Helix is only available to professionals by Parker Laboratories, so you can feel confident in stringent quality control, product availability, and most importantly, patient satisfaction — all great reasons for putting Helix Professional Pain Relief into practice!