

The Economic Value of Physical Therapy in the United States



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Leo Bosco, PT, DPT

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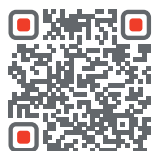
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/ 24

The Economic Value of Physical Therapy in the United States

A new APTA report shows just how cost-effective physical therapy really is.



/ 14

25 Years of PT Residency Accreditation

The American Board of Physical Therapy Residency and Fellowship Education celebrates its silver anniversary.



/ 34

What's the Impact of AI on Physical Therapy?

How artificial intelligence can enhance physical therapist services — and when PTs should use caution.



/ 44

New CPT Codes Will Support the Critical Role of Caregivers

Beginning in 2024, PTs can bill for caregiver training.

COLUMNS

/ 58

Defining Moment

Taking a teaching job on a lark proved to be the perfect fit for this physical therapist.

DEPARTMENTS

/ 4

Quoted

/ 6

Viewpoints

Forum

/ 48

Professional Pulse

Health Care Headlines
APTA Leading The Way
Member Value

/ 56

Marketplace

Career Opportunities
Continuing Education
Products

/ 57

Advertiser Index

SPONSORED CONTENT

/ 10

Orthostatic Hypotension and Fall Risks in Older Adults

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— C.J. Morrow, PT, DPT, in “What’s the Impact of AI on Physical Therapy?” on Page 34.



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Forum

Authenticity Versus Professionalism: A Crossroads

[In response to “Being Authentic Offers Better Patient Care,” in the June 2023 issue,] we are human. Our innateness seeks and desires authenticity and to be authenticated by those with whom we are surrounded. As physical therapists, infusing our individual beliefs, values, and underlying spirit into a professional patient relationship can be a slippery slope. We can be authentic within the depths of our souls by knowing the inner traits we possess. However, our first and foremost responsibility to the patient is to be professional. Our state laws lay the legal groundwork for being a professional and our elective

membership into APTA is the cornerstone, set to a higher standard, of how we place our professionalism into action.

Yes, our authenticity is intimately intertwined with our professionalism. Expressions of our own authenticity must first take into consideration the sensitive nature and needs of the patient. To act professionally, we must accept that our patients have different values, their ages span the generations, and honor their rights to their beliefs, even if we don’t always agree.

Our gender identification, our political stances, our race and religious views, and any topic

or agenda that we carry and exhort into a patient relationship must, first and foremost, pass the test of truly meeting the needs of our patients. We can be passionate regarding our authenticity only if we are fiercely compassionate in regard to placing the sensitive physical, psychological, and emotional needs of our patients first!

Our patients’ needs for professionalism versus one’s personal desire for authenticity may at times conflict. Just remember, it’s not about me, but rather the patient I serve!

ROBERT WOOD, PT

Highlighting Residency and Fellowship Opportunities

I was wondering if APTA Magazine would be interested in doing a potential article feature on Spine Physical Therapy Fellowship programs or a general highlight of all ABPTRFE residency and fellowship programs (with small features on different specialties). I think it would be great to recognize what is happening in the post-professional education of physical therapists and how it changes the profession.

JUSTIN M. LANTZ, PT, DPT, Director, USC Spine Physical Therapy Fellowship Program

EDITOR’S NOTE: For more information on postgraduate education, read the story on Page 14. Thanks for your timely feedback!

Congratulations to McMillan Lecturer



Judith Deutsch, PT, PhD, FAPTA

Brava, Judith Deutsch, PT, PhD, FAPTA.

As a DPT student under Karen Huhn, PT, PhD, MS, ... I remember when [Huhn] was doing her PhD as I was writing my thesis on the Nintendo Wii Fit and its use of the EXIT25 and Executive Function in the elderly while she was in the lab in New Jersey with you.

Direct or indirect, your presence has been felt by so many.

Brava.

JESSICA SCHWARTZ, PT, DPT, in a reply to an APTA tweet announcing that Deutsch is the recipient of the 55th APTA Mary McMillan Lecture Award

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Arming the Profession With Evidence

Kudos to the American Physical Therapy Association for their recent landmark report “The Economic Value of Physical Therapy in the United States.” I sincerely hope this report, which was developed by the international management consultant Nous, is internalized, processed, and sung from the mountaintops by physical therapists across this country. Whether for patient recruitment, patient buy-in, lobbying, or market acquisition, this report arms our profession with evidence demonstrating the incredible value of physical therapy in providing cost-effective care for the most common musculoskeletal ailments that affect our population.

To illustrate one example of the enormous benefit of this report, consider the details provided for patients with carpal tunnel syndrome electing physical therapy over typical treatment involving surgical release. As summarized by the report, “The average net benefit of treating carpal tunnel syndrome with physical therapy is estimated to be \$39,533 per episode of care.” If this is not something you are sharing with your patients who are skeptical of physical therapy, read the report and consider including this gem as part of your elevator speech for the benefits of services our profession has been quietly turning out over the years.

While not as jaw-dropping as carpal tunnel syndrome, physical therapy for low back pain was found to have a net economic benefit of \$4,160 per episode of care. As we all know, back pain is the most common musculoskeletal condition in our world.

As a small business owner of an on-site industrial rehabilitation company, information like this justifies my paycheck. Rationalizing the cost of employing an on-site physical therapist becomes more straightforward when you compare it with anticipated costs per episode of

care for conditions like carpal tunnel syndrome or low back pain managed with non-conservative care. Reports such as these create opportunities for physical therapists or, at least, should create opportunities for physical therapists. What is a company willing to pay to reduce health care and workers’ compensation costs? I suggest you go ask. You might be pleasantly surprised. Oh, and bring the report.

ADAM LADWIG, PT, DPT, PHD

The Value of APTA Reports

This is why membership matters.

TODD SANDER, PT, MSPT, PhD, on an APTA post on LinkedIn on “The Economic Value of Physical Therapy in the United States.”

EDITOR’S NOTE: We couldn’t have said it better ourselves, Todd. For more information on APTA’s landmark report, read the story on Page 24.

The Economic Value of Physical Therapy in the United States

A Report From the American Physical Therapy Association



September 2023



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*Jacob Capin, PT, DPT, PhD
2017 PODS I and 2018 PODS II*

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Orthostatic Hypotension and Fall Risks IN OLDER ADULTS

By Laura Ham, PT

Orthostatic hypotension, or OH, is a condition characterized by a drop in blood pressure, or BP, upon standing that leads to symptoms such as dizziness, lightheadedness, and, in some cases, fainting.

Older adults are often more prone to this condition since the body's ability to regulate blood circulation to meet the needs of organs and other systems, also known as hemodynamic homeostasis, becomes less effective with age.

The drop in blood pressure caused by OH upon standing can affect cerebral blood flow and compromise brain perfusion, which can lead to momentary episodes of confusion and balance issues. The confusion and balance issues that are associated with OH place the person at an increased fall risk (Masaki, 1998).

The prevalence of OH in older adults is as high as 60% for those in a long-term care or acute-care setting (Hajjar, 2005). Physical therapists working with this population should be mindful of the increased fall risks and assess for OH and provide treatment interventions.

Know the Signs of OH and Risk Factors in Older Adults

Given the increasingly aging population, clinicians are likely to encounter OH more frequently. A thorough patient history, accurate measurement of orthostatic blood pressure, and evaluation of the autonomic nervous system are crucial for clinical guidance in managing OH.

The main goals for addressing OH are to achieve volume expansion and vasoconstriction. The clinical team,



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including the physical therapist and physician, should first identify any medications that may be contributing to OH, and, next, identify and address any conditions that could exacerbate OH.

Conditions that may contribute to OH include (Figueroa, 2010):

- Dehydration
- Time of day (early morning after nocturnal diuresis)
- Rising quickly after prolonged sitting or recumbency
- Prolonged motionless standing
- Physical exertion, especially vigorous or isometric exercise
- Alcohol ingestion
- Carbohydrate-heavy meals
- Heat exposure or fever
- Straining during micturition or defecation

Assessing OH

According to the Centers for Disease Control Guidelines for Properly Assessing OH, the procedure for measuring OH is:

1. Have the patient lie down for five minutes; then check their blood pressure and heart rate.
2. Have the patient stand for three minutes; then check their blood pressure and heart rate at one minute and again at three minutes.

If the patient has a drop in blood pressure of ≥ 20 mm Hg, has a drop in diastolic BP of ≥ 10 mm Hg, or is experiencing lightheadedness or dizziness, they have OH.

Understanding the Results

It is helpful to understand a few things related to the results of OH testing. First, most individuals with OH will experience a drop in blood pressure in the first minute of standing. Second, those who experience a continued drop in the second minute of standing tend to have an increased severity of OH.

Any drop in BP after three minutes is uncommon and can indicate vasovagal syncope, which is a sudden drop in BP and heart rate often associated with a stress trigger (e.g., heat exposure, sight of blood) or a mild or early form of sympathetic adrenergic dysfunction.



A recent study found that two-thirds of older adults with OH did not report typical symptoms of lightheadedness (Claffey, 2022). This study also found that symptoms did not correlate with the amount of blood pressure drop. These patients who have asymptomatic OH still commonly experience unexplained falls. Because of this, clinicians should evaluate OH in elderly patients who are having unexplained falls.

Treating OH

The recommendations for treating orthostatic hypotension include pharmacological and non-pharmacological options. Because many patients who have OH have concomitant hypertension when in the supine and seated positions, use of medications that increase blood pressure should be limited and must be used judiciously. Non-pharmacological approaches can be very effective in treating OH. The following clinical approach is recommended (Figueroa, 2010):

1. Address underlying conditions that can exacerbate OH, such as anemia.
2. Have the patient wear an abdominal binder and compression stockings when out of bed.
3. Make sure they are properly hydrated. Have the patient drink two 8-ounce glasses of cold water prior to standing. This will help increase blood volume and vasoconstriction at the same time. Additionally, salt and fluids can increase the blood volume, reducing the effects of OH.
4. Have the patient sleep with the head of the bed elevated 4 inches or about 30 degrees. This reduces supine hypertension and minimizes the severity of OH when getting up from the bed.
5. Teach counter maneuvers, such as isometric contractions of muscles below the waist, that can help to increase blood flow back to the heart and decrease OH. These could include toe raising, leg crossing and contraction, thigh muscle co-contraction, bending at the waist, slow marching in place, and leg elevation.
6. Prescribe medications such as midodrine or fludrocortisone, which can increase blood pressure levels. Droxidopa can be effective with patients who have neurogenic OH. These medications have to be dosed carefully and provided at the right times due to risk of increased supine hypertension.
7. Educate the patient on symptoms experienced prior to syncope.
8. Suggest lifestyle changes, including having the patient avoid hot showers, warm liquids prior to getting out of bed, heavy and high-carbohydrate meals, and alcohol. Exercising in a recumbent position or in a pool will help reduce the risk of falls with OH.

The management of orthostatic hypotension aims to alleviate symptoms, improve standing time and function, and minimize the risk of falls. Physical therapists can assist in this by utilizing a comprehensive approach that includes non-pharmacologic strategies, and appropriate medication selection can help optimize the management of this condition.

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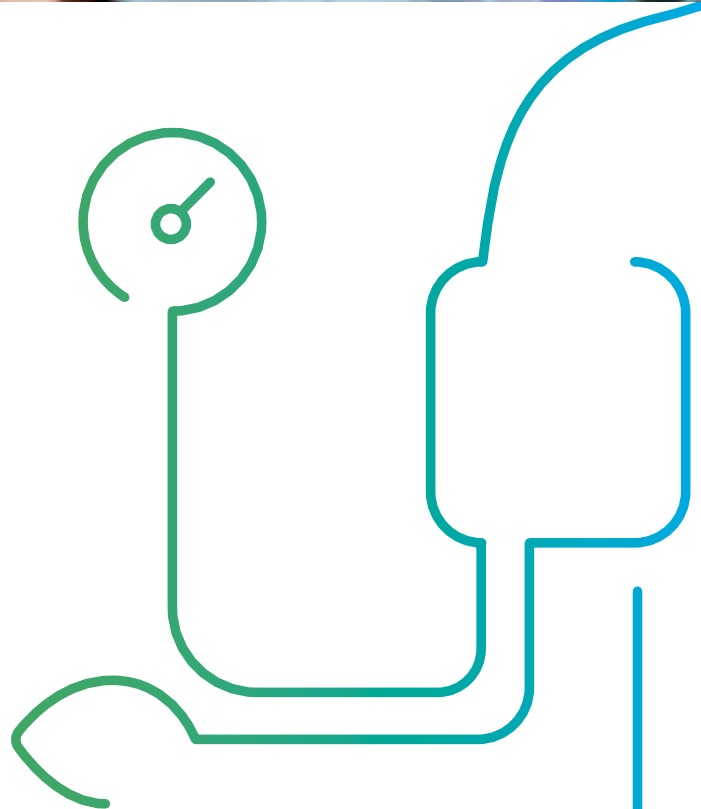


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ABOUT THE AUTHOR

Laura Ham has a master's degree in physical therapy from Florida International University. She has over 23 years of experience specializing in the treatment of spinal cord injury and seating and wheelchair prescription. She has worked predominantly in the acute rehabilitation setting and acute hospital setting with both adult and pediatric patients. Laura currently serves as the PT team leader at Encompass Health Rehabilitation Hospital and serves on the board of directors for the spinal cord injury support group of South Florida.



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25 Years of PT Residency Accreditation

By Jacqueline Conciatore

The American Board of Physical Therapy Residency and Fellowship Education celebrates its silver anniversary. Here's where ABPTRFE is now and where it's headed.



Until relatively recently, the land of physical therapy residencies in the United States was a desert, with virtually no accredited offerings for clinicians interested in advancing their expertise and careers. Today, that landscape is more like a rainforest, with over 400 accredited programs and others in the wings. For the past 25 years, APTA has supported and corralled that growth through policies tied to accreditation.

As the physical therapy field has evolved to meet society's health care needs, residencies have flourished, offering PTs a faster track to board



certification in specialty areas, a richer connection to the field, and the chance to gain advanced clinical and patient management skills and knowledge, as well as a heightened professional confidence at an earlier stage in their careers.

The American Board of Physical Therapy Residency and Fellowship Education, often shortened to ABPTRFE, describes the physical therapy residency as a post-professional planned learning experience comprising a curriculum that encompasses the essential knowledge, skills, and responsibilities of an advanced physical

therapist within a defined area of practice. ABPTRFE was created by APTA to set standards and serve as the accrediting agency of physical therapy residency and fellowship programs.

Clinical residency programs currently accredited by ABPTRFE include the areas of acute care, cardiovascular and pulmonary, clinical electrophysiology, geriatrics, neurology, oncology, orthopedics, pediatrics, sports, women's health, and wound management. ABPTRFE also accredits nonclinical physical therapist faculty residency programs.

ABPTRFE also accredits fellowship programs, similar to residencies only even more advanced and specialized. Currently, there are 48 accredited fellowship programs and 2,588 fellowship program graduates. A clinical fellowship candidate has either completed a residency program in a related specialty area or is an American Board of Physical Therapy Specialties board-certified specialist in a related area of specialty.

Residencies can be conducted in a variety of settings, including hospitals, outpatient clinics, rehabilitation centers, and skilled nursing and assisted living facilities. According to ABPTRFE, 95% of residencies in 2021 were full-time programs, almost half were sponsored by hospitals or health care systems, and about 90% provided a salary.

By design, physical therapy residencies — which must be at least 10 months long and average 13

months — blend didactic, clinical, and mentored training and experiences.

“They combine all three approaches, but the majority of hours are what ABPTRFE defines as patient-care practice hours,” says Kendra Harrington, APTA’s director of residency/fellowship education and accreditation. “Unlike in college and university, where students do a lot of the learning in the classroom environment, in clinical residencies and fellowships, they are really focused on the clinic.”

The curriculum for each specialty is defined and standardized by a document known as the specialty’s Description of Residency Practice, which, among other things, requires residents to rotate through different settings. A resident in a geriatric program might, for example, rotate from a skilled nursing facility to an acute care environment and then perhaps to outpatient or home care.



When it comes to what residents pay or get paid, the picture varies, which reflects the variety of program models that ABPTRFE accredits, says Jacqueline Osborne, chief experience officer at YouMeCare and past ABPTRFE chair. Some programs are supported by the parent organization, and their residents pay no tuition. Other programs charge tuition but pay a full salary. And still others charge tuition and pay a reduced salary or stipend. One contributor to the variation is that physical therapy residencies are not federally supported, as medical residences are. So institutions such as hospitals are reimbursed through various graduate medical education programs, including Medicare.

Early Days

The origins of residency training for PTs in the U.S. are hard to pin down. According to a 2016 perspective article written by Jennifer A. Furze, PT, DPT; Carol Jo Tichenor, PT, MA; Beth E. Fisher, PT, PhD, FAPTA; Gail M. Jensen, PT, PhD, FAPTA; and Mary Jane Rapport, PT, DPT, PhD, FAPTA, in *PTJ: Physical Therapy & Rehabilitation Journal* (then titled “Physical Therapy”), the “first foray into post-professional formal education” may have been in the 1960s, when PTs underwent interdisciplinary training in pediatrics via a government-funded training grants program. In the 1970s, PTs seeking to elevate their skills and knowledge had to find their own solutions — traveling the country and even the world to learn under recognized experts.

It wasn’t until 1979 that a physical therapy residency was developed in the United States — Kaiser Permanente’s program in advanced orthopedic manual therapy, based in Hayward, California. As more postgraduate programs were born, the American Academy of Orthopaedic Manual Physical Therapists developed standards and a “recognition process,” according to Furze and the other authors.

Fast-forward to the 1990s. APTA recognized the need for standardization and quality control and in 1997 appointed a dedicated committee to develop and oversee a

“Unlike in college and university, where students do a lot of the learning in the classroom environment, in clinical residencies and fellowships, they are really focused on the clinic.”

— Kendra Harrington

credentialing process for post-professional physical therapy clinical residencies. In 1999, the committee credentialed the first program, Kaiser Permanente’s in Los Angeles.

Over the years, there was continued evolution. The credentialing committee took on fellowship programs and eventually became the seven-member ABPTRFE. In 2014, “credentialing” was changed to an accreditation process aligned with best practices in residency and fellowship education. By 2019, ABPTRFE was 10 members strong and had accredited 288 residencies and 53 fellowships, representing more than 6,600 post-professional PT students.

The new spate of residencies helped solve a practical problem — the difficulty that some PTs faced accumulating the hours required to sit for the board-certification exams governed by the American Board of Physical Therapy Specialties.

“We needed to make it easier for people to get the hours,” says Gail Freidhoff, PT, a former Board member and long-time member of the on-site accreditation team. “Our profession was changing. When I graduated, you took a job where you could work with a variety of patients to get a good foundation, because the didactic and clinical portions of your education weren’t strong or as thorough as they are now.” The changes in entry-level physical therapy education and training have allowed residencies to flourish, she says.



Matt Briggs



Gail Freidhoff



Kendra Harrington



Chase Kuhn



Jacqueline Osborne

Essential Element

If there is a hallmark of residencies, it is mentors. “Mentoring is the foundation of residency and fellowship training — that’s really the reason to participate in it,” says Matt Briggs, PT, DPT, ATC, PhD, who is ABPTRFE’s chair, a researcher who studies the efficacy and impacts of physical therapy residencies and fellowships. Briggs was also Ohio’s first physical therapy resident, at the Ohio State University Wexner Medical Center.

A surprising number of people, he says, don’t understand what residencies are, believing them to be a clinical internship or a continuing education course. “It’s not that,” he clarifies. “It’s really about developing who you are as a professional, who you are as a person, learning how to think differently.”

On mentoring, Briggs says, “The mentors are role models and leaders. And so you’re learning how to become a leader through role modeling. You can learn knowledge and skills in a CE course — but how do you use that to make yourself better, and how do you think critically about that?” Briggs asks. “That’s really what that mentoring is about. It’s that kind of metacognitive, bigger picture perspective.”

Osborne remembers one resident in particular who demonstrated the kind of initiative and higher-level decision making Briggs seems to be describing. The patient was an 88-year-old woman with a UTI and altered mental state. But two weeks earlier she’d been playing tennis. Now in a skilled nursing facility, she said that she wanted to get back on the court. To meet that goal, the resident’s treatment plan included hallway jumps. “So, what was she doing in this skilled nursing facility, jumping, right?” Osborne asks. “But it’s what she needed. And so, he did it.” The resident later wrote a case report titled “Jumping into 88,” which outlined his decision making about why it was safe and a good idea for the woman to perform these exercises.

Intentional Process

The mindset fostered by residency programs and mentors is one of constant questioning, Osborne says. “Why are you doing what you’re doing? What is your patient trying to tell you? Whether that mentor is physically present or not, they’re in the mind, and I think that’s part of what develops that inherent stance of, ‘Alright, let’s do what needs to be done for this person.’”



“It’s really about developing who you are as a professional, who you are as a person, learning how to think differently.”

— Matt Briggs



APTA and ABPTRFE have worked hard to shape the mentoring aspect of the accredited residencies through standards and guidelines. “When we talk about mentoring in residency and fellowship education, it’s an intentional process,” APTA’s Harrington says. “It’s structured and formalized — there’s a lot of criteria” formulated to help build clinical-reasoning and patient-management skills.

Depending on the area of specialty practice, residency mentors are required to be board-certified clinicians or have at least three years of clinical experience in their specialization. These senior clinicians are required to track mentoring sessions and continually improve their mentoring skills, Osborne says. The process can include a site visit in which accreditation team members observe a mentoring session or two. “It is critical to ensure that the mentor is doing an exemplary job,” she says.

Chase Kuhn, PT, DPT, who completed about a year of a residency at OSU’s Wexner Center before taking a job as a health policy specialist at APTA, says his program featured periodic reflection and review meetings with mentors to discuss patient care.

As a new DPT he found this experience invaluable. “Initially, unless you have somebody watching over you, you’re really just kind of hoping you’re doing the right thing. And that was the piece that

was helpful in building my confidence as an early clinician. When I was on the right track, somebody would say so.”

Wexner’s program also required residents to do research. Kuhn worked on two studies related to one of his mentor’s areas of specialty: femoroacetabular impingement syndrome. They looked at whether level of activity was correlated to the experience of pain in people with this condition.

“Among patients with a very particular kind of hip pain, we were looking at how much activity they were getting on a daily basis,” Kuhn says. “We found out there’s not a massive correlation between the amount that somebody’s moving and the pain they were experiencing.”

PTs can use such knowledge to encourage patients to move more, knowing that moving more might not cause more pain but will provide the usual benefits of physical activity and exercise. As part of the residency, Kuhn presented the findings during poster sessions at the 2023 APTA Combined Sections Meeting.

Some residency programs also require the residents to teach. Kuhn taught in the first year, which he found valuable for several reasons. “We got the chance to learn, ‘Hey, do I want to be a professor at some point in my career?’ And we got to not only interact with faculty and experience the curriculum process, but also interact

Chase Kuhn, PT, DPT, (far right) met weekly with his mentors and fellow residents.



During his residency, Chase Kuhn, PT, DPT, (in blue) demonstrates the use of hand splints to first-year DPT students.

with the students themselves and be reminded about where we were three years ago, and how much we've learned since then."

Critical Feedback

Research has shown that physical therapists who pursue residencies are motivated by a desire to provide better patient care, prepare for specialty practice, shorten the time it takes to reach expert practice, and advance their careers. Kuhn's motives tracked with these and also included a desire to build confidence in one area he believed needed shoring up: orthopedics.

"I felt like there was a lot more that I had to learn to feel competent in that area," Kuhn says. "And I thought, what better way than to have an ongoing mentorship that's built in, where I can ask all the questions that I need to."

He especially wanted to help patients experiencing back pain. Arguably the spine is more complicated than, say, a knee or elbow, Kuhn

says, making it more difficult to pinpoint the source of pain. Assessing back problems often requires "a lot of trial and error and guesswork and forming those pattern recognitions that come with being in practice for many, many years that residents typically don't have," he says. "So, I really focused the first couple months on saying, 'You know what, when I get patients who come in with low back pain, I feel the least confident about this. Can you guide me through how to do a thorough assessment?'"

An unexpected benefit of his residency was a reality check. "There were three orthopedic residents in my cohort, and it was good to see where I fit on the knowledge-and-skill spectrum. It was great that we could bounce things off each other and not necessarily compete but test where we were in different aspects of clinical care. It was definitely a fast-track way to become more confident in my skills."



“Initially, ... you’re really just hoping you’re doing the right thing. And that was the piece that was helpful in building my confidence as an early clinician: When I was on the right track, somebody would say so.”

— Chase Kuhn

Soft Skills

Kuhn also valued the program’s incorporation of so-called soft skills. When he was erring or could have done something in a better way, that feedback was there. “They’d say, ‘Hey, the next time this comes up, why don’t you phrase it in this way?’ Or ‘Why don’t you dive a bit deeper into this aspect?’”

Training in soft skills such as effective communication is critical, Osborne says. She tells of one patient who was in a skilled nursing facility. It was the older woman’s third time in recent weeks, and the third time symptoms pointed to medication mismanagement.

“It was my resident who got to the bottom of what happened. The patient kept her medications in the refrigerator. And she had fractured her wrist, so she couldn’t open the refrigerator. So she didn’t take her medicine. We said, ‘Well, let’s change this; let’s figure out a way that you can pull the door open.’ That kind of stuff is important, taking the time to sit and talk and find out the root cause of something.”

Sometimes physical therapist practice can feel like throwing darts, Kuhn says. “It’s helpful to have a more experienced clinician say, ‘Yeah, we don’t really know what the exact problem is. But as long as we can get the person to the next stage in the healing process, that’s all you need.’ Those are the moments that really help when it is something that is a little muddier.”

This ability to acknowledge uncertainty is a hallmark of experience, Osborne says. “The thing that a resident does well — and sometimes it takes the whole entire residency experience to get there — is to be comfortable with not knowing,” she says. “To really be like, ‘Oh, my, I don’t know, but I know where to look. I have a network that I can tap into to find out, or I know the questions to ask to find the answer for you.’ That’s a more evolved approach to high-quality patient care.”

Research Findings

What research has been done on physical therapy residencies and their efficacy leans positive. A 2022 study in the *Journal of Physical Therapy Education* by Briggs and colleagues showed that residency-trained PTs had an overall higher job satisfaction score and higher career satisfaction

“The thing that a resident does well — and sometimes it takes the whole entire residency experience to get there — is to be comfortable with not knowing.”

— Jacqueline Osborne

than PTs who were not residency or fellowship trained. The study, “Factors Contributing to Physical Therapists’ Job and Career Satisfaction in the United States: Results From a National Survey,” is the largest such study to date, examining 3,080 survey responses.

Another study by Briggs looked at clinical competency and found that residency- and

fellowship-trained PTs had “elements of higher self-perceived clinical competency.”

“Most all the literature that’s out there examining outcomes of some form of residency and fellowship training is positive,” Briggs says.

Osborne’s residency program surveyed program graduates and consistently found that residents felt they’d progressed tremendously. “Routinely, they say, ‘I would be a completely different clinician today if I didn’t have the mentoring.’ There’s constantly someone there, asking why, helping that resident see another perspective, helping that individual not only hone their knowledge and clinical skills but also their patient management,” she says.

“The challenge for the field is how to quantify that value,” Osborne says. “But, anecdotally, every single resident would say they wouldn’t have traded it for anything.”

Kuhn concurs, saying, “My career might be very different had I not been exposed to the kind of broader world of physical therapy” through the residency.



“One of the fringe benefits of residency is that interconnectedness with the profession that I think a lot of my colleagues who graduate and go work in their hospital or facility might be missing,” Kuhn says. “They go to work, they do their job, they interact with their co-workers, and that’s kind of the extent of their connectedness to the profession. But with residency, I was connected by everyone else to the whole profession, which is why I think I’m where I am today.”

Career Impacts

After completing a residency, how do graduates fare? Researchers are still filling in that picture. One 2019 study by Briggs and colleagues (“Employer Perceptions of Physical Therapists’ Residency and Fellowship Training: Insights for Career Development Planning” in the *Journal of Physical Therapy Education*) showed that employers value residency- and fellowship-trained employees more than those who were not residency or fellowship trained.

Looking at earning potential, APTA’s recent state-of-the-profession wage analysis shows that completing a residency can boost wages, especially for early-career physical therapists. According to the report’s findings, board-certified specialists earn an estimated \$4,540 more per year on average across specialties. Those who complete residency training in a specialization eligible for board certification have higher first-time pass rates (94%) on the exam compared with those who didn’t complete a residency (77%). The exam pass rates were better in every specialty area. For example, 81% of sports residency first-time test-takers passed, compared with 60% of non-residency-trained. In orthopedics, the gap was 13% (91% versus 78%). And APTA found that there is also evidence that PTs who’ve done residencies take their certification exams earlier in their careers, Harrington says.

Freidhoff believes residencies have helped the profession better serve patients by evolving toward evidence-based practice. “I think that we have taken our profession to the next level. When I came out 40-plus years ago, there was no quality research to justify much of what we were doing. And a lot of what we did was intuitive, with no research behind it. Now there’s more research, and those who have gone through residency and fellowship programs have contributed to that research.

So, the benefit I see is that it’s starting to provide even more evidence regarding what the best plan of care is and what the best treatment options are.”

Up Ahead

There has been talk of making residencies a mandatory part of the pathway to a career in physical therapy. Briggs, Osborne, Freidhoff, and others agree this is the direction in which the field is headed.

“About 10 years ago, it was a radical idea,” Osborne says. “Where the debate used to be was along the lines of ‘Residency: yes or no?’ Now it’s probably more, ‘Yes, and how do we do it?’”

One significant challenge: There are financial barriers to residency training, including the student debt load. And then there is a much more practical matter. Currently, there aren’t enough accredited residencies to accommodate all therapists.

But ABPTRFE is accrediting programs at a pretty good clip. For example, by 2019, it had accredited 288 residencies, representing more than 6,600 graduates of those programs. Today, there are 401 accredited residency programs, representing 6,996 graduates since its inception.

To Kuhn and others, the growth in both interest in and number of residencies is a positive development.

“I think everyone should do a residency because it does expedite how quickly you become competent and confident,” Kuhn says. “And I want my colleagues to hold themselves to the standard that the residency held me to, because if I have colleagues who are practicing better, it’s going to make me practice better. And the winners at the end of the day are the people who we’re treating.” ■

Jacqueline Conciatore is a writer and editor living in Fairfax, Virginia.



To learn more about physical therapy residency and fellowship programs in the United States, go to abptrfe.apta.org or scan the QR code.

The Economic Value of Physical Therapy in the United States

By Chris Hayhurst

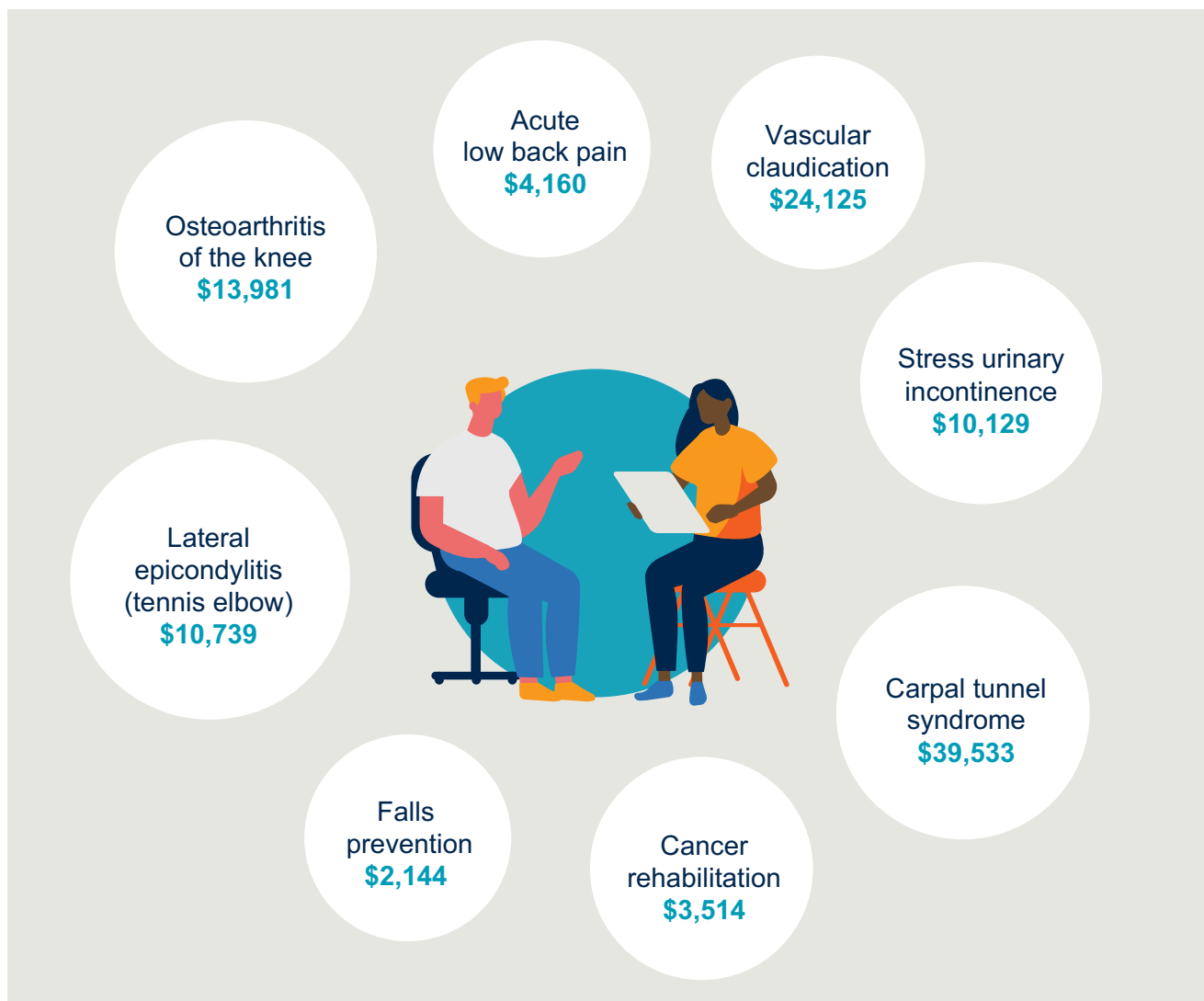
A new APTA report shows just how cost-effective physical therapy really is.

As senior director of operations for the Department of Rehabilitation Services at Bayhealth Medical Center, James Tompkins, PT, DPT, is often asked to assign a dollar value to the care his department provides. He does his best, which is to say he relies on his 30-plus years in the field to inform his calculations and arrive at a reasonable answer. Still, he notes, it's not an exact science — and for as long as he's practiced, it never has been.

“Some interventions have qualitative benefits that are challenging to quantify financially,” Tompkins says. “As a PT, I understand what we do, and I know how valuable our services are. But how do you monetize care? That can be a difficult question.”







The net benefit of choosing physical therapy for eight conditions analyzed.

Images and illustrations used in this story are available, for free, in our Co-Branding Portal at apta.org/marketingportal.

It's a question that's so difficult, in fact, that Tompkins was recently invited by APTA to help do something about it. A former co-chair of the APTA Acute Care Practice Committee, he was asked to participate in a work group dedicated to producing a report on the economic value of physical therapy.

About a year and a half after the project was conceived by the APTA Public Policy and Advocacy Committee, "The Economic Value of Physical Therapy in the United States" was released to APTA members in September. The report leverages economic modeling and analyses provided by a third-party consultant to spell out the costs and benefits of physical therapist services for eight different conditions.

Tompkins says his job involved reviewing sections on cancer rehabilitation, acute low back pain, osteoarthritis of the knee, and stress urinary incontinence. Other conditions covered in the report include falls prevention, vascular claudication, lateral epicondylitis — known as tennis elbow — and carpal tunnel syndrome.

A wider range of conditions initially was considered and then narrowed down to the eight in the report, based on specific economic evaluation

criteria applied to the currently available research evidence base. As stronger evidence becomes available, additional conditions may be considered for analysis and inclusion in the future versions of this report. “It’s just a total of eight conditions out of everything we see as physical therapists,” Tompkins says, “but I don’t think that matters at all. What is important is the fact that we now have numbers we can confidently point to that show the economic value of physical therapy. What we have isn’t comprehensive, but I think we’re off to a great start.”

A Tool for Physical Therapists

Plenty of other physical therapists are echoing Tompkins’ assessment. “The Economic Value of Physical Therapy in the United States” is just the beginning, a “dynamic resource that will evolve over time,” APTA President Roger Herr, PT, MPA, and CEO Justin Moore, PT, DPT, write in the foreword of the report.

Likewise, the report is a tool that therapists can use “to tell our story,” they say. Herr and Moore’s urgent recommendation: “Do not just read this report,” but “join us in sharing it and using it to its full potential to benefit the physical therapy profession and society for today and in the future.”

That’s also the take-home message from Justin Elliott, APTA vice president of government affairs. “I think that, for APTA, it will be critical for us to use this in our national advocacy efforts on Capitol Hill and with federal agencies,” Elliott says. At the state level, he hopes APTA chapters will use the report as they work to convince legislators to enact policies that expand access to physical therapy, improve payment, and decrease administrative burden. And at the local level, he pictures the report and corresponding resources supporting practices when communicating with commercial payers or state Medicaid programs.

Elliott also would like to see physical therapists and physical therapist assistants use the report to promote their services to consumers and other providers, and to share it with their patients so they can use it to advocate for themselves.

The report includes numbers that some readers may find surprising, Elliott says. The average net

benefit of physical therapist services per episode of care for tennis elbow amounts to \$10,739, for instance. For vascular claudication, it’s \$24,125, while for osteoarthritis of the knee the benefit totals \$13,981. Values were calculated using estimates of the average total cost of delivering care for each condition and the average total benefits that arise from that care.

“It is important to stress that this report reflects the estimated economic value of an average physical therapist intervention for an average patient for whom physical therapy is a plausible and safe treatment as compared to a commonly used alternative,” Elliott notes.

Elliott also points out that it’s important to know what the report is not. “This report is not a clinical practice guideline and the articles used do not

A Teaching Opportunity

Jason Falvey, PT, DPT, PhD, who served as co-chair on The Economic Value of Physical Therapy in the United States work group, says he plans to share the report with his DPT students at the University of Maryland School of Medicine.

“Obviously, the focus with students is on teaching them how to make good clinical decisions and developing the skills they’ll need to work with patients,” Falvey says, “but I think it’s also important to talk about advocacy.”

He says that his message will be to look at the report not as a set of clinical guidelines but as a body of economic evidence they can turn to when communicating physical therapy’s value to anyone outside of the profession.

And, more immediately, he says, he’ll tell them they should be proud of where the profession is headed, and to understand that “as physical therapists, we’re more than just range-of-motion and strength specialists; that we really can have an impact on the health care system and on our patients’ quality of life.”

necessarily reflect optimal clinical practice but instead represent a plausible average physical therapy episode.”

A Push for Value-Based Care

One PT who’s spent much of her career focused on the value of physical therapist interventions is Kate Minick, PT, DPT, PhD, director of research and quality in rehabilitation services at Intermountain Health. A board-certified clinical specialist in orthopaedic physical therapy and a member of APTA’s Scientific and Practice Affairs Committee, Minick joined Tompkins on the Economic Value of Physical Therapy in the United States work group as one of four appointed co-chairs.

When she was asked to participate in the project, Minick recalls, she immediately jumped at the opportunity. “It’s very much aligned with my background and my research, but also with where I believe we need to go as a profession in this changing health care environment.”

Health care has been moving — slowly but surely — away from the standard fee-for-service model to structures that pay providers based on the value of the care they deliver, Minick notes. “In fee-for-service, physical therapy is something that

is often seen as a cost or an extra expense that should be reduced, but in a value-based model, PT becomes a cost saver,” reducing downstream health care utilization and contributing to the value equation. “This report stakes a claim for where physical therapy belongs in a value-based environment,” she says.

In her work at Intermountain Health, Minick supports research within everything from physical, occupational, and speech therapy to orthopedic surgery, sports medicine, and podiatry. About half of the organization’s patients are in a value-based arrangement, she estimates. She was nominated to co-chair the report work group for her expertise on the literature around clinical trials and the efficacy of physical therapy.

“The way Nous approached this,” Minick says, referring to the consulting firm that conducted the economic analysis at the heart of the report, “it was a really robust methodology with many layers of review by highly qualified work group members.”

Furthermore, because the report was built on “a reproducible framework,” APTA, Nous, and even outside organizations “can come back to it if there are ever any questions or to evaluate other conditions,” she says.

**Story continues
on page 31 »**



Research confirms that choosing physical therapy for tennis elbow outperforms alternative options, including all the hidden costs of your time, pain, missed life events; and the dollar paid for services.

Research confirms that choosing physical therapy for

acute low back pain

outperforms usual care, including all the hidden costs of your time, pain, missed life events; and the dollars paid for services.



Key Takeaways

In producing “The Economic Value of Physical Therapy in the United States,” APTA’s goal is to increase access to therapist services proven to strengthen health outcomes for populations, communities, and individuals who PTs treat. The report features eight interventions that reflect a variety of patient demographics, stages of life, and the breadth of physical therapist practice.

As the report’s work group co-chair Janet Shelley, PT, DPT, chief disruption officer at Therapy Partner Solutions, explains, “There is plenty of evidence on the efficacy of physical therapy, and quite a bit of data that compares a single physical therapist intervention with another physical therapist intervention as we pursue best practices. This report differs in that it highlights the monetary savings to the health care system that physical therapy provides.”

While APTA is using the report to inform policymakers, payers, and employers about the significant role and economic value that physical therapy can bring to the health care system, members also can leverage its findings to:

- Educate patients and their families about the economic value of physical therapy.
- Advocate for improved coverage of and payment for physical therapist services.
- Improve interdisciplinary collaboration to increase referrals.

Also the chair of the Payment Policy Committee of APTA Private Practice, Shelley says the section intends to present the report to payers who have historically limited coverage of physical therapist services as a cost-containment strategy. The section also plans to share the report with self-insured employers and insurance brokers to show them how physical therapy can save their organizations money.

“We now have a scientific tool with a robust economic research basis that we can use to inform policymakers, health care providers, and the general public about the importance of physical therapy in reducing health care costs,” she says.



Research confirms that
choosing physical therapy for

osteoarthritis of the knee

outperforms steroid injections,
including all the hidden costs of your
time, pain, missed life events; and the
dollars paid for services.

The Work Group's Work

While the international consulting firm Nous led the modeling and statistical analyses that form the backbone of "The Economic Value of Physical Therapy in the United States," the interventions for the eight conditions included in the report were identified and reviewed by an internal APTA work group.

The work group comprised experts from APTA's various specialty academies and was led by four co-chairs from its Public Policy and Advocacy Committee and Scientific and Practice Affairs Committee. These members attended presentations by Nous representatives on the economic methods used in their calculations, and they were introduced to health care metrics such as a quality-adjusted life year, referred to as a QALY in the report, and equal value of life years gained, known as evLYG. They were not expected to become fluent in the math — just confident that the report's methodologies were sound.

As the project got underway, work group members were assigned chapters to read and critique based on their clinical and research expertise. They were asked to verify the economic assumptions made in the Nous models to ensure they were valid in the United States;

to ensure comparison interventions were plausible and accurately reflected contemporary practice; and to identify any problematic language or framing that might diminish the report's findings. In the end, work group members considered close to 30 different conditions before narrowing the scope of the report to the eight included in the final draft.

Jason Falvey, PT, DPT, PhD, assistant professor in the Department of Physical Therapy and Rehabilitation Science at the University of Maryland School of Medicine and work group co-chair, says the process of combing through the literature and relevant data and viewing physical therapy through a policy and economics lens was a "big challenge for all of us." Still, he adds, the work was well worth it, and now that it's done, he's happy with the results.

"I think the biggest thing that came out of this report is that physical therapy is cost-effective and has high value across a range of conditions," Falvey says. "Ultimately, I think we came up with a tool that can complement our clinical research when we talk to policymakers."

Economic Value of Physical Therapy in the United States Work Group

Co-Chairs

- Greg Bennett, PT, DSc, MS, Scientific and Practice Affairs Committee
- Jason Falvey, PT, DPT, PhD, Board-Certified Geriatric Clinical Specialist, Public Policy and Advocacy Committee
- Kate Minick, PT, DPT, PhD, Board-Certified Orthopaedic Clinical Specialist, Scientific and Practice Affairs Committee
- Janet Shelley, PT, DPT, Public Policy and Advocacy Committee
- Julie Fritz, PT, PhD, FAPTA, APTA Academy of Research
- Joseph Hannon, PT, DPT, PhD, American Academy of Sports Physical Therapy
- Ellen Hillegass, PT, EdD, FAPTA, Board-Certified Cardiovascular and Pulmonary Clinical Specialist, APTA Academy of Cardiovascular and Pulmonary Physical Therapy
- Tiffany Kendig, PT, DPT, MPH, APTA Oncology
- Trevor Lentz, PT, PhD, MPH, Academy of Orthopaedic Physical Therapy

Members

- Ryan Boggs, PT, DPT, DSc, APTA Academy of Clinical Electrophysiology & Wound Management
- Christine Cabelka, PT, PhD, MA, APTA Pelvic Health
- Rachel Prusynski, PT, DPT, PhD, Board-Certified Neurologic Clinical Specialist, APTA Geriatrics
- Erin Simunds, PT, MS, APTA Pediatrics
- James Tompkins, PT, DPT, APTA Acute Care

Minick says that much of the work she did in the report's production involved reviewing its sections on osteoarthritis of the knee and acute low back pain. For the economic analysis of each of the eight conditions, data from existing studies were identified and used to figure out the estimated net benefit per episode of care.

For example, with knee OA, Nous, Minick, and others in the APTA work group used a 2022 study published in JAMA Network Open, "Cost-Effectiveness of Physical Therapy vs. Intra-Articular Glucocorticoid Injection for Knee Osteoarthritis." The report notes that the study was chosen for "its relevance to the U.S. population, robustness of methodology, availability of details to support cost-benefit modeling, and recency of publication."

In other cases when recent data wasn't available, cost data from older studies was used but adjusted for inflation. For the analysis of acute low back pain, the report's authors turned to a 2017 study that was led by work group member Julie Fritz, PT, PhD, FAPTA, and published in Spine. The cost data used from that study was inflation-adjusted to reflect 2023 U.S. dollars.

Data the Profession Needs

The fact that the "The Economic Value of Physical Therapy in the United States" sticks to solid ground while paving the way for economic analyses of additional conditions in the future strikes Greg Bennett, PT, DSc, MS, as key to its strength. A clinician, educator, and executive leader with years of experience navigating payer relationships, Bennett says the report provides the profession with "exactly the kind of data we need."

Like Minick, Bennett is a member of APTA's Scientific and Practice Affairs Committee and was invited to participate as a work group co-chair. (The other two co-chairs — Jason Falvey, PT, DPT, PhD, and Janet Shelley, PT, DPT, — are members of the APTA Public Policy and Advocacy Committee; see the story on Page 30, "The Work Group's Work.")

And also like Minick, he gets frustrated by the tendency of payers to see physical therapy as a cost center. "Most of them don't consider the big picture, and that shortsightedness has led us to where we are now, where every year [Centers for Medicare & Medicaid Services] and Medicare wind up with budget cuts," he says.



Research confirms that choosing physical therapy for **carpal tunnel syndrome**

outperforms surgery, including all the hidden costs of your time, pain, missed life events; and the dollars paid for services.

That mentality “has to change,” Bennett adds, and he thinks the new report is going to help. “The one word that comes to mind is ‘validation.’ We all recognize that the cost of medical care is really high, and we want to provide high-quality care through the most cost-effective means possible. Here’s an answer: physical therapy. Across a fairly large spectrum of conditions, the total net savings are astounding.”

Bennett agrees with Justin Elliott that the challenge for the profession now is to spread the word about the report’s existence. “If it’s going to make a difference and lead to a change in mindset, there has to be tremendous outreach at the individual therapist level,” he says. “That’s the only way this eventually becomes a game changer and not just a flash in the pan.”

For his part, Tompkins says he plans to wield the report strategically in his role as Federal Affairs Liaison for APTA Acute Care. He also anticipates it will prove useful for any APTA section or academy that is collaborating with other health organizations, or with organizations that advocate for aging adults or other populations commonly seen for the eight conditions highlighted in the report. “I think it can be a catalyst to get these discussions going,” Tompkins says.

More immediately, Tompkins says he’s hopeful that his colleagues in acute care will share the report’s findings with their practice administrators. In his own case, he notes, he’d been “champing at the bit for months” to do so with several leaders in particular, including his organization’s vice president and its chief financial officer. He knew what the data showed, but he had to keep everything under wraps until the final report was published.

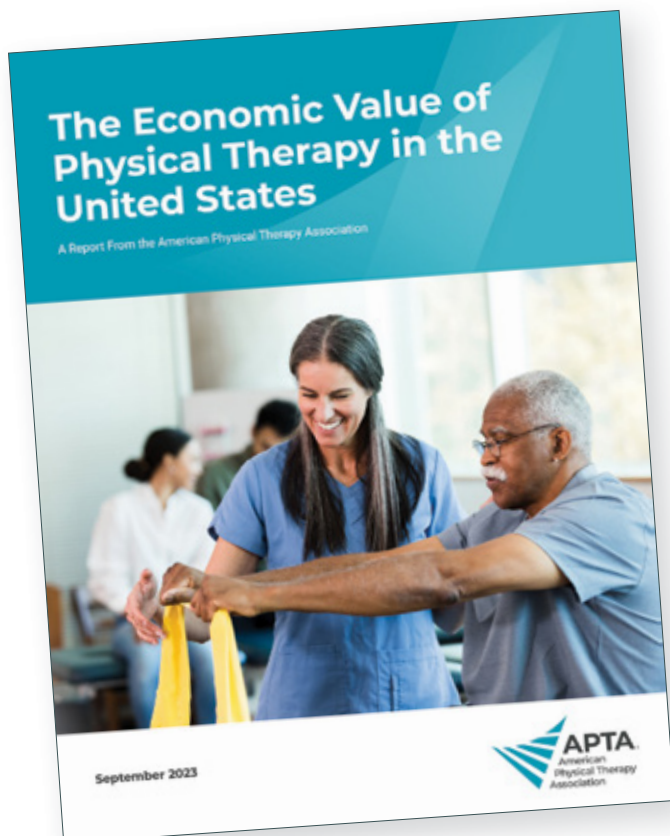
Now, of course, the report’s findings are public, and Tompkins can move ahead with his plans. “I’m excited about what’s next,” he says. “These conversations are going to be really interesting.” ■

Chris Hayhurst is a freelance writer and a frequent contributor to APTA Magazine.



To view “The Economic Value of Physical Therapy in the United States” online and see resources available to help promote this landmark report, go to ValueofPT.com or scan the QR code.

Spread the Word About the Value of Physical Therapy



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What's the Impact of AI on Physical Therapy?

How artificial intelligence can enhance physical therapist services — and when PTs should use caution.

By Keith Loria





Drew Contreras

Talk of artificial intelligence, commonly referred to as AI, has been running rampant in physical therapy circles recently, as many PTs envision how the technology will revolutionize the way physical therapists work and the care they can give.



Ryan Eder

Drew Contreras, PT, DPT, vice president of clinical integration and innovation for APTA, has seen a lot of companies try to use AI in various digital platforms to either help provide physical therapy or enhance the type of physical therapy they are delivering digitally.



C.J. Morrow

“In clinical applications, AI has been used to try and predict injury or predict what services would be better suited for individuals with certain presentations, and, more so today, people are starting to pay more attention to it,” he says. “AI has the unique ability to give us honest information about what we do well and what we don’t do really well.”



Carol Passarelli

For instance, some PTs are realizing they are underbilling for their services, thanks to using AI tools that assess documentation, so it’s helping the business side and helps clinicians better capture the value they bring.



Ryan Smith

“It should be value-added, not just another administrative tack on just because it’s available,” Contreras says.



Arvie C. Vitente

Ryan Eder, founder and CEO of IncludeHealth, has been working on digitizing physical therapy since 2018 and using AI since 2020, focusing initially on computer vision, which is when AI is used to derive information from images or videos, to extend care into the home. Most recently, in 2023, IncludeHealth was part

of tech company Vercel’s AI Accelerator program. Through this accelerator program, IncludeHealth input clinical practice guidelines into large language models — a deep learning model that is trained on vast datasets, such as ChatGPT or Google Bard. The end goal? To assist physical therapists in developing more comprehensive plans based on evidence-based research.

“I see AI as a tool to supercharge physical therapy,” Eder says. “To start, companies like Prediction Health are able to leverage AI to remove some of the pain of documentation that burdens the entire industry. This allows therapists to focus more on patient care, enhancing both the quality of treatment and the patient experience.”

Plus, with the appropriate datasets, AI can help the industry standardize best practices from all the evidence-based research and then become both predictive and prescriptive to optimize care pathways, he says.

“This combination has the potential to significantly impact the number of patients a PT can efficiently and effectively manage,” Eder says.

Ryan Smith, PT, DPT, is part of Pro-Activity, a Lebanon, New Jersey-based human achievement company that, in part, provides physical therapist services that incorporate digital monitoring. The company aims to be on the cutting-edge of technology, and he notes AI is on the forefront of everything.

“Honestly, I don’t know how important AI is right now for physical therapy; it’s this wave of technology that everyone

is trying to catch up on and understand what the possibilities are,” he says. “As of today, I don’t think it has enough applicability to be used broadly by the entire profession.”

Still, Smith sees a massive amount of demand and need for physical therapists to use AI for documentation purposes.

He believes it can smooth a lot of processes and lessen clinicians’ administrative time. “I know a lot of folks want to look at how this can affect patient care immediately, but it’s on the administrative side where it will probably make leaps and bounds to make our day-to-day life easier.”

Carol Passarelli, PT, DPT, leads operations and strategy at ViFive, an AI health tech company whose platform allows real-time movement capture with a camera and gives immediate range-of-motion and movement correction information.

She sees AI being used currently as a solution to the problems of inefficiency in the outpatient workflow.

“There are countless startups looking to improve the patient scheduling mechanisms, streamline the documentation flow, and optimize reimbursement,” she says — but with a caveat. “At the end of the day, though, AI is getting applied to an already archaic system. [Electronic Medical Records] are digital analogs to the clunky paper filing systems we used to use. AI might improve on the current logistics of patient/provider/payer interactions, but we ultimately will see AI reinventing how the larger health care delivery workflow will go.”

C.J. Morrow, PT, DPT, is the clinical quality manager at Hinge Health, a digital musculoskeletal clinic. She also is a co-lead representing digital health within the APTA Frontiers in Rehabilitation, Science, and Technology, or FiRST, Council. Morrow prefers to think of AI as “augmented intelligence,” because she views it as taking physical therapy to the next evolution of care, but not replacing physical therapists.

“We, as physical therapists, have been working with hand-held tools like a regular screwdriver, and the availability of AI is like someone handing you an electric drill now,” she says. “There are certain precautions we need to take, like making

sure we are wearing the figurative safety goggles, but it is going to make our jobs so much easier.”

How AI Can Help You

AI is already empowering physical therapists, according to Morrow, with predictive analytics being a top benefit.

“Predictive analytics is being used across the nation and has been integrated into some EMR systems, and this empowers us to use an evidence-based approach for each patient that comes through our doors,” she says. “For instance, utilizing this technology helped hospitals provide ventilators to the

patients who needed it the most and would get the most benefit from it during the supply shortage during the height of COVID.”

Hinge Health uses AI to provide its members with immediate analysis on their home exercises.

“Our AI-empowered computer vision technology can allow for real-time form feedback and movement strategies when a physical therapist is unable to be present, like when a member is completing their exercises at home,” Morrow says. “This leads to an empowered patient with greater confidence in their movement and their ability to move without a PT present. Ultimately, this leads to better patient self-efficacy

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and better outcomes, as movement becomes more consistent.”

Hinge Health is also currently evaluating AI-empowered documentation software, which can integrate with the video visit technology to analyze the unfiltered video, images, and spoken words during a digital health appointment, leading to AI-written chart notes in real time.

“In addition, it can draft a post-visit summary to send home with our patients, which can include the pertinent education discussed during the visit,” Morrow says. “This means a better patient experience since they have a clinician who is present with them, making eye contact with them, and listening to them with their full attention. In essence, it drives a more human experience.”

Arvie C. Vitente, PT, DPT, PhD, MPH, director of admissions and clinical associate professor of physical therapy at Graceland University in Albuquerque, New Mexico, says another way that AI has the potential to benefit the physical therapy profession is in the precision of diagnosis.

“AI algorithms can analyze patient data, including medical history, symptoms, and imaging results, to

assist physical therapists in making accurate diagnoses,” he says. “This can lead to more targeted treatment plans and improved patient outcomes.”

Additionally, Vitente notes, AI can help create personalized treatment plans based on individual patient data, such as range of motion, strength, and functional abilities. This can optimize therapy sessions by tailoring exercises and interventions to each patient’s specific needs.

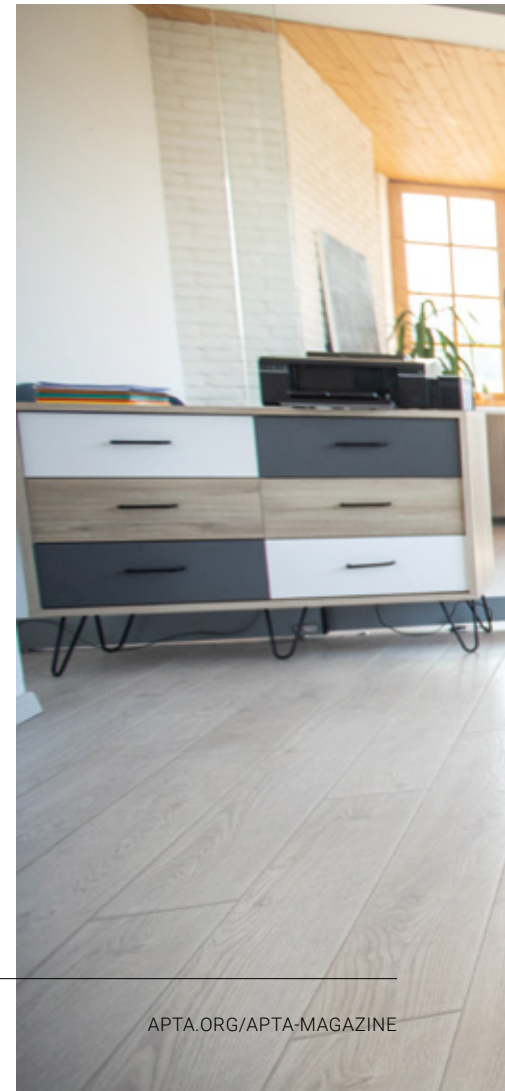
Then there are AI-powered wearable devices, which can track patients’ progress outside of therapy sessions, providing real-time data to their physical therapist. This enables remote monitoring of patients’ performance and adherence to treatment plans, allowing the therapist to make timely interventions and adjustments.

“Overall, AI has the potential to revolutionize the physical therapy profession by improving diagnostic accuracy, personalizing treatment plans, enabling remote monitoring, enhancing therapy experiences, and optimizing administrative processes,” Vitente says.

Considerations Before Adopting AI

On the flip side of all those benefits, PTs say, is that these technologies are now available to everyone, which can sometimes cause issues. Patients now also have access to AI and large language models, also known as LLMs, such as ChatGPT or Google Bard, and they are able to ask them any and all questions, including medical questions.

“Even though ChatGPT has passed the medical board licensing exam, I don’t think I would trust it with a medical question,” Morrow says. “These LLMs are trained on data that is unregulated and unknown. In addition, it is data that may be outdated, biased, or just plain wrong.



“AI has the potential to revolutionize the physical therapy profession by improving diagnostic accuracy, personalizing treatment plans, enabling remote monitoring, enhancing therapy experiences, and optimizing administrative processes.”

– Arvie C. Vitente

And LLMs do not have a commitment to 'do no harm' like PTs do."

That means patients may go to a PT and say that they asked ChatGPT about their knee pain and it told them to do a certain type of exercise that could cause more harm than good, leaving that PT to fight misinformation on a whole new level, and making their job harder.

So how should PTs go about using AI to complement, rather than detract, from their practice? Most AI experts agree that PTs shouldn't just jump headfirst into using it in their practices — at least not without doing their homework and some fact-checking before implementing these tools.

"There are some simple considerations and some more existential questions we should answer before diving in to using AI tools," Passarelli says. "On the simple side, PTs need to ensure that they apply the same clinical rigor and decision making to their treatments, even if they use ChatGPT to help generate diagnosis ideas or list out special tests to try. More so, if you want ChatGPT to write your SOAP note, make sure you're complying with HIPAA standards."

Legal and Liability Issues

Some of the biggest concerns with AI in the physical therapy profession are data privacy and transparency in how answers are generated,

which will be important to look at as the practice of using different types of AI increases in health care.

Eder notes that legal and liability issues are paramount when introducing AI into a medical context such as physical therapy.

"We must always remember that this is about practicing medicine, which has its own set of legal and ethical responsibilities," he says. "While AI can augment and supercharge the capabilities of a physical therapist, it is not a replacement for the specialized knowledge and human touch of a trained medical professional."

Eder says that AI can only be truly effective and ethical "if it operates



“While AI can augment and supercharge the capabilities of a physical therapist, it is not a replacement for the specialized knowledge and human touch of a trained medical professional.”

– Ryan Eder

under the supervision of a licensed physical therapist. This ensures that the technology serves as a tool for the clinician, rather than a substitute, thereby maintaining the highest standards of patient care and reducing liability risks,” he says.

Assessing the Available Tools

When using tools like AI, Morrow notes that PTs need to take on the role of editors and fact-checkers, as some of the data that these LLMs are trained on are over six months or a year old.

“When thinking about using AI tools, the first question I would ask is, ‘Can I trust the data that it is trained on?’ Each LLM is trained on an exceptional quantity of data, but if you are going to invest in AI, you need to understand where the data is coming from,” Morrow says. “Another question is, ‘How much data has the tool been trained on?’ The more data the better, generally, but the quality of the data is the most important part. Having visibility to this is important.”

One important thing to note: AI tools aren’t infallible. PTs need to ensure they are not receiving so-called hallucinations that will

wrongly inform treatment. In AI, a hallucination is when an LLM generates false information but presents it as fact.

“I don’t think this is a problem if every provider is operating under high integrity,” Passarelli says. “AI can assist in problem-solving and free up your treatment to do just that: treat the patient. When used judiciously, AI tools can and should be used safely.”

Another way to assess AI tools? Consider the source. Many AI startups are entering the health care space with a lack of understanding about the industry’s complexities and the critical nuances of care delivery. This can be risky because these inexperienced companies may offer AI models that haven’t been rigorously validated, leading to inaccurate or even dangerous recommendations.

“Therefore, it’s important for PTs to partner with organizations that have a deep understanding of the health care landscape, robust clinical validation, and a commitment



Resources for AI

In the rapidly developing world of AI, it's imperative to keep up-to-date with the latest guidance. Here are some recent guidelines and resources on the topic.

Health AI Partnership, Duke University School of Medicine.

Ethics and Governance of Artificial Intelligence for Health, WHO guidance. World Health Organization; 2021.

Artificial Intelligence: Compliance Considerations for Provider Organizations, Compliance Today. Health Care Compliance Association; 2023.

The AI Roadmap, Healthcare Communications Association position paper. Current Medical Research and Opinion, 2023.

Crigger, Reinbold, Hanson, et al. Trustworthy Augmented Intelligence in Health Care. Journal of Medical Systems, 2022.

Matheny, Thadaney Israni, Ahmed, et al, editors. Artificial Intelligence in Health Care: The Hope, the Hype, the Promise, the Peril, National Academy of Medicine special publication. National Academy of Sciences, 2022.

to ongoing improvement and accuracy," Eder says. "This ensures that the technology not only augments the care process but also adheres to the high standards of safety and efficacy that are imperative in health care."

He notes they should first look at a company's background to understand the origins of the company offering the AI tool, and ensure they are experienced in health care and have experts in physical therapy and AI on their team.

Another consideration Eder notes is how the AI was developed and whether the technology is based on sound scientific principles relevant to physical therapy.

"Has the tool undergone rigorous validation processes? Are there peer-reviewed studies or clinical trials that support its efficacy?" Eder notes. "Its recommendations are only as good as the data it was trained on. Ask about the data sources, and whether they are comprehensive and representative."

Finally, the tool should be easy to

integrate into existing workflows and should not add an extra layer of complexity that could become a barrier to patient care.

"By keeping these factors in mind, PTs can make a more informed decision about implementing AI tools in their practice," Eder says.

Enhancing Patient Care

While AI is already being used by PTs in administrative areas, the hope is that in the future, patient care can be improved by AI tools.

In some cases, that's already happening. Passarelli points to computer vision as an example.

"By having a patient perform movements in front of a camera, the PT now has a way to save time during the appointment — they don't have to use a goniometer — and they can recall that information automatically and retroactively, which could decrease documentation time," she says.

Another way that AI can enhance patient care is by leveraging the

technology to extend care into patients' homes, addressing one of the biggest barriers to physical therapy — access to care.

"AI allows us to extend high-quality PT services right into the homes of patients, dramatically improving access for those who may be geographically or physically restricted," says Eder. "Second, AI can enhance outcomes by leveraging both normative and individualized data, tailoring treatment plans to be more effective and efficient for each patient."

"The net result is a win-win scenario where both patients and health care providers benefit from more focused, data-driven, and accessible care," Eder says.

AI can also improve patient education and, ultimately, patient outcomes.

"What we've seen anecdotally is that showing patients the AI rendering of their movement can help them better understand asymmetries and compensatory strategies they are employing," Passarelli says. "By using that

"AI allows us to extend high-quality PT services right into the homes of patients, dramatically improving access for those who may be geographically or physically restricted."

— Ryan Eder

“To further push our profession toward the doctoring level that we’ve been slowly going toward, AI can serve as our technicians, our schedulers, and our compliance trackers so that we can spend more time being physical therapists and less time on the administrative tasks.”

– Carol Passarelli

biofeedback, patients might have improved motor control outcomes in potentially any environment, not just in the clinic.”

Morrow also sees AI as helping with patient empowerment.

“If we can get the right LLM out there, trained on trustworthy medical data, we can empower our patients with more information about any diagnosis that they may have been provided,” she says.

“This can help us to create a collaborative environment in which we partner with our patients to develop care plans.”

AI in the Future

The current landscape for physical therapy is challenging. But technology experts say that AI can help with this, whether it’s by assisting with documentation or increasing access for patients via digital health monitoring.

“AI has the potential to shift this landscape dramatically,” Eder says. “It offers a path toward a more sustainable, effective, and equitable model of care for both clinicians and patients.”

Contreras believes AI will open the doors for more precision care,

allowing PTs to be more specific in their diagnoses and to assess the needs of patients faster.

“It will allow PTs to increase the number of patients they can work with, because some of the lower-level decision points will be expedited,” he says.

One thing Morrow is truly excited about for the future is the potential for AI to create a digital twin of each of us.

“This would be a digital representation of us, from the genetic level to the organ and musculoskeletal level, to our behavior and lifestyle level,” she says. “It could be used for research or to predict treatment probabilities. We rarely think about how genetics might affect a patient’s response to certain exercises, but we could do that with an AI-empowered digital twin.”

There’s no question that in the years ahead, AI will have a larger

role in the physical therapy profession, but one thing is certain, AI will never replace the clinician.

“To further push our profession toward the doctoring level that we’ve been slowly going toward, AI can serve as our technicians, our schedulers, and our compliance trackers so that we can spend more time being physical therapists and less time on the administrative tasks,” Passarelli says.

“I also think that using AI can allow PTs to have more asynchronous touch points with their patients while quantitatively measuring their progress,” she adds. “This opens up a lot of opportunities for hybrid care.”

Morrow sees a day when PTs might find more job satisfaction by using AI tools.

“I can see us sitting with a patient during an evaluation and making eye contact for most of it instead of looking at our computer,” she says. “I can see more of a coordinated care team approach to treatment rather than specific single providers.”

One thing everyone interviewed for this story can agree on? AI is the kind of technology you either work to adopt early or get left behind, so PTs should start looking into it. The future is now. ■

Keith Loria is a frequent contributor to APTA Magazine.



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New CPT Codes Will Support the Critical Role of Caregivers

Beginning in 2024, PTs can bill for caregiver training.

By Alice Bell, PT, DPT, and Wanda Evans, PT, DPT, MHS



As of Jan. 1, 2024, physical therapists, physical therapist assistants, occupational therapists, speech-language pathologists, and other providers will be able to submit Current Procedural Terminology, or CPT, codes for an important part of care: providing training to caregivers of patients who have a functional deficit. The new codes, which apply to training while the patient is not present, are based on a collaborative submission by the American Physical Therapy Association, the American Occupational Therapy Association, and the American Speech-Language-Hearing Association.

The three organizations presented the code change application to the American Medical Association's CPT Editorial Panel in May 2022, and the panel in turn approved the application, accepting the codes for use beginning in 2024. The codes will be listed in the 97000 series section of the CPT code set (Physical Medicine and Rehabilitation) and can be applied to the provision of training caregivers in strategies and techniques for supporting patients living with functional deficits. (See "What's in a Code?" for more about CPT codes and the 97000 series.)

Here's what that means for you – and how you can go about billing for this important training.

New Caregiver Codes

Effective Jan. 1, 2024, three new CPT codes will be available to physical therapists and physical therapist assistants to report when providing care. These codes were developed to address the unique situation in which there is a need to provide caregiver education in the interest of an individual or a group of patients without the patient present.

The three new codes, and the official CPT descriptors, are:

97550: Caregiver training in strategies and techniques to facilitate the patient's functional performance in the home or



What's in a Code?

Current Procedural Terminology, or CPT, coding is the uniform language employed by PTs, physicians, and other qualified health care providers to report the services or procedures they provide to patients. The American Medical Association holds the copyright for CPT codes, and code definitions are created through a process of the AMA's CPT Editorial Panel. The panel includes representatives from several professional societies and associations, and APTA is an active participant, with Kathleen Picard, PT, DPT, as an advisor to the panel and Jonathan Morren, PT, as an alternate advisor.

Although some CPT codes are used more frequently by certain providers than by others, codes are not intended to be discipline- or specialty-specific. Still, in some circumstances a code's use may be limited to a specific type of health professional or setting. In those cases, guidance is included in the code description.

The 97000 series encompasses CPT codes ranging from 97010 to 97763. This grouping is categorized as Physical Medicine and Rehabilitation, or PMR.

Codes in this set cannot accurately be described as physical therapy codes, because they are not used exclusively by PTs and PTAs. AMA defines this code series as describing the work of a qualified health professional who is delivering skilled services during face-to-face time with the patient.

community (e.g., activities of daily living, instrumental ADLs, transfers, mobility, communication, swallowing, feeding, problem-solving, safety practices) without the patient present, face-to-face; initial 30 minutes.

97551: Caregiver training in strategies and techniques to facilitate the patient's functional performance in the home or community (e.g., activities of daily living, instrumental ADLs, transfers, mobility, communication, swallowing, feeding, problem-solving, safety practices) without the patient present, face-to-face; each additional 15 minutes. List separately in addition to code for primary service 97750.

97552: Group caregiver training in strategies and techniques to facilitate the patient's functional performance in the home or community (e.g., activities of daily living, instrumental ADLs, transfers, mobility, communication, swallowing, feeding, problem-solving, safety practices) without the patient present, face-to-face with multiple sets of caregivers.

Here are two examples of when these codes are appropriate:

97550-97551: A patient with cognitive impairment and impaired mobility with weight-bearing restrictions requires specific verbal and tactical cueing for successful and safe ambulation in the home and to adhere to the weight-bearing restriction. The therapist works with the patient while the caregiver observes. The caregiver expresses significant

anxiety related to providing the required level of assistance correctly and needs to practice the ambulation strategy before attempting it with the patient.

The patient is easily agitated when the therapist engages with the caregiver, so the therapist determines it is important to schedule a session with the caregiver without the patient present to instruct the caregiver in the necessary techniques, respond to the caregiver's questions, and allow the caregiver to perform return demonstration with the therapist before attempting the assistance with the patient.

The therapist spends 45 minutes with the caregiver performing training, evaluating return demonstration, and responding to the caregiver's questions and concerns. Following this session, the therapist engages with the patient and caregiver together to assess the caregiver's performance.

In this scenario, the therapist would bill one unit of 97550 and one unit of 97551, because they spent 45 minutes in caregiver training.

97552: Four patients being treated in a clinic require limited assistance for ambulation with the use of an assistive device including verbal and physical cueing. All four patients share a goal of performing limited-assistance ambulation within the home setting so they can safely meet functional needs that require accessing bedroom, bathroom, kitchen, and dining areas. All of the patients present with difficulties processing and

following multistep instructions and require the use of similar techniques for cueing and assistance.

The therapist determines that the caregivers representing these patients would benefit from peer support and peer-to-peer demonstration and feedback to acquire the skills they need. Caregivers for these four patients attend a group session for 45 minutes, during which the therapist provides training in safe management and positioning of the assistive device, delivering concise and one-step directive verbal cues, appropriate hand placement for physical assistance, and safety techniques for falls prevention.

In this scenario, the therapist would bill this service-based code four times — once for each patient whose caregiver(s) participated in the group intervention. This methodology is similar to the 97150-group intervention code currently in the therapy code set.

Some things to keep in mind as you use these new caregiver codes:

- This procedure will meet a very specialized need for a select group of patients and will generally not be the only means of caregiver training for any patient.
- The standard for provision of caregiver training is to do so with the patient present. Deviation from this standard as evidenced by reporting these new codes should occur only when needed, and documentation must support the reason for this deviation.

More Resources for Coding

APTA encourages PTs and PTAs to consult AMA CPT 2023 Professional Edition for a full listing of CPT codes, available from the American Medical Association at commerce.ama-assn.org/store/.

You also can find AMA CPT resources on their website at ama-assn.org/amaone/cpt-current-procedural-terminology.

APTA also offers resources about updates and changes in coding and billing:

Why Does This Code Pay This Amount? "APTA Magazine," September 2019.

CMS on Beneficiary Payment for Dry Needling. APTA Regulatory Update, Feb. 2, 2022.

Exploring and Expanding Your CPT Code Inventory, "APTA Magazine," March 2019.

New APTA Member Benefit Clarifies Use of Remote Therapeutic Monitoring Codes, APTA News, Jan. 10, 2022.

Remote Therapeutic Monitoring: APTA Updates, APTA News, March 13, 2023.

In Case You've Forgotten ...

Here are two other recent sets of codes that APTA helped to develop for PTs to use. Although covered in previous articles, it is noteworthy to mention CPT code changes from the past five years that have impacted physical therapist services.

CPT codes 20560 (Needle insertion(s) without injection(s), 1-2 muscles) and 20561 (Needle insertion(s) without injection(s), three or more muscles, which are used to report Dry Needling, were added in 2019.

CPT codes 98975, 98976, 98977, 98980, and 98981, which are used to report Remote Monitoring services, were added in 2022.

Additionally, clarification was provided in 2022 for CPT codes 97545 and 97546 used to describe work hardening and work conditioning.

Although 97545 and 97546 appear under the 97110-97546 heading of Therapeutic Procedures, these services do not require one-on-one therapist contact. These codes represent a program developed to address the person's strength, endurance, flexibility, motor control, and cardiopulmonary capacity related to performance of the work tasks that are identified through a job description or through communication with others involved in the person's health care and return-to-work management.

If a provider reports code 97545 or 97546 on the same date of service as the codes that describe other therapeutic procedures that also address parameters of strength, flexibility, endurance, range of motion, motor control, or return of function (97110, 97112, and 97530), the documentation must support these as direct-contact, separately identifiable services, and must clearly differentiate these services from services provided in a work hardening or work conditioning program.

- When provided by a physical therapist, this service will be reported as part of a physical therapist plan of care, identifying when a more intense interaction with the caregiver without the patient in attendance is necessary to ensure adequate skill acquisition by the caregiver.
- When providing training in the interest of a single patient, codes 97550 or 97551 should be reported based on time spent regardless of the number of caregivers present for the training.
- When providing training in the interest of more than one patient, code 97552 should be reported per patient represented, not per caregiver present.

- As with all care, this service must be provided with the consent of the patient or their legal representative, and the provider must adhere to HIPAA guidelines.

These new codes enable providers to report a valuable and key component of care for a select group of patients in a specific situation. APTA collaborated with AOTA and ASHA in the development, valuation, and CMS acceptance of these codes, and we encourage PTs and PTAs to use them when appropriate.



To read more about the evolving Medicare regulations, including coding changes, view the Medicare Coding and Bill webpage by scanning the QR code.

Payer Policy for Coding and Billing

While private insurers overwhelmingly adopt the CPT codes that Medicare uses to pay for services, payer policies around coding vary, and it's up to the provider to check each payer's policy. Something to keep in mind is that the absence of a specific code within a payer policy does not necessarily prohibit its use. If you believe a certain code closely represents the services being provided to the patient, consider collaborating with the payer to explore options for using the code even if it is not expressly named in the payer policy.

In addition, provision of physical therapist services must follow state practice acts. Should a procedure or service be expressly prohibited under the state practice act, it should not be reported for payment. As with payer policies, the provider is responsible for reviewing their state's practice act. The Federation of State Boards of Physical Therapy maintains a listing of each state's licensing board at fsbpt.org.

The list of CPT codes will continue to expand and change as the health care delivery system evolves and practice advances, and APTA will continue to be an active participant in the processes. PTs and PTAs need to familiarize themselves with updated and new codes to ensure that they are reporting the codes most closely representing services provided and, accordingly, to fully document provision of those services. ■

Health Care Headlines

We've compiled highlights of APTA articles for a recap of reports on the physical therapy profession.



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CDC: Nearly 7% of U.S. Adults Had or Have Long COVID, With Rates Varying by Demographics

Survey data from the U.S. Centers for Disease Control and Prevention show that Americans have experienced long COVID at an estimated rate of nearly 7%, with 3.4% reporting long COVID at the time of the survey interview, which was conducted in 2022.

But rates weren't equal across the board. Certain groups reported higher rates, including women (8.5%), adults ages 35-49 (8.9%), individuals of Hispanic origin (8.3%), and those living in nonmetropolitan areas (7.7%).

The numbers, collected by the CDC's National Center for Health Statistics, are based on responses from 27,651 community-dwelling adults who participated in the 2022 National Health Interview Survey, a nationally representative household survey. ("Long COVID in Adults: United States, 2022," CDC Data Brief)

For long COVID resources from APTA, go to apta.org/long-covid.

An Estimated 1 in 5 Adults 66+ in Outpatient Physical Therapy Have Cognitive Impairment

Among Medicare beneficiaries 66 and older receiving outpatient physical therapy, an estimated 20% have some level of cognitive impairment, with 5.1% experiencing dementia, according to results of a study that analyzed data from 730 community-dwelling Medicare fee-for-service beneficiaries.

The study revealed certain demographic characteristics — including being older, Black, lower educational levels, and more comorbidities — were associated with higher rates of cognitive impairment, as were patients who reported more difficulty walking and lower levels

of moderate-to-vigorous physical activity, or MVPA.

Overall, 20.3% of participants were identified with cognitive impairment — 15.2% with cognitive impairment-no dementia, or CIND, and 5.1% with dementia. The age- and demographic-adjusted rates for cognitive impairment relative to walking ability was 16.3% for participants who reported no difficulty walking, 20.8% for those who reported difficulty walking several blocks, 25.9% for those who reported difficulty walking one block, and 29.8% for those who reported difficulty walking across a room. Participants who

reported MVPA of one episode a week or less were associated with a cognitive impairment rate of 27.1% compared with a rate of 14.1% among those who reported MVPA of more than one time a week.

Authors of the analysis believe that the results point to the need for PTs to perform more cognitive screenings and tailor interventions in ways that could help slow cognitive impairment. ("The Prevalence of Cognitive Impairment Among Medicare Beneficiaries Who Use Outpatient Physical Therapy," PTJ: Physical Therapy & Rehabilitation Journal)

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Researchers: Home-Based PT Interventions After Hip Fracture Get Results

An analysis that compared two different physical therapist-led multicomponent home-based rehab programs with usual care post-hip fracture has revealed something not unexpected, albeit with a twist: Researchers found that both physical therapy-heavy programs resulted in better functional improvement compared with the standard Medicare-approved path with more limited physical therapy, but that the improvements were achieved via two very different approaches.

One approach, known as PUSH, focused on strength, balance, aerobic, and function training; the other, called PULSE, used seated active range-of-motion exercises and transcutaneous electrical nerve stimulation. Both are home-based, 16-week interventions overseen by a PT. Researchers compared these interventions with what they called “standard treatment reimbursed by Medicare that includes limited duration physical therapy rehabilitation immediately after hospital discharge ... on average for three to 12 weeks.”

At the one-year mark, participants in the PUSH program averaged a Short Physical Performance Battery score that was 1.3 points higher than usual-care participants; the PULSE group averaged a 1.6-point difference at one year compared with the usual-care group. Differences of one or more are considered substantial. The PUSH group outperformed the usual-care group in gait speed by a difference of 0.18 m/s after one year; the difference between the PULSE group and usual-care group after a year was 0.16 m/s. Differences of 0.1 or higher are considered significant.

Authors believe that the nearly identical levels of improvement associated with the programs could mean that the “highly structured and progressive” format of both approaches is a key element in their success. (“Multicomponent Home-based Physical Therapy Versus Usual Care for Recovery After Hip Fracture,” Archives of Physical Medicine and Rehabilitation)

Physical Therapy After Dizziness Diagnosis Lowers Fall Risk by 86%

A study of more than 800,000 U.S. adults who were diagnosed with symptomatic dizziness or a vestibular disorder highlights the idea that when it comes to the risk of later falls, physical therapy can significantly reduce risk. Researchers found that, overall, patients receiving physical therapy within the first three months after initial diagnosis were 86% less likely to experience a fall up to one year later compared with those who didn't receive physical therapy.

Researchers analyzed patient data from the OptumLabs Data Warehouse, which includes commercial insurance and Medicare Advantage claims, focusing on patients who received a diagnosis of dizziness and giddiness or a vestibular disorder between Jan. 1, 2006, and Dec. 31, 2015. The patients were then tracked for a year after the initial diagnosis to identify the prevalence of subsequent falls as determined by a fall identification algorithm based on injuries that resulted in a medical encounter. Falls data was then matched up with patients who did or did not receive physical therapy within three months after diagnosis.

Overall, 7% of patients experienced a fall that resulted in a medical encounter within 12 months of initial diagnosis. Patients who received physical therapist services within three months of initial diagnosis were 7.1 times less likely to fall during the three-to-12-month study period, compared with patients who received no PT services, resulting in an 86% reduction in risk. That lowered likelihood fell to 5.6 times between six and 12 months, and 4.3 times between nine and 12 months. Multiple comorbidities and being female were associated with greater risk of falls between three and 12 months after controlling for physical therapy. The overall risk of falls during that period was lower for Asian, Black, and Hispanic patients compared with white patients. ("Use of Physical Therapy and Subsequent Falls Among Patients With Dizziness in the U.S.," JAMA Otolaryngology-Head & Neck Surgery)



Study: Rates of Physical Therapy Are Low for Children With Autism Spectrum Disorder

Children with autism spectrum disorder, or ASD, can experience motor difficulties, but the use of physical therapy to address those difficulties often doesn't keep pace with the amount of occupational, speech-language, and other therapies used to address other issues, according to an analysis of more than 13,500 children with ASD.

The analysis was conducted on data gathered from the Simons Powering Autism Research Study, also known as the SPARK study, a nationwide investigation of ASD and treatment patterns conducted across 21 clinical sites. In addition to gathering data from various assessments, the study includes multiple caregiver questionnaires that solicit responses on types and level of treatment provided to a child with ASD, as well as information on condition severity and setting for receiving ASD services (in-school, private/community, or a combination).

Among the findings: Overall, 83.2% of children received occupational therapy, 67.8% received speech-language therapy, 47.1% received social skills intervention, 34.8% received physical therapy, and 14.7%

received recreational therapy. Children with higher developmental coordination disorder, indicating risk of motor impairment, received higher rates of all therapies compared with those whose scores indicated little or no MI risk; however, disparities between motor therapies continued. Those at risk of MI received occupational therapy at rate of 84.7% versus 72.1% for the no-risk cohort; rates of physical therapy were 37.1% for the at-risk group compared with 17.9% for the no-risk group.

"Without adequate motor services, the motor gap and challenges increase as the child ages and the child may not choose to play outdoors and risk the emotional stress and anxiety," said study author Anjana Bhat, PT, PhD. "This leads to motor dislike, inactivity, overweight, obesity, social isolation, poor physical and mental health, and eventually greater risk of chronic conditions such as cardiovascular disease, diabetes, and shortened life expectancy." ("Fewer Children With Autism Spectrum Disorder With Motor Challenges Receive Physical and Recreational Therapies Compared To Standard Therapies: A SPARK Data Set Analysis," Autism)

APTA Leading the Way

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



Find the full text of these stories and more at apta.org/news or scan the QR code.

APTA Sets a Forward-Looking Research Agenda

APTA is charting a course for physical therapy research aimed at helping the profession evolve. The newly released “Research Agenda for Physical Therapy From the American Physical Therapy Association” identifies research priorities critical to APTA initiatives and provides a framework on which APTA components and other rehabilitation-focused organizations can build their research priorities.

The agenda considers current issues, new innovations, and forward-thinking

viewpoints to identify what authors described as areas that are “key to the evolution of our profession.” Compiled based on feedback from key physical therapy stakeholders and researchers, the six key areas of focus are population health research, mechanistic research, clinical research, education and professional development research, health services research, and workforce research.

NIH Now Includes People With Disabilities Among Groups Experiencing Health Disparities

APTA's participation in a coalition pressing for a greater focus on disability and rehabilitation research has helped fuel a significant change at the National Institutes of Health: People with disabilities now have that official designation as a population with health disparities. The change will open the door for research on how disability intersects with inequitable health outcomes, particularly among people with disabilities who are also part of populations that experience disparities due to racial, ethnic, socioeconomic, or geographic factors.

Along with the announcement of the change, NIH also issued a notice of funding opportunity "calling for research on novel and innovative approaches and interventions that address the intersecting impact of disability, race and ethnicity, and socioeconomic status on health care access and outcomes."

APTA is a member of the Disability & Rehabilitation Research Coalition that helped to drive the change.



Physical Therapy's Voice in Key Quality Measurement and Coding Groups Grows

As the U.S. health care system intensifies its focus on quality measures to inform key policy decisions, the physical therapy profession is increasingly finding itself at the table for important discussions on issues including which measures to use, which could be dropped, and how measures will be adopted and monitored.

Several APTA members will now be contributing to those discussions. Marissa Carvalho, PT, DPT; Ronald Langham Jr., PT, MBA; Lori Pearlmuter, PT, MPH; and APTA Senior Advisor for Scientific Affairs Anita Bemis-Dougherty, PT, DPT, MAS, have been appointed to the Battelle Partnership for

Quality Measurement's Pre-Rulemaking Measure Review Committees, which provide recommendations to the U.S. Department of Health and Human Services on the selection of quality and efficiency measures under consideration for use by the department, including within the Centers for Medicare & Medicaid Services' Quality Payment Program.

Langham also will serve on the Measure Set Review Committee, which is responsible for making recommendations on the removal of measures from the Medicare quality program. APTA Senior Payment Specialist Alice Bell, PT, DPT,

will serve on the Cost and Efficiency Committee, which focuses on the endorsement and maintenance of quality performance measures.

And in more good news for the profession: APTA member Kathleen Picard, PT, DPT, has been appointed to the nominating committee for the American Medical Association's Health Care Professionals Advisory Committee, known as HCPAC. Her new role identifies potential candidates for the HCPAC Editorial Panel, the group that plays a key role in the development and maintenance of current procedural terminology codes.

APTA Member Value

APTA members now have access to an online resource that helps PTs identify evidence-supported apps that meet rigorous standards.



To read more about the APTA Digital Health App Formulary, powered by ORCHA, visit apta.org/digital-health-app or scan the QR code.

Looking for the Best Health Apps? APTA Member Benefit Points the Way

PTs are no strangers to digital health apps — and with more than 50% of the U.S. population describing themselves as users of those apps, there's a good chance the same can be said for their patients and clients. But with the number of apps (and the level of hype) increasing every day, how do you know which apps are right for your practice and the people you serve? If you're an APTA member, now there's an answer.

The APTA Digital Health App Formulary, powered by ORCHA, is a recently launched free member benefit that helps take the uncertainty out of finding the right app for the right need.

At its most basic, it's a screening resource that offers up information on apps that have met

high standards for safety and effectiveness. But the formulary's usefulness goes beyond a basic list of approved apps — its user interface allows you to search based on a range of conditions, patient populations, and body areas.

You can even track and curate the apps you use or recommend to get a better sense of what works for you and your patients over time. The resource also offers filters for apps that can be used in conjunction with remote therapeutic monitoring, something PTs were empowered to bill for under Medicare beginning in 2022.

The formulary is the result of a collaboration between APTA and the Organization for the Review of Health and Care Apps, aka ORCHA, which has been assessing digital health technologies since 2015. ORCHA applies high assessment standards to the apps it reviews and worked with physical therapy subject matter

experts to incorporate the specific needs of the profession in its screening process. The result: a collection of digital health apps that providers can trust.

Here's how it works: After setting up an account, begin your search by condition, type of app, affected body area, or any of a number of parameters. Once you select an app review, you'll receive information on what condition the app addresses as well as the cost of the download and whether the app includes in-app purchases.

Even more important, each app in the formulary is accompanied by a Digital Health Assessment Framework score

based on a review of 400 criteria across three domains: clinical assurance and safety, data and privacy, and usability and accessibility. To further enrich your understanding of each app, the formulary provides a rating, known as the app's Evidence Standards Framework Level, that correlates the app's target area and associated level of risk with its evidence base — the more specific the condition targeted and the higher the risk, the more evidence is required to meet formulary standards.

The new resource is part of a larger effort by APTA to ensure that the physical therapy profession plays a

significant role in the evolution of digital health. In addition to the formulary, APTA is helping to shape the concept of what it means to be a digitally enabled physical therapist and has established a digital health transparency campaign that urges digital health providers to commit to restricting any offerings described as physical therapy to only those performed or directed by a licensed physical therapist. To date, 29 companies have signed the pledge.

APTA offers an overview and tutorial on using the formulary available for free at the APTA Learning Center.

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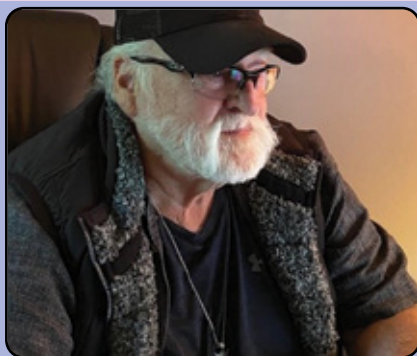
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Taking a teaching job on a lark proved to be the perfect fit for this physical therapist.

Opening a New Door

My physical therapy career started out like many others, but, over the years, it has evolved in ways I could have never imagined. If you are willing to go through doors when they open and take risks, you can create a career that matches your interests and passions.

I have been an athlete for as long as I can remember and ended up encountering physical therapy for the first time after having knee surgery in high school. Prior to having that injury, I always thought about movement and exercise from a performance standpoint.

I would spend hours reading magazines like “Muscle & Fitness” and “nerding” out over how the body could adapt with proper training. But after going through physical therapy myself, I learned that exercise could be used not only to improve performance but also to rehabilitate the body.

This new knowledge of physical therapy and my previous passion for exercise and performance led me to pursue exercise science and physical therapy during my university years. I became obsessed with learning about these topics and couldn’t wait to become a physical therapist.

Then I began practicing as a physical therapist and almost instantly felt unfulfilled. Clinical practice was much less stimulating in comparison with learning and discussing topics in the classroom. Although the initial evaluation could be fun, especially when I had a patient who was interested in learning,



Tom Walters, PT, DPT, is a board-certified clinical specialist in orthopaedic physical therapy and a certified strength and conditioning specialist based in Santa Barbara, California. In addition to his clinical practice, he runs one of the world's largest social media accounts dedicated to physical rehabilitation (@rehabscience on Instagram and YouTube).





Tom Walters, PT, DPT, (in polo shirt) working with students during a lab on how to perform spinal muscle endurance tests.



To hear this Defining Moment column in the author's own words and voice, check out our APTA podcasts at apta.org/podcasts or by scanning the QR code.

Defining Moment spotlights a particular moment, incident, or case that either led the writer to a career in physical therapy or confirmed why they chose to become a physical therapist or physical therapist assistant.



In his clinical practice, Tom Walters, PT, DPT, enjoyed using technology to help patients understand how movement impacted their pain. Here, he shares information with a patient taken from a force-plate-instrumented treadmill.

follow-up sessions were short, I was seeing 15 patients each day, and I was bogged down with paperwork. Not ideal!

While I was struggling with this internal conflict, a unique opportunity presented

I had always loved the energy associated with being on a college campus, and my gut told me that this was an opportunity I needed to pursue.

itself. The owner of my clinic, who taught as an adjunct professor at a local college, was leaving town for a year and asked if someone would be interested in taking over his course load at the school.

I had always loved the energy associated with being on a college campus, and my gut told me that this was an opportunity I needed to pursue. After a few minutes of quick thinking, I decided to take on this challenge, despite having no formal teaching experience. My physical therapy colleagues told me I was crazy for agreeing to teach biomechanics and human physiology courses. Those topics definitely weren't my specialty areas.

While I had a great deal of anxiety leading up to my first days teaching undergraduate kinesiology students, I was also very excited to

be back in the classroom. I left my first lecture feeling reinvigorated and high on life. The students were excited to learn from a clinical practitioner, as it allowed them to see more theoretical concepts in action and they usually stayed after class to talk about the day's topics in more depth. I loved teaching about human movement and helping my students understand complex topics. Teaching in the classroom made me realize that education was my true passion, which was why I had always enjoyed the initial evaluation process in the clinical setting.

One year of teaching turned into eight years and solidified my hypothesis that education was the best route for me. Because of this realization, I

ended up pursuing a doctor of science degree in rehabilitation science at Texas Tech University, which would give me an academic doctorate and allow me to apply for a tenure-track teaching position. Ultimately, taking the risk to try teaching and my return to academia as a teacher made me realize that I love the study of human movement and rehabilitation more than the clinical practice of it.

Learning this about myself led me also to begin teaching online. In 2017, while still working as a full-time kinesiology professor, I started an Instagram account dedicated to physical rehabilitation. My goal was to answer common clinical questions, teach people about their

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During a medical mission trip, Tom Walters, PT, DPT, (in black) taught students about musculoskeletal conditions and rehabilitation interventions.



bodies, and explain how exercise and movement could be used to help heal pain and injuries.

Six years later, my account (@rehabscience) has more than 1 million followers on Instagram and 500,000 subscribers on YouTube and helps people all around the world better understand pain and

injury rehabilitation. Running these accounts has allowed me to continue to work full time as an educator, albeit not in the traditional classroom setting. I love this new teaching environment because the internet and social media platforms allow me to positively impact considerably more people than I was able to reach when seeing patients or teaching at the college.

While I do still see some patients these days, I primarily filter career opportunities by whether they focus on education. But this evolution only occurred because I was willing to take a leap of faith and step outside my comfort zone to try something different.

I hope my story encourages other clinicians who might be feeling burned-out to try something new and innovative. As we all know, the current model of practice for physical therapy is often not ideal, but I believe you can shape your career into something you enjoy if you are willing to think creatively and have the courage to take a risk when an open door presents itself. ■

I believe you can shape your career into something you enjoy if you are willing to think creatively and have the courage to take a risk when an open door presents itself.



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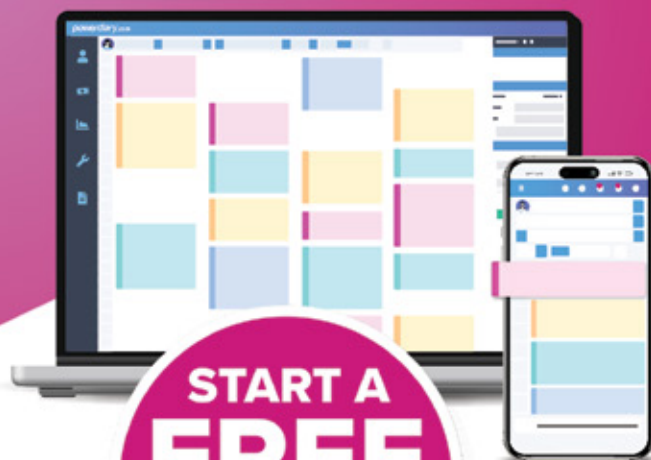
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