



Responding TO THE National Health Emergency

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-Isaac Newton



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The Profession Responds to a National Health Emergency

Members of the profession provided accounts of their varied experiences as the COVID-19 health crisis developed.

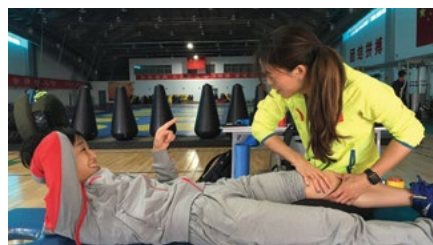
On the cover: Lauren Haegele, PT, DPT, in her PPE, with New York City in the background.



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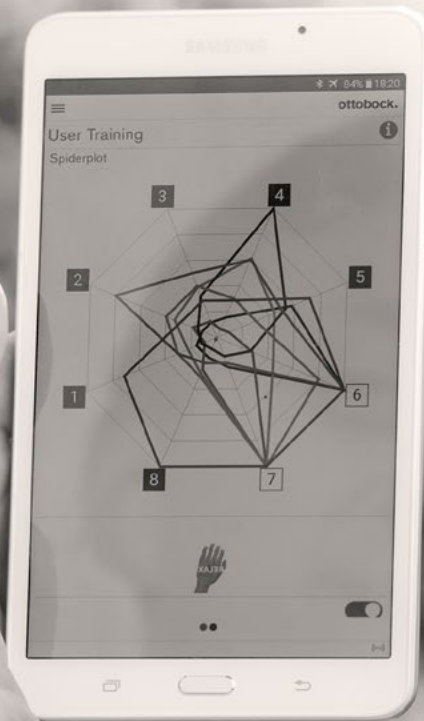
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“These athletes have an incredible work ethic, beautiful competitive drive, and a deep love for their sport ... Maybe it’s idealistic and fairytale-esque, but I love to help them work toward making their dreams a reality.”

Laurey Lou, PT, DPT,
in “Aiding the
Olympic Dream”
on page 42.



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THANKS TO PARTICIPANTS IN THE 2019-2020 VCU-MARQUETTE CHALLENGE

Due to the COVID-19 crisis, the Foundation for Physical Therapy Research suspended this year's Marquette Challenge. All donations received for the 2019-2020 VCU-Marquette Challenge will be added toward school totals for the 2020-2021 VCU-Marquette Challenge. Since 1989, students have raised more than \$4 million for research. For more information visit MarquetteChallenge.com.

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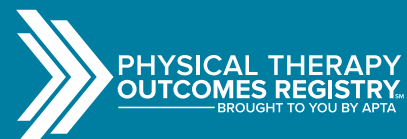


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Opinion

Why Telehealth Is the New Normal for Rehab Therapists

COVID-19 has taught PTs many lessons over the past several months. One of the most important is that telehealth is here to stay. It is convenient and meets people's needs where they are. It is our new normal.

That doesn't mean that all PTs are fully embracing telehealth or fully understand how to maximize its potential for their practices. As someone who has been conducting telehealth visits in my outpatient clinic for nearly 10 years, I recently was asked to present a webinar on the role of telehealth for PTs now and in a post-COVID-19 marketplace.

The range of questions highlighted that there remains a great deal of confusion and uncertainty about what telehealth can and can't do, and how to work it effectively and efficiently into our practices. Here are a few tips about telehealth for peers who are still struggling to adapt.

- Show how telehealth can facilitate high-quality care. Most PTs are trained to provide hands-on care. Many are concerned that the level of care they are comfortable delivering can't be attained through a telehealth visit. The good news is we now have several peer-reviewed articles that provide data highlighting that telehealth can provide outcomes equal to, or in some instances better than, those from a traditional office visit — especially for knee, lower back, and similar musculoskeletal injuries. These include articles that were published in the September 2017 issue of *Spine Journal*, the June 2019 edition of *Physiotherapy*, the April 2020 issue of *Journal of Shoulder and Elbow Surgery*, and the March 2019 issue of *Federal Practitioner*.
- Get creative. While telehealth is a great way to provide care, there are things you can and can't do over a video screen. However, there are still ways to obtain clinical insights on issues such as pain, mobility, and

functionality. For example, to see if patients have needed strength for ADLs, have them lift a gallon of milk — which weighs slightly more than 8 pounds. Use your imagination to find resources around the home that will help you assess and treat your patients.

- Talk to your payers. One of the most complicated parts of telehealth is billing. Ask the insurers you work with what modifiers they want you to use. Educate your staff to know payer preferences. APTA has excellent online resources on this topic. Search APTA.org for "Telehealth Billing and Coding."
- Think about convenience. Imagine your 80-year-old grandmother needing physical therapy via telehealth. What would she need to make the process easy for her? One important feature is a simple, reliable, one-click connection. That starts with having the right telehealth platform. There are several that include a HIPAA-compliant patient portal. As a reminder, always ensure that you secure appropriate permissions before starting a telehealth visit.

Of course, there's much more to an effective telehealth program than these tips, starting with the complex and always-changing world of what states will allow, what insurers will cover, and what CMS will permit regarding Medicare. The key takeaway is that we need to find ways to embrace telehealth and help our patients get comfortable with the technology and the "new normal" that is here to stay.

DAVID GRIGSBY, PT, MPT
 CO-OWNER OF TENNESSEE-BASED MIDSOUTH
 ORTHOPAEDIC REHAB

Forum



/ JUNE 2020

Defining Moment: Vulnerability and Courage

Thank you for this thoughtful essay. I am the director of rehab at a rural critical-access hospital. I have echoed all of your reasoning in speaking with patients, staff, and our administration. I think this is a defining moment for our profession. We are essential, no more so than at this time. Keeping people healthy and mobile and out of emergency departments and express clinics is an important part of what we do.

I, too, respect those who have chosen to close — particularly hospital clinics where the multitude of skills that we have as critical and big-picture thinkers can be utilized in all other areas of our facilities — but my choice was to continue to serve in this setting. I have been preparing my staff for the possibility of functioning as inpatient therapists or even as a second pair of hands in that setting, knowing that we may be called at some point closer to the front lines.

MITZI HAZARD, PT, DPT

/ APRIL 2020

Ethics in Practice: Cost Analysis

I faced the same ethical decision, but I did speak up right away. The home care agency I worked for was trying to implement a new utilization review system. Its goal was to generate more revenue by placing patients on the fast track for discharge, thus enabling professionals to work with more patients. The first day that it went live was the day I quit.

The new system procedure was that the opening nurse would do an assessment, then call into the quality control office and determine the visit frequency for each discipline. The next day I went to perform my assessment of the same patient. Per the system, I called into the same quality control office and discussed my findings. Using my professional judgment, I determined that the patient needed my services twice a week for six weeks — only to be told that the nurse specified three times a week for three weeks.

I said that my assessment and documentation would not support the high frequency. Further, the patient did not agree with a frequency of three times a week. I was told that I couldn't change what the nurse had determined the day before. I said okay, hung up the phone, told the patient I would work it out, and left the home.

I immediately called my supervisor. She asked me to come into the office to discuss my concerns with her and other management personnel. By the end of the meeting, my professional judgment was not enough for them to make any changes. I also

was concerned for my professional license — that I might be committing fraud if I continued to work there. If the Department of Health or Medicare ever performed an audit, my license could be revoked, as my documentation did not support or concur with the nurse's assessment 24 hours earlier. That's the reason I quit that day.

PEG GARLAND, PT

In the scenario, Ellen, a school-based PT, and Tom, a school administrator, have differing views of where a preschool student with a disability should be educated. Ellen believes the student is not ready to be placed in the general education setting and proposes during a meeting with Tom to place the student in a "specialized school." Tom does not consider this an option, citing the financial cost to the school district. The ethical problem is described as organizational, pitting finances against the student's needs as determined by the PT.

I believe the ethical issue in the scenario does not lie in a conflict between the school's resources and the PT's professional judgment. There are two major issues. The first is the ethical obligation of PTs to advocate for the rights of students with disabilities to be fully included with students without disabilities in school. That also is a legal mandate of the Individuals with Disabilities Education Act, or IDEA.

The second issue is a lack of adherence to the legal requirement under IDEA to hold team meetings with parents or caregivers when determining educational services and

»



placement. Ellen does not appear to recognize the student's right to an inclusive education and nor the legal implications of her meeting with Tom. As stated by the U.S. Department of Education, IDEA is intended to guarantee access to public education for children with disabilities. IDEA mandates the inclusion of students with disabilities in educational activities with students without disabilities. DOE's Office of Special Education and Rehabilitative Services states, "Placement decisions must be made according to IDEA's least restrictive environment requirements — commonly known as LRE. These requirements state that, to the maximum extent appropriate, children with disabili-

ties must be educated with children who do not have disabilities."

LRE corresponds closely to the concept of societal inclusion for people with disabilities. APTA — in online postings on the educator's role in teaching cultural competence — holds that disability is a form of diversity and that PTs must practice in a culturally competent manner. School-based PTs should advocate for the inclusion for students with disabilities in school settings in accordance with Principle 1A of APTA's Code of Ethics for the Physical Therapist. Similar language appears in APTA's Standards of Ethical Conduct for the Physical Therapist Assistant.

Students with disabilities do not have to earn their right to be educated with students without disabilities by demonstrating a prescribed level of functional competency. This right is guaranteed and protected by IDEA. The role of school-based PTs as part of an education team is to find solutions for access and promote equitable participation in the educational environment. School-based PTs share their discipline-specific knowledge with the education team working with students with disabilities, and help build capacity within teams to more effectively serve these students in the LRE.

There is another infraction of IDEA in the scenario. IDEA mandates a team process to make decisions about educational services for students with disabilities. Required team members include parents. Principle 2D of the APTA Code of Ethics for the Physical Therapist also sets the expectation of working collaboratively with families, as does Principle 2C of the APTA Standards of Ethical Conduct for the Physical Therapist Assistant. Conversations about educational services for students with disabilities, including placement, must occur within a team meeting, and the input of all team members must be considered. For those reasons, Ellen and Tom cannot unilaterally determine educational placement prior to a meeting.

The best practice, APTA's Academy of Pediatric Physical Therapy asserts, is for the entire education team to discuss the student's strengths, needs, educational goals, curricular modifications, necessary accommodations, and services required to support the student before educational placement is determined. Services in the general education classroom in a neighborhood school are the de facto starting point for the conversation about placement. Severity of disability (one of Ellen's reasons for her decision) and monetary resources (as Tom used to justify his decision) are prohibited from consideration in educational placement decisions.

Ellen may need to consider any potential implicit bias toward students with significant functional limitations. She also could reflect upon what participation in school may look like for these students and how she can facilitate effective inclusive educational practices as a school-based PT.

MICHELE WILEY, PT, DPT, DHSC
BOARD-CERTIFIED PEDIATRIC CLINICAL SPECIALIST,
ASSISTANT PROFESSOR, SHENANDOAH UNIVERSITY



/ APRIL 2020

Retirement Planning for PTs and PTAs

I agree that APTA membership for someone nearing retirement and working part-time is costly and should be reduced, or, at a minimum, the dues should include the educational courses offered online.

CHRISTINE BRUSSOCK, PT, DPT

/ APRIL 2015

Defining Moment: Getting a Rise Out of Him

What a truly inspiring story to know that there are PTAs out there who put others before themselves. Hopefully, some day when I become a physical therapist I can be that person to help them overcome whatever the patient is struggling with.

HARRISON WOOD

/ JULY 2017

First Choice for a Second Career

I have been a licensed massage therapist for 16 years and am looking to make a career change and would love to become a PTA. I live in a rural area and am wondering how I can earn my degree if I do not have access to a program locally.

TESSA C. ALLEN

/ APRIL 2020

Reckoning With Reentry

I can relate to all who face the challenge of reentry to their PT career. There are myriad reasons for making a choice to step away from one's career and equally numerous methods of staying engaged until a return. My reason for a hiatus was two-pronged: choosing a full-time mothering career and being a military spouse relocating around the world every several years. I, like many, maintained a current PT state license and completed continuing education courses to meet my biannual requirement. A good fit for me during my time away was to volunteer in health care, which allowed flexibility for both family needs and a military lifestyle, as well as keeping me connected to clinical care and professional dialogue.

As time moved forward and dynamics shifted, I began PRN work after nearly 12 years away from paid employment. This eventually grew into a return to full-time employment with a facility for which I had volunteered! The beautiful attraction to the profession of physical therapy (which holds me near to this day) is its quality of being dynamic, with so many options for gaining traction and continuing one's journey as one considers fitting.

DONNA GATTO



/ MAY 2020

Defining Moment: Two Degrees, Many Variables

I loved reading about Rose. I have spent my professional life studying neuroscience, brain injury, and, especially, the influence of the limbic system on motor control. As you so clearly identified, pain and anxiety (related to the limbic neurochemistry) affects motor performance, and many colleagues won't or don't want to see those relationships and their effect on the outcome of PT treatments and compliance.

Thinking outside the box — whether it be outside medical literature on disease and pathology or PT literature which should reflect movement function and dysfunction — truly is where the fun lies in being a PT and engaging in active human thinking. Throughout my life I have been confronted with the unknowns and nothing in the literature to explain what I was seeing and feeling. But for me in the last 30 years before I retired, it generally happened in front of 50-200 colleagues, which didn't allow my left brain to say it didn't happen. So my right brain just stroked the left brain and said, "Calm down."

»

We'll file it under unexplainable at the moment and try to figure it out later!" Those unknowns or unexplainable treatment outcomes make the practice of physical therapy fun and challenging.

DARCY UMPHRED

Excellent presentation of your college background and your profession and expertise. Kudos to you, and good luck!

NAPOLEON A. VALDEZ, MD

You have two interesting degrees to assist you in treating patients. Patients can be a puzzle that most therapists don't have time to evaluate and really treat. Keep up the good work.

VANIE L. JONES PT, DPT, MS

/ MARCH 2020

Ethics in Practice: In the Rough

As a new professional, the PT's moral sensitivity will mature with this experience. She did a great job of finding a motivator for Mike's rehabilitation but, with his taciturn personality, I suspect it was difficult to discern when it deviated from motivation to attachment. If I were a senior colleague in her clinic and if she were conferring with me, I'd talk about the nonverbal signs she may have missed, as well as the treatment/frequency decision, influences, and justifications.

I might have suggested a scenario having a conflict requiring a colleague to see the patient at the point when she is starting to question his comments. At my practice setting, we balance consistency with the benefit of another PT's toolbox and experience.

LESLIE GENTNER

APTA Asks

What will shake up the profession the most in the next 10 years?

Telehealth, in response to COVID-19. The profession will not just go back to normal. Telehealth will open doors for more self-employment and private practice options. It also will provide the ability to better connect physical therapy with health and wellness coaching, and will increase the overlap of physical therapy and the fitness industry. While telehealth cannot take the place of in-house physical therapy, it may change the way clinics perform back-to-back visits, and may require outpatient settings to reevaluate their patient-to-therapist ratio within a specific time frame.

PATRICIA STARKEY, PT, DPT

PTs with prescribing rights to order imaging, and PTs as primary care providers.

MARY GLOAN BARTOLOME, PT

Continued evidence supporting the effects of physical activity and altering movement patterns on long-term disability and outcomes.

KAITLYN BACHELDER, PT



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Things to Think About

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

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Best practice extends beyond the COVID-19 spotlight.

Telehealth Considerations Today and After the Pandemic



Steve Postal, JD, is a senior regulatory affairs specialist at APTA.

In the wake of the COVID-19 pandemic, more and more physical therapists are looking to provide telehealth services or expand their existing telehealth provisions. While it is important to keep up with the ever-changing payment landscape, it's essential not to lose sight of the evergreen aspects of telehealth best practice.

APTA supports telehealth as a modality of care that PTs can provide for their patients. The association's House of Delegates updated its telehealth position last September. APTA supports:

- Inclusion of physical therapist services in telehealth policy and regulation on the national and state levels to help address the growing cost of health services, disparity in the accessibility of those services, and the potential impact of health workforce shortages;
- Advancement of physical therapy telehealth practice, education, and research to enhance the quality and accessibility of physical therapist services; and



- Expansion of broadband access to give all members of society the opportunity to receive services electronically.

APTA has made the advancement of telehealth one of its chief public policy priorities and will continue to advocate for increased recognition of the service.

This March, the association developed a top 10 to-do list to help providers of physical therapy determine when telehealth is the right approach for patients, and what to consider. (See “Resources”

on page 14.) The following adds detail to considerations addressed in that list.

Consult State Law

Before offering telehealth, ensure that your state practice allows PTs and physical therapist assistants to provide such services. Simply put, if your state deems telehealth to be outside your scope of practice, you can’t provide such services.

As of April, APTA has identified 22 states with regulations either in the

state practice act or elsewhere that explicitly recognize telehealth as within the PT’s scope of practice. Of those, three states recognize it as being within the PTA’s scope of work, as well.

In addition to those 22 states, four others have open language — suggesting that telehealth may be within a PT’s or PTA’s scope. For example, state regulation may state that telehealth can be performed by licensed providers, without specifying which licensed providers.

Resources

APTA

(Search APTA.org by resource title)

- Telehealth Webpage (includes regularly updated tables showing the status of state emergency mandates and payers covering telehealth)
- House of Delegates Statement on Telehealth
- Top 10 Telehealth 'To Do' List
- Practice Acts by State
- Professional Liability Insurance for PTs, PTAs, and Students
- Telehealth: Risk Management Considerations
- Defensible Documentation
- HIPAA & Telehealth (APTA Learning Center; search for "telehealth" and scroll down)
- Implementing Telehealth in Your Practice STAT (APTA Learning Center)
- Digital Telehealth Practice – Connect for Best Practice (APTA Learning Center)
- Audio and Video Telecommunications System Vendors
- Ethics Documents
- Ethics and Professionalism
- Telehealth Ethics, Best Practice, and the Law: What You Need to Know (blog post)
- Telehealth: Billing and Coding Considerations
- Asking the Right Questions About Telehealth (news item)

Other Organizations

- **Licensing Authorities Contact Information**
fsbpt.org
- **Telemedicine: Risk Management Issues, Strategies, and Resources**
hpso.com
- **State Telehealth Laws & Reimbursement Policies**
telehealthresourcecenter.org

If the use of telehealth by PTs (and perhaps PTAs) is allowed in your state, familiarize yourself with its appropriate use, including current research, and information regarding payment and reimbursement for services delivered via telehealth.

The physical therapy practice acts in many states are silent on the use of telehealth. If this is the case in your state, contact your state licensure board to ensure that there are no limitations or restrictions on practicing telehealth.

Should your state physical therapy licensure law expressly forbid the use of telehealth by PTs, your best move is to contact your state's APTA chapter and work alongside staff to advocate for legislative change to permit the use of telehealth by PTs and PTAs.

In light of the COVID-19 pandemic, some states have been making emergency modifications, either to their practice acts or through gubernatorial declarations, to allow PTs and PTAs to use telehealth.

Additionally, some states are clarifying existing telehealth scope of practice in physical therapy. At this writing, APTA has identified 14 states with emergency declarations that recognize telehealth as within a PT's scope of practice. Six of those states also recognize telehealth as within a PTA's scope of work. One additional state has open language suggesting that telehealth may be within a PT's scope of practice during the crisis.

These emergency declarations are likely temporary; once the public

health emergency ends (if it hasn't yet), state laws regarding scope of practice for telehealth probably will revert to their pre-crisis status. Check with your APTA chapter for information on whether your state has issued such an executive order or has revised its physical therapy practice act. Also, please keep us posted on developments you encounter by contacting advocacy@apta.org.

Protect Yourself

Check with your malpractice insurance carrier for any coverage policies specific to telehealth before providing such services. APTA advises all PTs, PTAs, and students to have professional liability insurance, such as with the Healthcare Providers Service Organization.

Consent Obligations

Obtaining consent is much more than securing the patient's signature. The process of informed consent is more broadly part of a multistep process that ensures that the PT is in compliance with all rules, regulations, and ethical responsibilities, and that the patient understands and is comfortable moving forward with treatment via telehealth.

Research state law, the state practice act, and the policies of individual payers for informed consent requirements. Some jurisdictions, for example, require informed consent only on the first telehealth visit, while others require it for every such visit.

In addition to obtaining informed consent from the patient, be sure to familiarize patients with the technology and answer any questions. Explain that they:

If the use of telehealth is allowed in your state, familiarize yourself with its appropriate use, including current research, and information regarding payment and reimbursement for services.

- Have the right to refuse treatment via telehealth and can discontinue a telehealth visit at any time.
- Have the option (post-COVID-19 crisis) to be seen in the office and that the PT reserves clinical judgment to see them in the office for some or all subsequent visits.

For these and other consent considerations, visit the APTA telehealth page cited in the resources list accompanying this column.

Privacy and Security of Health Information

Be familiar with and understand all applicable federal and state requirements governing the privacy and security of medical records and health information. The Health Insurance Portability and Accountability Act does not contain a section devoted to telehealth, but the expectations and requirements are the same as those governing non-telehealth services. If, therefore,

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a HIPAA-covered entity is using telehealth that involves protected health information, that entity must meet the same HIPAA requirements as if the service was being provided in person.

Moreover, your state may have privacy and security laws more stringent than those required by HIPAA, and may afford greater privacy protections to individuals' health information, and/or greater rights to individuals with respect to that information. If this is true in your state, be aware of those additional protections.

That written, the U.S. Department of Health and Human Services' Office for Civil Rights in March announced that it would exercise enforcement discretion and waive potential penalties for HIPAA violations against

health care providers who in good faith serve patients using everyday communication technologies, such as FaceTime or Skype, during the COVID-19 public health emergency. Keep in mind, however, that this leeway has a limited duration.

The technology special interest group of HPA the Catalyst (APTA's Health Policy and Administration Section) and the association's FiRST Council have created a list of vendors offering audio and video telecommunications products. The link appears in the resources box accompanying this piece.

Ethical Obligations

Per APTA's ethics documents, it is incumbent upon PTs and PTAs to use their discretion regarding the

nature and frequency of telehealth use — abiding by state practice act restrictions and their obligations to the physical therapy profession.

Although telehealth is not specifically referenced in the Code of Ethics for the Physical Therapist or the Standards of Ethical Conduct for the Physical Therapist Assistant, the entirety of each document applies to telehealth services delivered by PTs and PTAs. Ethical practice in telehealth must account for the biological, social, psychological, and cultural needs of patients while working to improve their health. Additionally, knowing when to urge and how to persuade the patient to seek in-person care is key.

Continued Commitment

Rules and regulations governing telehealth are changing rapidly. PTs and PTAs who choose to provide care through telehealth must keep up not only with payment updates, but also with all laws and developments related to scope of practice, liability, informed consent, and ethics. APTA will continue keep members posted on developments in this arena and will keep advocating for telehealth in physical therapy. ■

Ethical practice in telehealth must account for the biological, social, psychological, and cultural needs of patients.

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A Novel Virus, Evergreen Concerns



Nancy R. Kirsch, PT, DPT, PhD, FAPTA, a former member of APTA's Ethics and Judicial Committee, is the program director and a professor of physical therapy at Rutgers University in Newark. She also practices in northern New Jersey.

I wrote this column in April and have the following scenario on patient-care issues readers were telling me they were experiencing in the early stages of the COVID-19 pandemic's spread across the United States. Look for a follow-up piece in the August issue of APTA Magazine on ethical issues related to practice competence under radically altered circumstances.

A Masked Response

To Loretta, it seems as if a virus initially specific to a region of far-off China has almost overnight been deemed a threat to people in the small Midwestern town where she grew up and has worked for several years at Pro Team Physical Therapy. Signs such as reduced traffic on the roads — as more people choose to work from home or are told to do so by their employers — quickly have expanded to include a significant number of cancellations by Pro Team patients and clients.

Some local school systems already have closed their doors, requiring Loretta to pick up some patients from peers who now are homeschooling their children. Although no local universities or community colleges have yet followed suit, Loretta, who coordinates clinical education at Pro Team, is concerned on behalf of a PT student who's on his final clinical placements at the clinic.

As the TV in Pro Team's breakroom increasingly is

tuned to news of the latest COVID-19-related developments in the country, state, and local area, Pro Team staff are doing their best to keep up with evolving health and safety recommendations. The clinic's corporate owners have been proactive — sending a supply of personal protective equipment to Pro Team soon after the news began taking a turn toward the ominous. All Pro Team staff now are wearing gloves, and many also are wearing N95 masks. Loretta wonders whether such precaution is necessary, as there haven't yet been any confirmed instances of infection by the novel coronavirus in the county, let alone the town in which the clinic is located. She doesn't mind the mandate that she wears gloves, however, because it's clear that doing so makes her patients feel more comfortable.

Loretta is happy that wearing a mask remains optional, as she finds them uncomfortable and, more important, she sees nervousness and even fear in the faces of many patients being treated by her masked colleagues. Also, she always has felt that smiles and calming facial expressions go a long way toward improving the patient experience, and that they even may improve adherence to her plan of care.

Social distancing is another concern. Pro Team has implemented various steps, including extensive signage, to promote recommendations

Considerations and Ethical Decision-Making

PTs and PTAs are ethically bound to ensure the safety of patients and clients, and to ensure that the risks of providing treatment do not outweigh the benefits after all prudent precautions have been taken. The circumstances described in this scenario present challenges to providers, patients, and students. The bottom-line question always is: Can safe and effective services be provided to the right patient, in the right place, at the right time? The appropriate ethical response lies in the answers to that multipart query.

Realm. The societal realm — the most complex because it is concerned with the common good — clearly applies here. So, too, does the individual realm, which is concerned with the good of the patient or client and focuses on right, duties, relationships, and behaviors between individuals.

Individual process. The questions raised in this scenario require moral potency — which combines ownership, courage, and self-efficacy.

Ethical situation. This scenario comprises a moral issue, in that important moral values are being challenged in various ways. It also exposes the moral temptation to choose a wrong action over a right one for the promise of personal benefit, such as in Loretta's case with the mask.

Ethical principles. The following principles of the Code of Ethics for the Physical Therapist provide guidance to Loretta and her PT colleagues regarding COVID-19-related decisions necessitated by these circumstances:

- **Principle 2A.** Physical therapists shall adhere to the core values of the profession and shall act in the best interests of patients/clients over the interests of the physical therapist.
- **Principle 3D.** Physical therapists shall not engage in conflicts of interest that interfere with professional judgment.
- **Principle 4B.** Physical therapists shall not exploit persons over whom they have supervisory, evaluative, or other authority.
- **Principle 5A.** Physical therapists shall comply with applicable local, state, and federal laws and regulations.

Resources

Coronavirus Webpage

- Links to continuously updated official guidance for the physical therapy profession, best practices, and resources.

Ethics and Professionalism Webpage

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

that individuals remain six feet apart to the extent possible. The number of cancellations has eased the danger of crowding in the waiting area, although of course Loretta and other therapy staff still are engaged in hands-on care.

The next development is an urgent plea from the county manager for any person or entity with unused PPE to donate it to local hospitals for use by front-line medical staff. In response, the corporate office directs Pro Team staff to share a portion of their existing supply of PPE, which it says it will replenish soon. This directive prompts a meeting during which some clinic staff, citing numerous reports of PPE shortages nationwide, question the corporate office's assurances and fear for patients' and their own ongoing safety. (There by now have been scattered cases of COVID-19 infection in the county, though none yet in the town.) The next day, after a portion of the clinic's PPE has been sent to local hospitals, Loretta happens upon a stash of N95 masks that someone clearly has set aside in defiance of corporate's directive.

Loretta is wondering what will happen next when Max, the PT student, asks to speak with her. His school is asking him to sign a waiver stating that he is continuing his placement voluntarily, regardless of potential health risks. He tells Loretta that he does fear for his health — and that of the clinic's patients — given constraints on social distancing and the possibility that the clinic's PPE supplies soon will run low. Max adds, however, that he feels he has little choice but to sign the document, as he wants to graduate on time and secure a job as quickly as possible to begin repaying his student loans.

Hearing the deep concern in Max's voice has one immediate effect on Loretta: She resolves to begin wearing a mask herself. In fact, she's suddenly glad that the illicit stash of masks exists. She tells the student that she understands his concerns but won't advise him one way or the other. "One thing I will say," she adds. "The way things are going, whether or not you graduate on time, the immediate job market for PTs and PTAs is looking increasingly grim."

Her words are prophetic. The next day, the governor issues an order that all nonessential businesses close their physical operations. Physical therapy clinics are among exempted health care employers, but the corporate office, citing safety concerns, announces that Pro Team will immediately close its doors but next week will begin offering all the telehealth services it is permitted to provide under the state's physical therapy practice act.

This news prompts another staff meeting. An array of concerns are aired. Layoffs look inevitable. A robust discussion follows about whether staff have the requisite knowledge and skills to provide telehealth services effectively. There's also the matter of how best to determine which patients can benefit from telehealth.

"I guess we can at least donate those masks in the supply closet now," one of Loretta's colleagues drily remarks. Everyone laughs, as the stash's existence is an open secret.

Afterward, Loretta ruminates on the rapid-fire series of events, and her and others' reactions to them. She now feels that she was wrong to decline to wear a mask. Was staff's hoarding of masks defensible, per the profession's Code of

Ethics for the Physical Therapist? She worries for the economic wellbeing of her junior colleagues, and of students like Max who face a depressed job market. The question of whether Pro Team is up to the task of effectively providing telehealth services gnaws at her, as well.

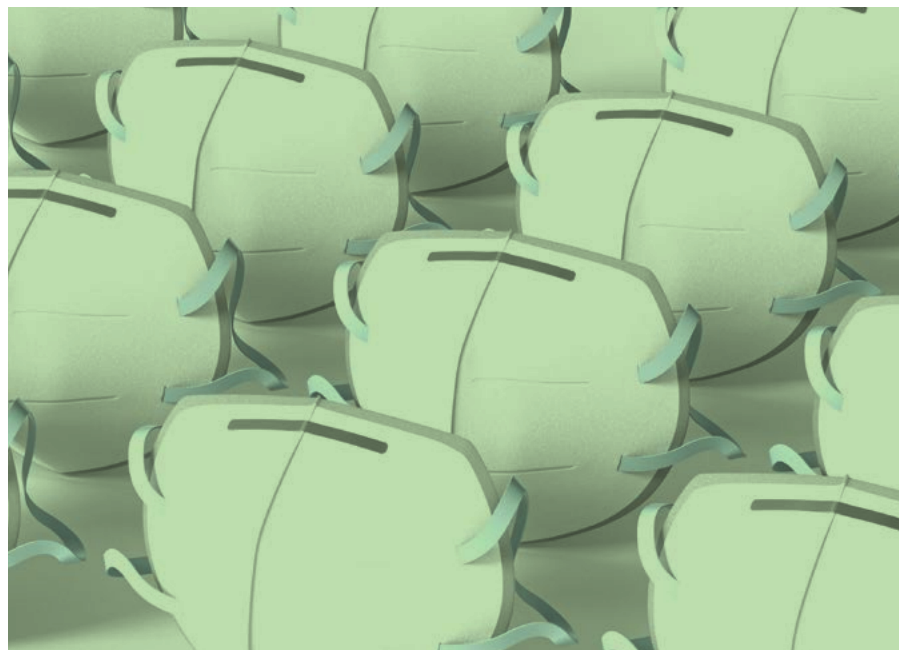
For Reflection

The COVID-19 pandemic has forced upon all of us a variety of personal and professional challenges, placing us at ethical crossroads we likely never envisioned. Reflecting on the decisions we subsequently have made, the thought processes that have gone into those decisions, and the ethical framework that has informed our choices is valuable — with potential benefits not only to ourselves but to all those with whom we interact, and to society as a whole. How well have you been living up to the professional dictates of APTA's ethics documents, and how faithfully have you followed the directions of your own moral compass?

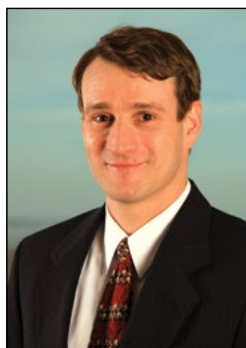
For Follow-up

If you are reading the print version of this column, go online to apta.org/apta-magazine and find this column in the July 2020 issue for a selection of reader responses to the scenario, as well as my views on how the situation might be handled. If you are reading this column online, simply scroll down to the heading "Author Afternote."

Be aware, however, that it generally takes a few weeks after initial publication for feedback to achieve sufficient volume to generate this online-only feature. ■



Medical Fraud. Are You Concerned?



Brian J. Markovitz

Labor & Employment

Whistleblower

(False Claims Act, Qui Tam)

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

Contact Brian to discuss your situation with full discretion.

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The Profession Responds to a National Health Emergency

These accounts from members of the profession about their experiences during the national health emergency created by the spread of COVID-19 were compiled in April. We don't know how the nation's landscape will look in July when you receive this issue of APTA Magazine, but we do know that our members have been making the profession proud with their actions, despite hardships and struggles in adapting physical therapist practice to make a difference for patients either fighting the disease or needing other services. To preserve contributors' full voices, these accounts are largely in their original formats — email messages, essays, social media posts, and more.

Compiled by APTA staff from member submissions

Left, Lauren Haegele, PT, DPT, in her PPE, with New York City in the background.



“I felt overwhelmed by the situation initially, as there were many changes occurring ... I had to brainstorm with our team on how to continue to provide care for our patients.”

Darah Shah experienced a clinic closing and reopening in Georgia. Her advice to others: “Challenge yourself in developing different models of care for your patients.”

GEORGIA Dhara Shah, PT, DPT

I work in a private outpatient clinic that closed for two weeks in March. Until then, we were seeing a shift in how we delivered patient care to attempt to minimize the spread. For one thing, since CMS and other private payers began allowing telehealth services, we encouraged this type of delivery. Patients, especially those postsurgery, are concerned about their rehabilitation progress. We are assuring them that they are still under our care, and supporting them in any way they need to continue with their plan of care with home exercise programs or telehealth visits.

In-person visits were significantly reduced when we reopened in April, but for them we used a set of screening questions pertaining to recent travel and close contact with anyone who was diagnosed with COVID-19, and we screened for presentation of symptoms such as cough or fever. We used extra cleaning methods and scheduled patients farther apart to limit exposure, and to maintain a clean and safe environment.

We did not anticipate any shortages of disinfectant supplies or equipment in our clinic; however, as the health crisis progressed we experienced shortages in supplies, especially masks, gloves, and hand sanitizer.

I felt overwhelmed by the situation initially, as there were many changes occurring. Being on the board of directors for APTA Georgia (the APTA Georgia Chapter), we had to make decisions on cancelling our annual state conference. As a treating clinician, I had to brainstorm with our team on how to continue to provide care for our patients.

Things have settled into a new norm, and I feel better-adjusted and less overwhelmed. I was lucky to be a part of teams that have strong leaders, and we were able to have effective plans in place.

My advice to colleagues during and after the health emergency: Take this time to challenge yourself in developing different models of care for your patients. We are faced with challenges, but how we react to them can determine the outcome.

FLORIDA

Amado Mendoza, PT, DPT

We are on the frontlines taking care of primary caregivers and military personnel, as I have been doing for the past 13 years. I own a small private practice, and we are able to stay open for now, as we are an essential service. We have strict universal precautions: We do not have more than 10 people inside our clinic at any one time. We make sure people wait in their cars and call before they enter the clinic. We use CDC screening criteria to ensure that we do not see any patient with symptoms. Finally, physical spacing is the most important change in how we perform our business. In addition to looking out for our patients, we have made sure that our therapists take time off if they need to spend time with their families.

We have been able to maintain our business in this new reality by training our team how to do telehealth and home visits. We are constantly watching for any new developments on how to prevent the spread of this virus, but there is joy in our patients, who know we are there to support them through their postoperative care. They appreciate our energetic and compassionate care, as most are struggling to maintain their independence throughout this crisis. Our team's primary focus is one-on-one care and staying small as a private practice, as we believe each person deserves to be shown respect and dignity. I believe this is the reason our patients continue to thrive in this pandemic.

We respect that we may have to close if the government mandates it, but we will be here to provide essential services for as long as we can.

WISCONSIN

Sylvestra Ramirez, PT, DPT

COVID-19 took over the airwaves in March. New visits to our clinic, Physical Therapy of Milwaukee, started to drop off, and patients were canceling their appointments in droves. The panic, anxiety, and fear started to set in, and my employees had questions I could not answer: Do we need to close the clinic? Would one or more employees get infected if we continue seeing patients? Is it safe for our patients to continue coming? What is my responsibility as a health care provider for our patients recovering from surgery or a work injury?

I began coming in between 5 and 6 a.m. to read about the latest local developments, check with APTA to see what they were advising, and review the newest CDC guidelines. I quickly realized that guidelines, rules, and recommendations were changing daily and even hourly. I turned to the Wisconsin Health Department and the Milwaukee Metropolitan Association of Commerce as my local resource for facts. It was extremely frustrating; it was like playing a board game and someone was constantly changing the rules. The energy and commitment to keep up was physically draining. If this is how I was feeling, I could not even imagine what my staff was going through. I vowed to have daily meetings to update them with correct, research-based information, while being completely transparent on the status of their jobs and the clinic.

I also vowed that we had a responsibility to be a resource for our patients and their families, many of which are Spanish-speaking. My team and I came up with bilingual messaging to ensure that we were compliant with CDC guidelines and the state's Safer at Home order. We ensured that the information our



Sylvestra Ramirez owns Physical Therapy of Milwaukee in Wisconsin, a local clinic that serves the Hispanic Milwaukee community, along with the underserved population. Ramirez shares her experiences for the benefit of other PTs, business owners, and female entrepreneurs. (yourptm.com)

patients were receiving from us via our social media channels, our emails, and in person was in line with continued efforts to mitigate further spread.

Navigating unknown territory and having to make hard decisions was not new to me. I had my fair share of struggles opening Physical Therapy of Milwaukee, and initially I felt able to take on this emergency. I quickly found out that this carried an enormous amount of responsibility that weighed heavily on my soul day and night. I didn't have enough hours in the day to keep up with ever-changing guidelines. My team depended on the latest information and on their jobs. On top of everything, the health of our patients remained the highest priority.

“I had my fair share of struggles opening Physical Therapy of Milwaukee, and initially I felt able to take on this emergency. I quickly found out that this carried an enormous amount of responsibility that weighed heavily on my soul day and night.”

I hit a breaking point when I finally realized COVID-19 was not going away. I felt like I was drowning, and no matter how hard I tried to swim to the top I was going nowhere.

Fast-forward a few weeks: I continue to lead my team with a transparent and honest message every day. Even though our clinic is not running on a full caseload, our time is consumed by applications for small business loans and grants in order to weather the storm.

I learned a couple of lessons that I want to share:

Pivot, shift, and focus. In life, in work, and when faced with a health crisis, assess the situation, pivot if needed, shift your immediate priorities, but remain focused on your mission and vision.

Have discipline and resilience. Opening a clinic and running a business take a lot of discipline, and an

even greater amount of resilience. You fall, you get back up, you fall, you get back up — rinse and repeat.

(Read more about Sylvestra Ramirez's practice in the May 2019 issue of PT in Motion magazine, predecessor to APTA Magazine.)

WASHINGTON

Anthony Yengo, PT, DPT, ATC

Board-Certified Clinical Specialist in Orthopaedic Physical Therapy, Manual Therapy Certified, Certified Strength and Conditioning Specialist

We closed our doors to in-office patient visits. The main reasons for this are:

- We lack testing to determine if sick people have COVID-19.
- Asymptomatic people can spread the virus.
- We want to do our part to reduce the spread so that hospitals can handle critically sick people.
- Gatherings of more than 10 people are prohibited.

I have all my employees on temporary unemployment, specifically designed for this situation, while I am in the office providing services via telehealth with patients. My receptionist and I are the only staff working, and we are preparing to completely work from home.

I have done two visits so far, and I have three scheduled today. The comments that I have received have been really positive under the situation. A new patient said, “Wow, this has been very helpful.”

Under the circumstances we can do a good job. It's not the same as an in-person visit, but we can still listen to patients, do a movement assessment, teach them exercises and treatment strategies, and walk a spouse through helping with treatment as well. We are also using an online exercise app for patients, so they have videos of all their exercises.



COLORADO

Dyanna Haley-Rezac, PT, DPT

Board-Certified Clinical Specialist in Orthopaedic Physical Therapy and Neurologic Physical Therapy, Fellow of the American Academy of Orthopaedic Manual Physical Therapists.

“May you live in interesting times” is both a proverb and a curse that aptly describes the state of the world during COVID-19. My husband and I are emerging with our amazing team at Rezac and Associates Physical Therapy in Colorado Springs during this time of global crisis with new meaning, purpose, and vision to not just survive, but to thrive. (Scott Rezac, PT, DPT, is a board-certified clinical specialist in orthopaedic physical therapy and a fellow of the American Academy of Orthopaedic Manual Physical Therapists.)

When I began exploring telehealth in 2018 it seemed futuristic for an insurance model but viable as a cash side-practice. Little did I know how valuable my investigation, training, and practice would be now. After our six PTs, a PTA, four final-rotation doctoral students, and a fellow who was studying with us all attended CSM in February, we started discussing how we could implement telehealth, and what I had learned in my functional medicine practice, into our physical therapy clinic, including modifiable lifestyle education and sport-specific courses online for cash revenue during challenging times for insurance reimbursement.

When the Colorado stay-at-home order was issued, we initially panicked. Like many others, we sought loans, grants, forbearances, and ways to cut expenses without furloughing anyone. Then we rallied and got creative. In Colorado, we were permitted to treat critical patients. But what about the others? Fortunately, we had been discussing telehealth and how

Dyanna Haley-Rezac and her husband and co-owner Scott Rezac demonstrate telehealth visits from their clinic, Rezac & Associates Physical Therapy, PLLC, in Colorado Springs. (drdyfmp.com)

it could be useful for home assessments and our pediatric patients to work with their parents in their homes. My experience treating remotely for the past year helped us move quickly.

We modified our schedule from 30-minute appointments with rehabilitation technician assistance to 45-minute slots to optimize billing and patient care. This allowed enough time for each PT to see patients one-on-one the entire time, avoid unnecessary contact with technicians, and have fewer people in the clinic for appropriate social distancing. Also, we moved waiting room chairs and all treatment encounters six feet apart. We sewed masks that can be washed after every patient use, performed temperature checks, conducted Zoom team

meetings, and, yes, frequently washed our hands and every surface of the clinic that was touched.

Meanwhile, we prepared to shift from in-person visits to telehealth. Our tech-savvy rehabilitation technicians became our computer technicians, helping patients learn how to do telehealth visits, setting up our secure platform, and disseminating information to our patients via social media and email (as well as multitasking by sanitizing the treatment areas after every in-clinic patient). Our admin team — on staggered schedules to limit the number of people in the facility — tirelessly navigated insurance requirements for performing and billing for telehealth.



Haley-Rezac acknowledges that it has “taken a village” to navigate through the public health crisis, and she is “grateful to have an awesome team at Rezac PT, the incredible Colorado APTA community that rallied to make things happen, and the phenomenal support of APTA and PPS, as well as our local bank, accountant, and information technology company to help us navigate this storm and not just survive, but to thrive on the other side.” Demonstrating clinic protocols are Rezac’s team, including, from left, Megan Berg, PT, DPT, Nick Szczepanik, PT, DPT, Sophie McNeely, PT, DPT, and Valerie Morse, PT, DPT, board-certified orthopaedic clinical specialist.

Just one month after the stay-at-home order, we were treating at about 80% of our pre-COVID volume, but with optimized billing due to longer treatment sessions and about half in-clinic and half telehealth visits.

Our patients are enjoying the flexibility of having telehealth sessions from home and are reporting positive outcomes. We have been able to provide care not only to those at higher risk, but also to patients with COVID-19, including creative postural drainage and self-mobilization using vibration from a washing machine — which we submitted to the American Academy of Orthopaedic Manual Physical Therapists as a case series for publication.

Our four DPT students were disappointed that their affiliations were ended early by their universities for health and safety reasons. We agreed that legally they could not practice if they technically were not students, but we kept them on as volunteer observers with patients' permission — essentially implementing a 1-4 clinical instructor-to-student model. The students could chat privately with the clinician after the session to continue their clinical experience. The response from students and patients has been overwhelmingly positive. With board exams delayed and job prospects limited, we are paying some of them to help us with other projects, such as developing courses, collecting research data, and writing case series.

We also started asking how we could help others. My husband is president of the Colorado Physical Therapy Network and is on the Colorado APTA board, and he has worked closely with those entities to get insurers in Colorado to approve telehealth for physical therapy. The collaboration of state and national organizations has resulted in approval for telehealth for physical therapy from nearly every insurance company.

In addition, my colleagues Sarah Gallagher and Mark Milligan recorded Zoom meetings discussing how to implement telehealth in physical therapy in Colorado, to help other clinics convert. Some had shut down or had severely diminished volume, and this helped many of them reopen.

I am an affiliate faculty member at Regis University in Denver and participated in a virtual forum to educate other universities on implementing telehealth into the physical therapy curriculum. I also was invited to be part of an American Council of Academic Physical Therapy task force writing recommendations for academic institutions, clinics, and students for returning students to clinical practice and developing alternative models.

“Our patients are enjoying the flexibility of having telehealth sessions from home and are reporting positive outcomes. We have been able to provide care not only to those at higher risk, but also to patients with COVID-19, including creative postural drainage and self-mobilization using vibration from a washing machine.”

We are developing a virtual program showing physical therapists how to instruct their patients via telehealth on self-mobilization techniques using common household items. Another online program will be for patients on optimizing their health and immunity through lifestyle modifications. Finally, we're collating best-practice information from national and international sources to put out small free education modules, based on setting, for treating patients who have had COVID-19.

We often are asked what we have learned during the pandemic. To quote the African proverb, “It takes a village.” It is clear that we are stronger together, and now, more than ever, it is imperative that we join forces through APTA to achieve our goals.

ARIZONA

Heidi Jannenga, PT, DPT, ATC

The COVID-19 pandemic has brought on stark and rapid changes to our personal and professional lives. Admittedly, it can be hard at times to stay motivated and positive. We're all trying to wrap our heads around what's happening and how it will affect our future. However, I'm comforted in knowing we're all in this together — even while apart for the time being.

At WebPT, we have run the gamut of emotions. On one end of the spectrum, it's been extremely difficult to hear from some of our members who have shut their clinic doors and most likely will not be able to reopen them. On the other side, we are proud of how our industry has banded together as advocates for the physical therapy profession, determined to ensure we make it through these turbulent times. We are humbled by the many therapists serving as "essential" providers in clinics that remain open — as well as those volunteering to assist as front-line providers in hospitals. And we are inspired by clinics that have pivoted their businesses to add telehealth and embraced

creative solutions to continue serving their patients.

The current climate is changing rapidly, and that has led to a lot of confusion and uncertainty within rehab therapy. Many people have asked me why PTs can't universally use telehealth, whether they should keep their clinics open, and how things will be different in the future.

These are serious concerns, yet I believe we are also staring down a serious opportunity to build a better, stronger, more foundationally sound industry for decades to come. I know we are strong enough to persevere. But to do so, we must adapt — and technology, now more than ever, is an essential tool for providers seeking to deliver a positive experience to every patient, whether seen in the clinic or virtually. In light of recent events and policy changes, there's been a telemedicine awakening within rehab therapy. And I believe telehealth is here to stay, because patients will expect and demand it as an option.

Evolving the format of patient visits isn't the only change we'll see. Clinic owners will have to revise their policies to accommodate public health requirements, introduce work-from-home options, and balance the needs of their employees' families. They'll also have to be even more diligent with outcome measurements, as clinical protocols may evolve rapidly and potentially reshape the demand for, and growth of, brick-and-mortar clinics.

During this crisis, we focused on empowering rehab therapists to adapt to these changes. We quickly mobilized our teams to get free, actionable information and tools into their hands, and to expand our technology to make telehealth easy and accessible.

While we are focused on keeping our heads above water, we can't let our foot off the gas when it comes to advocacy on behalf of the profession. We can start by pushing to get PTs permanently approved as telehealth providers, convincing legislators to nix the 2021 8% cut to Medicare payments, and leading the charge in defining what the patient experience will look like as we blend virtual options with in-person visits. Now is the time to come together so we can emerge as an even stronger industry than before.

Heidi Jannenga is cofounder and chief clinical officer of Scottsdale, Arizona-based WebPT, the leading rehab therapy software platform for physical, occupational, and speech therapists. The company is a seven-time "Inc. 5000" honoree, representing the nation's fastest-growing companies. (webpt.com)

"I believe we are staring down a serious opportunity to build a better, stronger, more foundationally sound industry."





MARYLAND

Monique Caruth, PT, DPT

Yesterday was my first day of treating COVID-19-positive patients in their homes. Was I nervous? Heck, yes; however, I knew I had a job to do.

One home patient, in his 70s with underlying comorbidities, tested positive and is still symptomatic. He's very weak, and had been lying in bed for seven days since hospital discharge. The family is frustrated and desperate, and voiced that they hated seeing him wasting away. The wife, also in her 70s with comorbidities, said she feels like "they sent him home to die." I donned full PPE, and after taking vitals and having a pep talk with the patient and family (and one for myself), I had him doing some exercises in bed and encouraged him to drink and eat.

Then I had him sit up at the edge of the bed with support, because he had fair trunk control. Lying in bed drains you, and a patient with COVID-19 is already really drained. He sat up for a while and, then, with help, he stood. His wife was begging me to come every day. Unfortunately, that won't be happening

"Yesterday was my first day of treating COVID-19-positive patients in their homes. Was I nervous? Heck, yes; however, I knew I had a job to do."

for a few reasons: PPE is being rationed, and clinicians need to limit their exposure with positive clients. Rehab is being encouraged to start with one in-person visit a week and another via telehealth.

These patients need to move. They need to be up. Families are struggling to motivate them to eat or even sit up or move a limb. We encourage patients to move in home health so they won't run the risk of acquiring pneumonia, having skin breakdown, or being rehospitalized. APTA's Home Health Section knows that PTs, OTs, SLPs, nurses, MSWs, and home health aides will have to step up big to limit the pressure on hospital and SNF admissions as this virus spreads. However, home health agencies have to compete with hospitals and others for PPE.

There has already been a staff shortage at agencies since elective surgeries are cancelled and parents have to be home with their children. I know managers are doing their best during this pandemic. Let's not forget that our goal in all this is to put patients first. Home health care providers need PPE so we can routinely do our jobs, reduce the death toll, and avoid hospital admissions.

What is the right thing to say if other patients ask you if you're treating COVID-19-positive patients? I tell the truth and say yes, and I schedule all COVID-19-positive or potentially positive patients on the same day and schedule others on a different day. Some are scared and may cancel or request PT who's not treating those patients.

Monique Caruth dons her PPE to prepare for providing home health services to her patients.

More Stories

Space limits the number of stories the magazine can share from PTs, PTAs, and students who have responded to the health crisis, but we've published several others within various APTA venues. If you want to keep reading and continue to be inspired by our profession, here are more accounts from your colleagues. (Search APTA.org by title to find the articles.)

- Outpatient Services During a Pandemic: Finding Your Ethical Footing (APTA blog post, May 14, 2020)
- Podcast: ED PT (The Pulse podcast, April 24, 2020)
- Adaptation, Reflection, and More Adaptation: Recent Graduates Use 3D Printer to Make PPE (From APTA's student blog, The Pulse, and partially republished in this issue on page 57)
- Defining Moment: Vulnerability and Courage (PT in Motion magazine, June 2020)
- Physical Therapy's Role in the Fight Against COVID-19 (ChoosePT.com podcast, April 30, 2020)
- When Your Race Is a Comorbidity, COVID-19 Sheds Light (APTA blog post, April 22, 2020)
- Flexibility in the Face of COVID-19: Lessons From a Rural Washington Critical-Access Hospital (APTA blog post, April 16, 2020)
- Staying Resilient in a Time of Crisis (APTA blog post, April 14, 2020)
- The Heart of the Storm: I'm a PT in Manhattan. Here's What It's Been Like (APTA blog post, April 2, 2020)
- How Climbing Has Shaped My Perspective as a Physical Therapy Student (The Pulse blog post, April 2, 2020)

NEW YORK

Lauren Haegele, PT, DPT

(From a series of Facebook posts over several weeks)

April 6:

Last night, I was interrupted during a video chat by the eruption of the city around me. I didn't know what was happening, so at first, I was a bit frightened. But then a voice on the video chat said, "They're cheering for you, Lauren." I got really emotional. I could hear the entire city making noise to show appreciation for NYC's health care workers. People were shouting from their apartment windows of isolation and using noise makers.

It reminded me that my efforts are not in vain and millions of people are grateful. Health care can be a thankless job, but it doesn't feel that way right now. This is something I will remember forever. I've seen the faces of each worker left on the subways, and in their eyes, I see the way the virus is taking its toll. I encourage you to celebrate with me — the beauty of human solidarity.

April 13:

Breaking news: I am positive for COVID-19. I've been in home isolation, lying low, and recovering. I'm well again and return to work this week. (I followed all physician's orders, informed work, etc., and I didn't step foot outside a single time during isolation!) I infected my boyfriend as well; his fever wouldn't break for six days, and this was very scary.

April 23:

I began working in home health this February after spending five years in Seattle working in a private practice ortho and sports setting, both clinically and in leadership roles. My heart is in sports and performance physical therapy, but in a strange and unexpected way home health is exactly where I belong right now. Due to the initial census drop in home health patients at the start of the outbreak, income suffered (I am paid per visit). On top of that, my company cut wages to 80% of my regular rate. Recently, I have been making 30% total of what I would normally make, due to the census drop and pay cut combined. Many home health therapists from other companies in NYC were furloughed, but this was not offered to me.

By the end of March, I was provided a handful of surgical masks, vinyl gloves, and a few gowns from my company. I became acutely aware of a difficult choice: Do I want to earn some money yet be at risk, or do I want to earn no money and be safe? In other words, treat COVID-19 patients in their homes (who desperately need care) while rapidly rebuilding to a full caseload at a reduced pay rate; or resign from my job with unlikely unemployment eligibility, yet safeguard myself and work on rolling out a telehealth business, which would take time to turn a profit. While launching a business has been a dream of mine since before the pandemic, many physical therapists are filling these virtual needs beautifully. For me, the place and time is right to help, live and in action.



“We are doctors of physical therapy, and we are also human. The emotional burden of treating these patients is too much for me to bear, and the pressure of living up to ‘hero’ status is beginning to erode my psyche. I’ve cried every day this week while walking throughout the city. I’m labile, lost, and overwhelmed.”

April 29:

I am primarily working in home health with a full caseload of 100% COVID-19 patients, immediately after hospital discharge. However, I also began working Mondays in a Manhattan hospital that had converted all its units to treating COVID-19; normally it is known for its top spine surgeons. A large bubble tent was also built on the land adjacent to the hospital, where I will be treating more COVID-19 patients, alongside military medical professionals who were brought in as emergency aid.

The psychological effect of my first acute care shift was like attending an open-casket funeral. I knew the severity of the pandemic was real, and I’ve even had a home health patient pass away from COVID-19, but seeing firsthand the multitude of COVID-19 patients in the ICU really hit home. It shattered any last bit of denial that I was unknowingly hanging on to. My PT and OT colleagues have described their patient-facing experience as “unimaginable.” Acute hypoxic changes can occur without warning for patients with COVID-19, and we have to be ready. One therapist encountered a patient whose SpO2 dropped to 57%. During the worst of the outbreak, another therapist said he found some patients with their oxygen masks off, due to confusion or delirium, and he helped by placing their masks back on. Some PTs helped COVID-19 patients call their family for the first time in days or weeks. Yes, our team also performs proning for select patients and pulmonary reconditioning for other patients, per our profes-

sional expertise, but I never thought this would be happening when I went to PT school to help athletes with knee pain. I know my colleagues from the University of Kentucky DPT program would rise to help just the same way. But I wouldn’t wish this on anyone. We are doctors of physical therapy, and we are also human. The emotional burden of treating these patients is too much for me to bear, and the pressure of living up to “hero” status is beginning to erode my psyche. I’ve cried every day this week while walking throughout the city. I’m labile, lost, and overwhelmed.

(Haegele also was featured in an article, “I Keep Telling Them How Strong They Are: Therapist From NC Fighting Pandemic in New York,” published April 17 in *The News & Observer*, the local newspaper in her hometown of Raleigh.)

To get to work quicker and safer, Lauren Haegele abandoned the New York City subway and buses, and either walks or rides her moped. She has journaled her experiences working with COVID-19 patients on her Facebook page.

Kylie Roberts and her grandmother, Gloria.



CONNECTICUT

Kylie Roberts, SPT

I am a physical therapist student at Sacred Heart University. My first year in the program was unfortunately brought to a halt and transitioned online earlier this year due to the COVID-19 pandemic.

The past two months have been inundated with news and information about COVID-19. News has been populating social media — negative stories about death and supply shortages, and positive stories about donations and the community coming together. For my classmates and me, COVID-19 and its many implications have been a popular discussion in class.

Sadly, this pandemic has affected my family and me in more ways than school moving to online courses. My grandmother, Gloria, passed away due to COVID-19 in mid-April while residing in an assisted living facility. After she passed away, we shared many loving memories of her, including how she loved to stay

active. My grandmother would always try to beat her personal best walking on the treadmill and often bragged about how she was the star of her balloon volleyball team. I could not help but think about how residents in assisted living facilities were being affected physically, which drove me to create a “quarantine routine” for our geriatric community titled “6 Safe, Simple Exercises Older Adults Can Do on Their Own.”

“Anything that you can do, big or small, to help those in need can make a positive impact.”

Anything that you can do, big or small, to help those in need can make a positive impact.

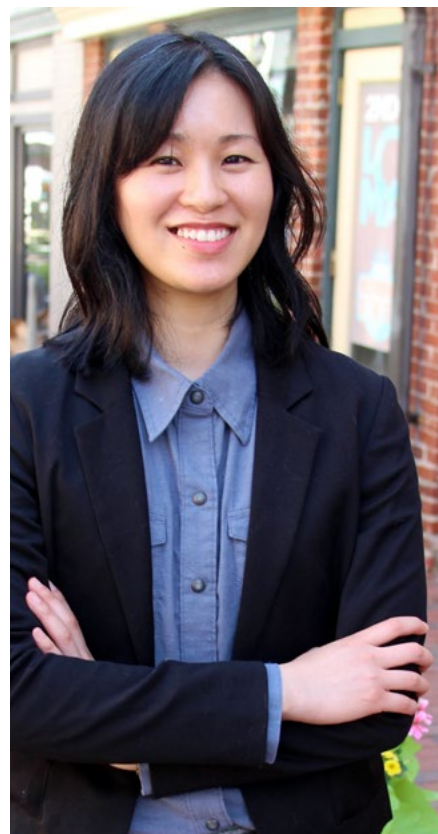
(This account is excerpted from Kylie Roberts’ blog post “Giving Back to Our Communities During COVID-19 Pandemic” that APTA published June 1 on its website. She can be reached at robertsk25@mail.sacredheart.edu about “6 Safe, Simple Exercises” and other initiatives she and classmates have undertaken to make a change during this challenging time.)

DELAWARE

Linh Ly, SPTA

I was into the second day of my last clinical rotation when I received news about the suspension of our clinicals. I’ve been keeping myself busy: studying for the boards, learning new things (language and instrument), as well as exercising. I was initially worried — this would be the second soon-to-be recession that I’m graduating in (graduated during the 2009 recession with a BA) — but there’s a saying that goes something like, “I have been through some terrible things in my life, some of which actually happened,” attributed to Mark Twain. Thus, I am taking things one day at a time. ▀

“I am taking things one day at a time.”



Linh Ly remains positive and determined to finish her PTA program despite setbacks caused by the COVID-19 pandemic.



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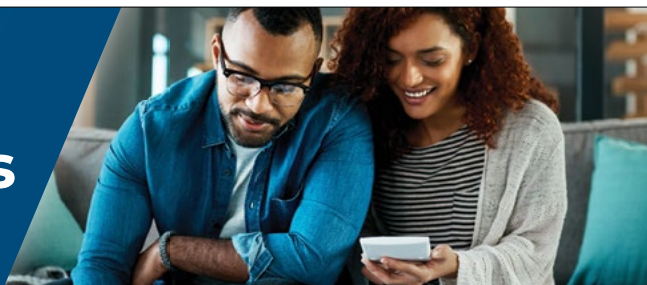
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The Ethics of Value-Based Payment in Physical Therapy Models

Physical therapy experts take a look at some issues that must be considered in the movement to value-based payment models.

By Bruce Greenfield, PT, PhD, FAPTA,
Nancy R. Kirsch, PT, DPT, PhD, FAPTA,
Rhea Cohn, PT, DPT, and
Heather Smith, PT, MPH



Historically, the U.S. health care system has had different payment methodologies, depending on the care setting. Hospitals, skilled nursing facilities, and home health agencies typically have been paid under a prospective payment system model, while outpatient care typically has been reimbursed on a fee-for-service or discounted fee-for-service basis.


FFS, which has been used for decades, directs health care insurers to pay health care professionals for each intervention provided to the patient. (Discounted FFS, typically within managed care arrangements, calls for discounts

on regular FFS fees when patients use in-network providers.) Critics of FFS — as described in the June 5, 2014, *Forbes* article “More Health Care Is Better Health Care: Myth or Reality?” — long have argued that it incentivizes health care professionals to provide and bill for the highest number of health care services per patient during each visit, even if the need for such services is not indicated.

The temptations of the FFS payment methodology provided little incentive for health care professionals to encourage lower cost and higher-impact care, such as preventive services. Also,

FFS did not require providers to track patient outcomes. Many health care providers not overly concerned with resource utilization or evidence embraced the myth that doing more was better for patient outcomes, and that mindset provided support for taking advantage of the FFS payment system.

Consequently, FFS payment methodologies have contributed to mounting health services costs. Lack of accountability for quality care that produces measurable outcome improvement has become increasingly unsustainable for hospitals, employers, and individuals. According to CMS national health



expenditures data, overall total U.S. health care spending increased 4.6% in 2018, reaching nearly \$3.6 trillion. CMS estimated that health care spending would grow an average 5.4% annually to reach about \$6.2 trillion by 2028. [Note: This estimate was generated prior to the coronavirus pandemic.]

Looking only at Medicare, total spending was projected to increase from \$523 billion in 2010 to approximately \$900 billion by 2020. From 2010 to 2030, Medicare enrollment is projected to increase dramatically, from 47 million to 79 million.

The mounting costs of health care services, combined with the historical lack of oversight for care that produces measurable improvement in outcomes, has become increasingly unsustainable for all stakeholders. So, how can existing resources be used wisely across the health care system?

To address this burgeoning crisis, Medicare, Medicaid, and commercial payers are moving toward value-based payment. This represents a shift from payment solely based on the volume of services provided, such as traditional FFS, to payment more closely tied to care outcomes.

Value-based payment models, also called alternative payment models or APMs, use measures of quality and cost to determine payment to providers. These models — such as bundled payment and accountable care organizations — typically require providers to share some amount of financial risk. These models seek to ensure high quality of care while controlling cost, aligning with the quadruple aims of VBP, as suggested in the November-December 2014 *Annals of Family Medicine* article “From Triple to Quadruple Aim: Care of the Patient Requires Care of the Provider.” The four aims are to:

- Improve health outcomes.
- Lower costs.
- Improve patient experiences.
- Improve health care professionals’ satisfaction.

The Affordable Care Act of 2010 emphasizes increasing quality and efficiency in health care. Section 2713 of the ACA authorizes the U.S. Department of Health and Human Services to establish guidelines to permit a health insurance plan to use value-based insurance design.

When the Medicare Access and CHIP Reauthorization Act was signed into law in 2015, the existing Medicare payment schedule came to an end. MACRA, with its Merit-Based Incentive Payment System and Alternative Payment Systems components, focuses on payment tied to value. Value-based payment is the growing trend for Medicare and Medicare Advantage payment.

HHS set a goal to move 30% of Medicare payments to value-based payment models by 2016, with a further goal of 50% by the end of 2018. According to the 2019 Methodology and Results Report from the Health Care Payment Learning & Action Network, in 2018 36% of U.S. health care payments were tied to either alternative payment models or population-health payment.

Value-Based Payment in Physical Therapy

Whatever one’s personal feelings about VBP models, physical therapy is moving to them. In a 2012 editorial published in the *Journal of Orthopaedic Sports Physical Therapy*, Julie Fritz, PT, ATC, PhD, FAPTA, writes: “Failure to focus on value has had devastating consequences, including fragmentation of care, imprudent efforts to contain costs instead of maximizing value, a disincentive towards efficiency, more mistakes, and worse outcomes.”

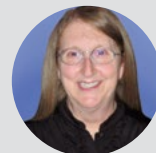
The editorial points to a 2011 summit sponsored by the United States Bone and Joint Initiative that focused on VBP as the future of health care. Fritz identified key considerations discussed at the summit as being relevant to the future practice of physical therapy. Of particular importance, she writes, value cannot be viewed as a standalone property dispensed by an individual provider. To obtain the



Rhea Cohn, PT, DPT



Bruce Greenfield, PT, PhD, FAPTA



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



Heather Smith, PT, MPH



best outcomes, PTs need to reimagine what professional autonomy means in a changing health care system that is professionally interdependent to provide the complete cycle of care for patients with specific conditions.

She argues that PTs no longer can entrench themselves in a professional silo and expect that type of practice model to produce value outcomes. The emergence of interprofessional collaboration should be considered the new norm in health care.

In keeping with Fritz's arguments, to foster true multidisciplinary practice, providers need to move away from thinking "You do this and I do that." Rather, the thinking needs to be "We do this together." For example, hospitals and postacute care providers have developed care pathways and bundled payment models for episodes of care such as total hip and knee arthroplasty. Together, they are trying to solve the problem of improving outcomes at a lower cost.

Ethics and Value-Based Payments

Along with good intentions to integrate VBP models into clinical care, however, health care professionals have raised ethical concerns. Let's explore a few ethical issues and consider if they fit into the individual, organizational, or societal realm of ethical problem-solving. For this discussion we will be using the Realm-Individual Process Situation Model of Ethical Decision-Making, as more fully described in "Ethical Decision-Making Tools" on APTA's website.

In the individual realm, what constitutes a quality outcome from the patient's perspective? Will a patient's preferred use of resources be different from that of a health care professional or a health care administrator? Inclusion of measures that focus on the patient, such as patient experience — satisfaction — are import-

ant, but what about measures of cost and resource use?

Could a clinician be caught between trying to manage an individual patient's recovery and being asked to trim services? What if that patient is an outlier, with comorbidities that slow recovery? Patients with the same diagnostic label, let's say a stroke, may vary in acuity and severity. Other demographic variables may influence patient and family access to care, as well as clinical decisions about care delivery.

From the standpoint of distributive justice, the U.S. health care system is considered by many to be one of the most inequitable in the western world. Part of the problem is that health care often is viewed as a commodity rather than a right. There is a tension between health care as the purview of the public domain or the private sector. This arises in part from the division between state and national government. Additionally, politics influence policy.

Amid the tension between private and public health care, social determinants of health often are overlooked. The result has been an overarching focus on bedside care, with less consideration of how social factors influence long-term outcomes. But the tide may be changing. For example, Humana announced on March 4 that it is launching a VBP

"Failure to focus on value has had devastating consequences, including fragmentation of care, imprudent efforts to contain costs instead of maximizing value, a disincentive towards efficiency, more mistakes, and worse outcomes."

— JULIE FRITZ

program designed to support clinicians who address nonmedical risk factors affecting health. A focus will be on food insecurity and lack of stable housing. Humana's first clinical partner is Ochsner Health in Louisiana.

This raises broader questions at the organizational level. What outcome measures are being used, and are they risk-adjusted? Are facility managers asking clinicians to trim costs regardless of the patient's complexity? Are patient outcomes being uniformly measured with the same tool? Can the "one-size-fits-all" approach to outcome measurement work, or can a value-based system that looks at outcomes and cost recognize and account for patient differences?

Setting targets for outcome metrics can be challenging because different stakeholder groups have different incentives. Who will determine the optimal outcome? At the organizational level, managers will be looking to create efficiencies in care delivery by reducing resource spending. Ethical issues could be based around the level of provider hired and used — such as PT versus PTA and PTA versus aide — to decrease costs. The PT of record may feel that he or she should treat the patient, but management may direct use of a PTA or aide (although the use of an aide for patient



care is prohibited in many state practice acts, and many payers will not pay for care delivered by aides).

The targeted outcome may influence the use of evidence-based practice. For example, targets for an episode length and personnel use may be lowered for certain admissions or procedures. Telehealth may be implemented to reduce overhead associated with higher cost of in-person care. Will clinicians or clinician teams feel they are abandoning their patients prematurely or not providing care that has historically been the accepted standard?

Another organizational-level concern arises if providers are incentivized to “cherry-pick” patients to make their numbers look good. Would this trigger favorable financial incentives? This poses ethical challenges for both organizations and individuals, as patient care decisions may become based more on what is financially compelling than what is medically necessary.

Other ethical questions might arise because PTs may not have the “systems thinking” needed to understand VBP models. In those models, payment for services provided by multiple entities is aggregated into a single amount.

Consider a bundled payment for 90 days of postacute care following a total lower extremity joint replacement. Potentially, the money is shared by a SNF, home health agency, and an outpatient pro-

vider. Payment must be divided among these entities. Although the consolidation of health systems keeps different care settings under one umbrella and eases barriers to allocation of payment, VBP still may create tension between services and payment allocation.

ACOs have various risk-sharing arrangements. Participants in an ACO are responsible for managing health care for a large group of people, leading to more of a population health focus. Some models include either “upside” or “downside” risk sharing; others include both. “Upside” risk sharing, sometimes termed “one-sided” risk sharing, occurs when providers share in the savings if the spending is below a benchmark but are not penalized if spending is above the benchmark. In “downside risk,” providers share in the savings and in some of the losses, if they occur.

Regardless of the model, providers must work together to achieve the best outcomes at the lowest cost. PTs can’t isolate themselves. They must understand the system in which they work so they can see how all providers in VBP models contribute to the outcome.

On a societal level, all health care providers must try to improve the value of care being delivered in the United States. There is a finite pot of money available to manage the health of as many people as possible. The level of waste in the system must be reduced. This includes unnec-

essary emergency room visits, health care fraud, and provision of services that have little or no value.

Yet another concern is that complicated outcome reporting systems reduce the time and resources available to offer care. In response, many outpatient clinics have moved to a cash-based system to eliminate the excessive administrative burden and cost associated with outcome reporting and insurance billing. Medicare patients are being turned away. Will this cause harm to patients who need to access to care?

Navigating Ethical Challenges in VBP Models

In all the years the profession has been confronted with changing payment models, there has been one constant: Each change has entailed ethical challenges.

You can argue that VBP does not create new ethical challenges but, rather, challenges that are somewhat different from those that preceded it. One compelling reason for the revision of APTA’s Code of Ethics for the Physical Therapist in 2010 was to provide better guidance specifically regarding practice and payment conundrums facing PTs and PTAs in all practice settings.

Regardless of a plethora of payment changes, the focus of the profession has not changed. Principle 2 of the Code of Ethics establishes the backdrop for all patient interactions: “Physical therapists shall be trustworthy and compassionate in addressing the rights and needs of patients/clients.” With every change in payment, organizations and associated staff must adapt to ensure that payment requirements are met while balancing changes in service delivery that may be necessary to continue to provide safe and effective care in a new payment environment.

Principle 7 of the Code of Ethics offers guidance for interactions with organizations, coworkers, and employees as these

Another organizational-level concern arises if providers are incentivized to “cherry-pick” patients to make their numbers look good.



changes evolve: “Physical therapists shall promote organizational behaviors and business practices that benefit patients/clients and society.” The goal of CMS and other payers, we are told, is to improve patient outcomes at lower cost. This laudable objective is in concert with Principle 7. The challenge lies in how to align the realities of practice with

We will continue to see growth in VBP among both public and commercial payers. Alignment of provider and patient incentives will require more transparency in care delivery, more education of patients as consumers, more meaningful use of data, and more assumption of significant risk by providers — all of which, according to

Yet, as suggested in this article, PTs should approach the use of VBP models with consideration of the potential ethical issues that might arise, and be prepared to recognize and navigate them. As ethical situations arise, PTs should be mindful that APTA’s Code of Ethics for the Physical Therapist and the APTA Guide for Conduct of the Physical Therapist Assistant remind us of our obligations and the rights of our patients. ■

PTs should approach the use of VBP models with consideration of the potential ethical issues that might arise, and be prepared to recognize and navigate them.

the values and the principles that guide patient interactions and practices.

Principle 7A provides the template for decision making. PTs are compelled to accept the responsibility to be actively engaged in “promoting practice environments that support autonomous and accountable professional judgments.” Principle 7E provides further guidance on how to communicate about the skilled professional services we provide and justify the associated costs. The final guidance in this principle relates back to Principle 2, defining our responsibility as PTs to the patients/clients with whom we have the privilege to work.

Principle 7F, meanwhile, reminds us that if we are unable to fulfill our professional obligations to patients/clients, we should refrain from that type of employment arrangement. Finally, Principle 8 speaks to our partnership with agencies outside physical therapy to “participate in efforts to meet the health needs of people locally, nationally or globally.”

both public and commercial payers, are coming in the years ahead.

As ethical issues emerge in clinical practice related to VBP, PTs and PTAs must be able to navigate them in a reasonable and justifiable manner. Ethical decision-making models such as RIPS provide a systematic way to consider, explore, understand, and address ethical issues related to VBP.

Summing Up

Given the emergence of VBP models for physical therapy, this article has focused on potential ethical issues PTs might encounter with regard to reimbursement using a VBP model. We reviewed literature that indicates that integration of VBP models into a health care system that focuses on quality outcomes per unit dollar is an antidote to controlling spiraling health care costs, while addressing the quadruple aims of health care.

Bruce Greenfield, PT, PhD, FAPTA, is a professor in the Division of Physical Therapy, Department of Rehabilitation Medicine, at Emory University School of Medicine in Atlanta. He is a senior fellow at the Emory University Center for Ethics; affiliated faculty for Emory’s Certificate Program under the Disability, Health and Culture Center for Health Law and Ethics; and a fellow of the National Academies of Practice.

Nancy R. Kirsch, PT, DPT, PhD, FAPTA, is a professor and director of Doctor of Physical Therapy Programs in the School of Health Professions at Rutgers, The State University of New Jersey. A former chair of APTA’s Ethics and Judicial Committee, she writes the Ethics in Practice column in APTA Magazine.

Rhea Cohn, PT, DPT, is an adjunct professor at the George Washington University School of Medicine and Health Sciences and a private consultant. She is a member of APTA’s Ethics and Judicial Committee and has served on the Maryland Board of Physical Therapy Examiners.

Heather Smith, PT, MPH, is APTA’s former Director of Quality.



Daryl Homer, left, and Ilya Mokretcov of Kazakhstan compete in the men's individual sabre during the Rio 2016 Olympic Games.
DEAN MOUHTAROPOULOS/GETTY IMAGES SPORT VIA GETTY IMAGES



Aiding the Olympic Dream

Physical therapists help athletes in their goal of successfully competing in the Olympic Games. The postponement of the 2020 Tokyo Games does not diminish the roles of the PTs, athletes, or the lessons to be learned from previous Games.

By Keith Loria

Daryl Homer is one of the world's best saber fencers. He represented the United States at the past two Summer Olympic Games, taking home a silver medal in Rio de Janeiro in 2016.

Having devoted his life to the sport, Homer takes his conditioning seriously. So, when he felt a tweak in his ankle about 10 years ago, he sought out help from Scott A. Weiss, PT, DPT, of Arista Physical Therapy & Wellness in New York City.

"He was providing a teammate of mine with soft-tissue treatment," Homer says, "and I wasn't super-aware of the benefits of it before I started working with him. But to this day, we work in a really collaborative capacity. Scott handles my recovery work and optimization of my body. I'm very grateful for everything he's done."

"At this caliber, the athletes know a lot about their bodies and the treatments they need. Education is vital in this population, and listening is key."

— Scott Weiss

Over the past decade, Weiss has worked with Homer using an extensive list of techniques to help him continue competing as a world-class athlete. These include recovery, cryotherapy, massage, ultrasound work, breathing techniques, and flexibility exercises.

The 29-year-old will be competing again at the next Summer Olympics, and although he's "a bit bummed" the

Games were postponed by the COVID-19 pandemic until 2021, he knows he'll be ready thanks to Weiss' help.

"Fencing is the type of sport that puts a strain on a lot of muscle groups, and you're doing that over the course of years and years," Homer says. "Many fencers don't see a PT, but I have found it to be a wonderful thing. Scott helps me increase my performance and get more out of my body so I can train and get out there at a high level."

Weiss has a long history of working with Olympic athletes. He started as a volunteer with the United States Olympic & Paralympic Committee in 1998 after the Nagano games in Japan and has provided physical therapy services at three Olympic Games, two Pan-American Games, and more than 25 World Cups.

"At this caliber, the athletes know a lot about their bodies and the treatments they need," he says. "Education is vital in this population, and listening is key. Elucidating evidence-based treatment is paramount. Sharing with them what has worked for other Olympians also can be extremely very beneficial."

For the Summer Olympic Games in Tokyo that now are scheduled for 2021, Weiss will work with the U.S. fencing, wrestling, and triathlon teams.

He recently worked with a member of the triathlon squad who had a sports hernia and was having difficulty during the swim portion of the competition. After three months of physical therapy — including hands-on therapy, modalities, and education — he was able to return the athlete to competing at the highest level to get ready for the Olympic Games.

Blake Butler, PT, MPT, a board-certified orthopaedic clinical specialist with TRIA Orthopaedic Center in Bloomington, Minnesota, regularly trains elite-level high school and college runners and multisport athletes who compete in both summer and winter sports.



Scott Weiss at the 2008 Beijing Olympics closing ceremonies, left, and with Lopez Lomong, USA flag bearer.

Physical Therapists and the Olympic Games:

A Long History

PTs' involvement with the Olympic Games goes back decades, and at least one PT actually competed. Here are two of their stories.

Arnold Bell

Arnold Bell, PT, PhD, ATC, was the first African American board-certified clinical specialist in sports physical therapy. Born in the Bronx in 1951, he earned his bachelor's degree from Springfield College, a physical therapy certificate and a master's degree in exercise science at Columbia University, and a PhD in higher education at Florida State University.

He was employed at Cleveland State University in Ohio when he was recruited by Florida A&M to establish its physical therapy department. He taught there for 31 years.

In 1991, he earned his sports specialty certification. Bell worked with the United States Olympic Committee as an athletic trainer, serving at the committee's Sports Medicine Center in Colorado Springs and at two Olympic Games. He was a chief athletic trainer for the sport of shooting (rifle, pistol) at the centennial Olympiad in Atlanta in 1996.

In 1997, Bell was inducted into the Olympic Alumni Hall of Fame at Springfield College, which also bestowed upon him the Gertrude Lamb Award in 2000 for outstanding contributions to the physical therapy profession by an alumnus.

At Florida A&M, he was named teacher of the year in 2000-2001 in the School of Allied Health. He was a 2003 inductee into the school's sports hall of fame. He died in 2013.

A longtime APTA member, Bell was a member of the Advisory Committee on Minority Affairs.

Theodore ("Ted") Corbitt

Another PT with an Olympic connection was Theodore "Ted" Corbitt, PT, MPT, an Army veteran, professor, and clinician for 44 years at the International Center for the Disabled in New York City.

He was born on January 31, 1919, in Dunbarton, South Carolina, on the same day as Jack Roosevelt Robinson, better known as Jackie Robinson of the Brooklyn Dodgers. There were other parallels in their lives: Both men were named after President Theodore Roosevelt, both would achieve greatness in their respective sports, and — as the official website of Jackie Robinson notes — both peacefully challenged the racial views of their time.

As a child, Corbitt saw a film about the 1932 Olympic Games and a photo story about Tarzan Brown winning the 1936 Boston Marathon. Those inspired him to run competitively, with the goal of completing marathons.

In high school and later at the University of Cincinnati, Corbitt ran sprints — his long-distance dreams deferred by racial prejudice. After college, race organizers did not allow him to compete in Cincinnati-area track meets. Undaunted, he looked to road races, which were less restrictive. In 1947, after moving to New York, he joined the New York Pioneer Club, a small distance-running club that accepted minorities. But other considerations — the need to make a living, attendance at night school to get his master's in physical therapy, two years of military service, marrying, and starting a family — left Corbitt little time to train until after age 30.



finding that the 26.2-mile distance was too short. He began entering 30-, 40-, and 50-mile races, adapting his training program to prepare for these longer distances. He began routinely running 200 miles a week, eventually working up to 300. Normally, Corbitt woke early to run 20 miles to work and then ran home at the end of the day, for a total of 40 miles on those days.

Corbitt twice entered and placed second in what is considered the world ultramarathon championship, the London-to-Brighton 52.3-mile race. In 1969, he also set the American record for 100 miles, covering the distance in 13 hours 33 minutes and 6 seconds.

In 1973, Corbitt set another American record by running 134.7 miles in 24 hours. The next year, he ran the Boston Marathon again, finishing in 2 hours and 49 minutes — only a minute slower than his first Boston Marathon 23 years earlier.

Unlike today's professional athletes, whose sport is their job, Corbitt also was putting in a 40-hour workweek as a PT at the Institute of Crippling Diseases in New York City.

In 2003, at the age of 84, Ted Corbitt still was testing limits. He ran 240 miles in a six-day ultramarathon race — a record and a first for his age group.

Corbitt was a member of APTA and the American Registry of Physical Therapists. He received his bachelor's degree in education from the University of Cincinnati in 1942 and his certificate in physical therapy from New York University in 1948. He received his master's degree in physical therapy from New York University in 1950.

Corbitt died in 2007 at the age of 88.

Portions of this profile were adapted from the Ted Corbitt Archives at tedcorbitt.com.



Top, Ted Corbitt, Gordon McKenzie, and John Sterner. Below, Ted Corbitt with a patient. Courtesy of tedcorbitt.com.

After returning from World War II, he earned a master's degree in physical therapy from New York University. Two years later, he became the first African American Olympic marathon runner to represent the United States and is known as the "father of American distance running." A professor at Columbia University for 20 years, he was one of the first PTs to teach connective tissue massage, proprioceptive neuromuscular facilitation, progressive resistance exercise, and applied kinesiology.

It was assumed that most runners' best days were behind them once they reached age 30, but Ted Corbitt broke that assumption. Within a year, he entered the Boston Marathon and placed 15th. In 1952, he entered the Yonkers Marathon and placed third, which qualified him for the 1952 Olympic marathon squad. Due to an error in reporting, Corbitt was unaware that he had made the team until only a short time before the race, so he entered the Olympic marathon ill-prepared. Still, he ran in Helsinki and finished 44th.

(See "The 1952 Olympic Games: A PT's Perspective" on page 49 for some of Corbitt's observations about physical therapy at the Olympic Games.)

By 1954, he had won three of the four marathons he had entered and was

In 2015, when he received an email asking if he'd be interested in volunteering at the Olympic Training Facility and working with Team USA Olympic-level athletes, he jumped at the opportunity. A year later, he was watching some of those athletes compete at the Rio Games.

For example, he worked with two swimmers who were experiencing pain that impaired their performance. He performed dry needling to address their shoulder pain. Both improved their performance, swimming with little pain.

"A patient to whom I believe I made the biggest difference came to me with some upper thoracic and lower cervical region issues that were affecting this individual's athletic ability," Butler explains. "I gave that person specific exercises for scapula stabilization and worked privately with the athlete after the team workout. That competitor was the first to medal for the USA in that sport in a very long time."

Up to the Task

Kent E. Timm, PT, managing director of Renue Physical Therapy in Saginaw, Michigan, started working with Olympic athletes as a result of a two-week experience with USA Team Handball at the United States Olympic Training Center in Colorado Springs in 1988.

In the 32 years since, he has worked with USA Baseball, USA Gymnastics, US Rowing, and USA Table Tennis, reaching the 1996 Olympic Summer Games in Atlanta with USA Shooting Sports and USA Track & Field, and the 2000 Olympic Summer Games in Sydney, Australia, with US Soccer.

"While, in general, non-athletes seek services from a PT to improve function from a disability or to restore normal ability after an injury or surgery, world-class athletes frequently look for methods to 'fine-tune' themselves to prevent injuries and improve their performance abilities in pursuit of national team berths and Olympic medals," Timm says. "This challenges the PT to be well-versed in the current professional literature not only for the rehabilitation sciences, but also for human performance."

"This challenges the PT to be well-versed in the current professional literature not only for the rehabilitation sciences, but also for human performance."

— Kent Timm

But being at the Games also means being ready to help prepare an athlete to compete after injury strikes. For example, at the 1996 Summer Olympics, Timm helped a track and field athlete correct a functional leg-length difference from a sacroiliac joint sprain just before the event's final race. The competitor won the gold medal and set a world record.

Laurey Lou, PT, DPT, a PT at HSS Westchester in White Plains, New York, has had a few Olympic athletes come through sport clinics where she's worked, but the bulk of her experience working with them came when she worked at the Olympic Training Center in Beijing. She is a board-certified clinical specialist in sports physical therapy.

"This opportunity came about when I was living in California and connected with a company there that helps



Kent Timm

the Chinese government bring in Western-trained sports medicine staff for Olympic athletes,” she explains. “Once in China, I worked mainly with the wrestling and judo teams, although I also covered other sports, including gymnastics. My daily responsibilities included team programming, specific athlete treatments, and education for the Chinese staff.”

One of her favorite athletes to work with was a female wrestler.

“I want to help them understand that if the upcoming event is the priority, we can assume a higher risk for preparing for it.”

— Laurey Lou

“She tore her meniscus soon after I arrived in China, so we spent a lot of time together. Although her rehab was steady, she had a lot of pressure on her,” Lou says. “We worked through many things together, including typical knee rehab and nutrition. Being in a weight-class sport, she was anxious about the weight she was gaining during her early stages of rehab and had tried to stop eating. We worked on mental readiness that incorporat-

ed imagery and videos, and on her remaining part of the team despite not being able to fully participate.”

The wrestler went on to medal at the Rio Olympic Games. Along the way, she taught Lou a lot of Chinese vocabulary, as well as a few takedowns that Lou tries to integrate into her own jujitsu performance.

“Olympic athletes represent pure passion,” Lou says. “These athletes have an incredible work ethic, beautiful competitive drive, and a deep love for their sport. The vast majority of Olympic athletes have no financial incentive to compete — many forgoing a salary to pursue their dreams. Maybe it’s idealistic and fairytale-esque, but I love to help them work toward making their dreams a reality.”

Currently, Lou works with athletes at all levels, from weekend warrior to professional, providing them with physical therapy services that include return to play and performance testing using motion capture, force plates, and isometric training devices.

“In school, we learned about timelines for healing, muscle strengthening, and return-to-play progressions. When I started treating high-level athletes, I had to adjust the way I created timelines, including planning for peaks, ensuring appropriate loading, and making sure to prioritize performance for the most important competitions,” she says. “This is an important concept for all athletes, whatever their level of competition.”



Laurey Lou works with an Olympic athlete at the Rio Games in 2016.

Ted Corbitt with a patient. Courtesy of tedcorbitt.com.



The 1952 Olympic Games:

A PT's Perspective

Ted Corbitt wrote an article for the December 1952 issue of Physical Therapy Review (APTA's journal, now titled Physical Therapy and known as PTJ) on his observations as both an athlete and a PT at the Summer Games of the XV Olympiad, held in Helsinki, Finland, earlier that year. His full article highlighted the importance of physical therapy and the ways in which the profession had evolved and grown. Among the observations that he presented in the article:

The majority of the athletes lived and trained in a suburb of Helsinki called Kapyla. The Kapyla Olympic Village consisted of a new modern housing project built for that purpose...

The U.S. Olympic Committee assumed responsibility for medical care for minor illnesses and injuries suffered by the Americans. Accompanying the U.S. Olympic team were two doctors and a nurse. They were responsible for the medical care of about 400 American athletes and officials. A medical clinic for all Olympic personnel was set up at the Kapyla school building, located near the Olympic Village. A physician was on duty at all times. Regular clinic hours were held in the mornings. Several wards were set up in one part of the school, staffed by Finnish medical personnel, and used for observation and minor illnesses. In emergencies and serious illnesses, Olympic personnel were sent to a Military Hospital in Helsinki....

There were three Finnish physical therapists on duty in the mornings at the Kapyla School Polylinic and they were paid for their services. They administered physical therapy, as prescribed by the team doctors, to injured athletes of all nations in the big Olympic Village. These young women worked either in local hospitals or did private physical therapy work in the afternoons. Physical therapy measures receiving most use included infra-red and diathermy....

Among the injuries suffered by the U.S. Olympians were: sprained ankles, hands, and shoulders; low back sprains; soft tissue injuries, especially "pulled" muscles; and a

dislocated clavicle. Physical therapy was also administered by a team of seven college (or university) athletic trainers who accompanied the U.S. Olympic team.

Physicians and trainers held meetings to establish policies and procedures and to coordinate activities in the care of the athletes. The result was a good working relationship between these units. The trainers took care of minor troubles of the athletes. Serious problems were referred to the team physicians....

The excellent care given to the athletes aided recovery but the element of time was the paramount factor. An additional few days or a week of rest and treatments would have made a big difference in the performances of some of the athletes — including several potential gold medalists. Physical measures used by the trainers included massage, simple exercises (e.g., passive stretching), and heat in various forms. Most of their work consisted of massaging the athletes before and/or following the training sessions or competitions. These men also had equipment in their quarters for use if required at other times.

The modern series of Olympic Games is not as important in the scheme of things as were the celebrations of the ancient Olympiads, but their universal appeal means that they are here to stay. As the competition gets progressively stiffer, the stresses and strains on the human body also increase, with tougher training routines being used to meet these greater demands on the body.

Even with her weekend warriors, she'll ask, "What is your priority?"

"I want to help them understand that if the upcoming event is the priority, we can assume a higher risk for preparing for it," she explains. "However, if it's not the priority, and what they really want is to be healthy for the following event, maybe we can skip this one."

Challenges of the Job

Since the Olympic Games cover only at most a 16-day span, PTs must be effective in a very short period of time if they are to be successful in helping Olympic athletes compete at their peak level of performance.

There also are certain rules PTs must abide by when working with Olympic athletes.

Weiss notes that during the games, the hardest part often involves dealing with non-athlete issues that pop up due to the event's large physical and vast cultural scope.

"The challenges may be the language, or sometimes a venue can be in a remote location. To coordinate with emergency services can be quite difficult unless practiced beforehand," he says.

When working with world-class athletes, Lou says it's important to understand that they are both the same and different from recreational athletes. For instance, they need the same foundational movement and strength as others do. They need to get to a different physical level, however, and what they are willing to do to achieve that also is different.

"Sometimes we try to make the exercises unique and high-level for these athletes when they're lacking the requisite core stability," she says. "The level of strength, power, speed, and overall play is at a higher level than for those just getting back to recreational sport. They need more than to return to play. They

need to return to performance at the same or a higher level than before."

When it comes to risk, that's much greater, as well. For world-class athletes, the stakes are high — including competition and endorsements.

"Depending on the situation, the level of risk we're willing to assume may be higher than for a weekend warrior who loves to play basketball but whose number-one priority is childcare," Lou says. "And for an Olympic athlete, the level of risk we're willing to assume just before the games is even higher, since the next opportunity may be four years away or maybe never again."

The athletes often know exactly what they want because they've been on a strict schedule for a long time, Lou explains. A PT, therefore, must factor in their dedication and not look to make drastic changes.

"I still analyze everyone through the same professional lens," Butler says, "but I also keep in mind that they have their coaches and have been doing things a certain way for a long time. That makes it difficult to reinvent the wheel. You have to be respectful of how you can retrain their muscles a little differently while still showing respect for their technique."

One of the biggest challenges, he adds, is that these athletes have hard deadlines for their competitions — specifically, world championships, trials, and the Olympic Games. The challenge is being respectful of the healing time required for the injury while enabling athletes to continue to train and compete at the highest level.

"You need to consider when and how much they need to rest from their sport, or modify how much they are doing, and how to get them back as quickly as possible so they can still gear up for a peak performance," he says.

For PTs who want to work with world-class athletes, Weiss recommends volunteering at one of the training centers.



"You need to consider when and how much they need to rest from their sport, or modify how much they are doing, and how to get them back as quickly as possible so they can still gear up for a peak performance."

— Blake Butler

"This entails filling out an application, with a possible interview and many references," he says. "From that point, you will have the ability to connect with many sports governing bodies and athletes, and improve your possibility of working with them directly."

The Finish Line

Much of what PTs do in working with Olympic athletes can be applied to recreational athletes, as well. Many techniques and services that PTs provide the Olympians and Olympic hopefuls are as helpful to the Sunday softball player, novice runner, or backyard swimmer.

"Working with Olympic athletes challenges PTs to be at their highest level of ability as a practitioner, which carries over into the quality of services they provide to all of their clients and patients," Timm says.

He also believes all PTs should be able to learn something new from their professional peers, whether they

work with Olympic athletes, recreational athletes, or non-athletes.

"I have been incredibly fortunate to have had a variety of experiences with Olympic athletes and at Olympic Games, and I'd be happy to share such information with any PT who aspires to practice in those areas," he says.

Some of the allure of working with the Olympic athletes, Weiss says, comes from a desire to be involved with the best.

"In my opinion, working next to anybody trying to be best in the world at something is simply a treat," he says. "Whether you're going to be the best electrician or the best athlete, the foundation and the common denominator are the same: unrelenting discipline and a will to succeed." ■

Keith Loria is a freelance writer.

Congratulations to the 2020 Catherine Worthingham Fellows!



William Bandy, PT, PhD, FAPTA, Board-Certified Clinical Specialist in Sports Physical Therapy

Leland "Lee" Dibble, PT, PhD, FAPTA

Joseph Donnelly, PT, DHS, FAPTA, Board-Certified Clinical Specialist in Orthopaedic Physical Therapy

Stacey Dusing, PT, PhD, FAPTA, Board-Certified Clinical Specialist in Pediatric Physical Therapy

Theresa "Terry" Ellis, PT, PhD, FAPTA, Board-Certified Clinical Specialist in Neurologic Physical Therapy

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Nominations for the 2021 APTA Honors and Awards Program will be accepted September 1–December 1, 2020.

Congratulations to the 2020 APTA Honors & Awards recipients!



Lecture Awards

52th Mary McMillan Lecture Award

Colleen Kigin, PT, DPT, MS, MPA, FAPTA

26th John H. P. Maley Lecture Award

Timothy Flynn, PT, PhD, FAPTA
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Practice and Service Awards

Lucy Blair Service Award

LeeAnne Carrothers, PT, PhD

Craig Johnson, PT, MBA

Dennise Krencicki, PT, DPT, MA

Charles L. McGarvey, III, PT, MS, DPT, FAPTA

Alan Meade, PT, DScPT, MPH

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Elmer Platz, PT

Paul Rockar Jr., PT, DPT, MS, FAPTA

Dorian K. Rose, PT, PhD

Danny Dale Smith, PT, DHSc
Board-Certified Clinical Specialist in Orthopaedic Physical Therapy and in Sports Physical Therapy

Nicole Stout, PT, DPT, FAPTA
Certified Lymphedema Therapist

Anne Thompson, PT, EdD

Douglas M. White, DPT
Board-Certified Clinical Specialist in Orthopaedic Physical Therapy

Henry O. and Florence P. Kendall Practice Award

Michael Moore, PT

Marilyn Moffat Leadership Award

Sheila Nicholson, PT, DPT, JD, MBA*

Paul Rockar Jr., PT, DPT, MS, FAPTA

Outstanding Physical Therapist Assistant Award

Natalie Christine Noland, PTA, BS

Outstanding Physical Therapist-Physical Therapist Assistant Team Award

Christine Davidson, PT and Nanako Barry, PTA

Societal Impact Award

Skye Donovan, PT, PhD

Board-Certified Clinical Specialist in Orthopaedic Physical Therapy

James Cole Galloway, PT, PhD, FAPTA

James R. Giebfried, PT, DPT, MA

Humanitarian Award

Justin Dunaway, PT, DPT

Board-Certified Clinical Specialist in Orthopaedic Physical Therapy

Michael Geelhoed, PT, DPT

Board-Certified Clinical Specialist in Orthopaedic Physical Therapy

Meredith Harris, PT, DPT, EdD

Cathie Smith, PT, DPT, PhD

Board-Certified Clinical Specialist in Pediatric Physical Therapy

Publications Awards

Chattanooga Research Award

Amit Kumar, PT, PhD, MPH, Deepak Adhikari, Amol Karmarkar, PhD, Janet Freburger, PT, PhD, Pedro Gozalo, PhD, Vince Mor, PhD, and Linda Resnik, PT, PhD, FAPTA, for their article "Variation in Hospital-Based Rehabilitation Services Among Patients With Ischemic Stroke in the United States," published in Physical Therapy, Vol. 99, No. 5.

Dorothy Briggs Memorial Scientific Inquiry Award

Richard Severin, PT, DPT, Edward Wang, MD, Adam Wielechowski, PT, DPT, and Shane A. Phillips, PT, PhD, for their article "Outpatient Physical Therapist Attitudes Toward and Behaviors in Cardiovascular Disease Screen: A National Survey," published in Physical Therapy, Vol. 99, No. 7.

Helen J. Hislop Award for Outstanding Contributions to Professional Literature

Kirsten Ness, PT, PhD, FAPTA

Jules M. Rothstein Golden Pen Award for Scientific Writing

Daniel L. Riddle, PT, PhD, FAPTA

Research Awards

Eugene Michels New Investigator Award

Trisha Kesar, PT, PhD

Daniel Kenta White, PT, ScD, MS

Marian Williams Award for Research in Physical Therapy

Christopher M. Powers, PT, PhD, FAPTA

Education Awards

Dorothy E. Baethke-Eleanor J. Carlin Award for Excellence in Academic Teaching

Mark Bishop, PT, PhD, FAPTA

Signe Brunnström Award for Excellence in Clinical Teaching

Sara E. Wallace, PT, DPT

Margaret L. Moore Award for Outstanding New Academic Faculty Member

Leah Lowe, PT, PhD

Board-Certified Clinical Specialist in Pediatric Physical Therapy

F. A. Davis Award for Outstanding Physical Therapist Assistant Educator

Jennifer L. Jewell, PT, DPT

Minority Initiatives Award

"Preparing Our Tomorrow Uniquely in STEM" (POTUS) Fellows Program

Tennessee State University

Scholarships

Mary McMillan Scholarship Awards

Elizabeth Hermodoson-Olsen, SPT, St. Catherine University

Allison C. Kemp, SPT, Indiana University

Kaylee Pobocik, SPT, Elon University

Brittanie Brantley, SPTA, Institute of Technology

Mary Underwood, SPTA, Somerset Community College

Minority Faculty Development Scholarship Award

Kellee Harper-Hanigan, PT, DPT

Board-Certified Clinical Specialist in Geriatric Physical Therapy

Minority Scholarship Awards

Mercedes Aguirre, SPT, Rutgers Schools of Health Professions

Gabrielle Blanchette, SPT, University of Southern California

Alicia Canton-Rodriguez, SPT, University of Miami Miller School of Medicine

Juan Pablo Gonzalez, SPT, University of Miami Miller School of Medicine

Rachel Herron, SPT, Pacific University

Diana Cordova, SPTA, Cerritos College

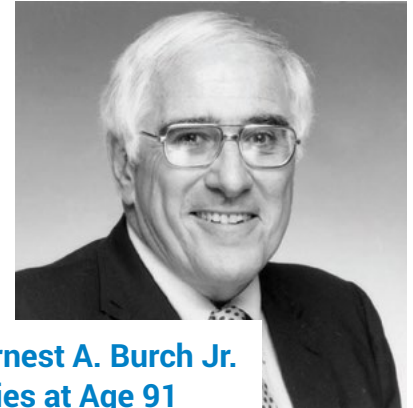
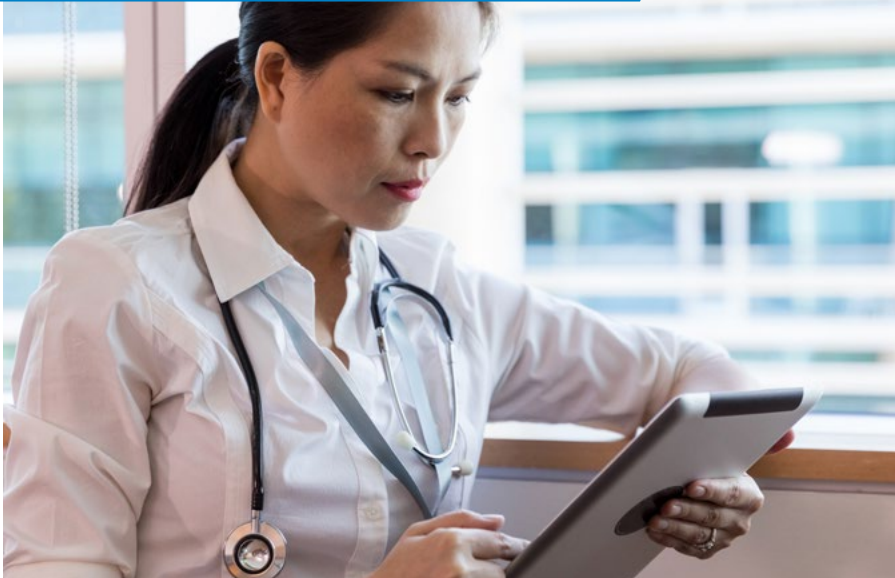
*Awarded posthumously

This could be you! The call for nominations for the 2021 APTA Honors & Awards Program is open September 1–December 1, 2020.

Visit apta.org/HonorsAwards to learn more about the recipients and awards.

Health Care Headlines

We've compiled highlights of stories published in APTA News for a recap of reports on the physical therapy profession.



**Ernest A. Burch Jr.
Dies at Age 91**

Ernest A. Burch Jr., PT, FAPTA, considered a pioneer in physical therapy, had a highly successful career that included work at Union Memorial Hospital in Baltimore and establishment of a private practice that eventually expanded to 10 offices. Burch also was known for the depth and breadth of his service to APTA, where he served as vice president of the Board of Directors and as chair of the Nominating Committee, among other roles. In the 1970s, he became a leading advocate for physical therapist autonomous practice legislation in Maryland. APTA CEO Justin Moore, PT, DPT, described Burch as a “gem and a gentleman” who was “a stalwart for physical therapy advocacy.”



Find the full text of these stories and more at apta.org/APTANews

Commercial Insurers Continue To Embrace Telehealth

BlueCross BlueShield of Tennessee announced that it is making coverage of in-network telehealth service, including telehealth services delivered by PTs, a permanent part of its benefit packages rather than an exception carved out in response to the COVID-19 pandemic. Meanwhile, Humana took its first step into full telehealth adoption by expanding its temporary telehealth provisions to include a wider range of providers — PTs, occupational therapists, and speech-language pathologists among them. The Humana expansion applies to both participating/in-network providers and specialty providers, as long as the services don't violate state laws and regulations.

TRICARE Allows Telephone-Delivered Services, Drops Copays

TRICARE, the health insurance used throughout the military, has adopted a new interim rule that allows for the use of audio-only remote services for office visits “when appropriate” and eliminates copays for beneficiaries who receive services delivered via telehealth. The rule, which became effective May 12, also relaxes provisions around licensing requirements for providers. It will remain in effect until the COVID-19 public health emergency ends.

PTA Home Health Maintenance Therapy Codes Ready for Use in October

Since January, PTAs have been allowed to provide maintenance therapy under Medicare, but something had been missing — namely, the distinct codes indicating when that type of service was being delivered. The codes now are identified: G2168 for PTA-provided therapy (as well as G2169 for therapy provided by an OTA). But it's premature to start using them quite yet. The change won't go into effect until October 5, but it will apply to dates of service as far back as January 1. Until then, HHAs should continue to report G0157 for PTA services provided in 2020.

APTA Leading The Way

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

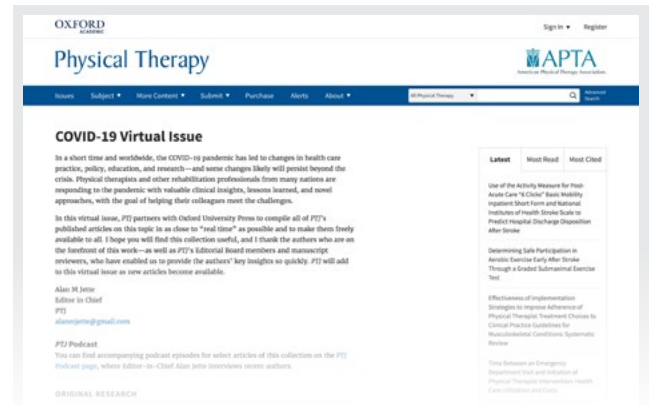
Contributing to Updated National OA "Agenda"

Developed through a collaborative effort between the U.S. Centers for Disease Control and Prevention, the Arthritis Foundation, and the Osteoarthritis Action Alliance, of which APTA is a member, the 2020 update of the National Public Health Agenda for Osteoarthritis describes OA as "still an under-recognized chronic condition." The report states that OA is estimated to affect one in seven Americans, and that, given growing obesity rates and an aging population, its prevalence is likely to increase in the coming years. The agenda offers eight strategies for addressing the problems, with an emphasis on the importance of physical activity and evidence-based self-management programs.



Support for Diversity, Equity, and Inclusion on Track

APTA believes one of the best ways to foster the long-term sustainability of the physical therapy profession is to make the association an inclusive organization that reflects the diversity of the society served by the profession. Recently, APTA acted on that belief by taking four important steps: establishing a standing committee on DEI, expanding its fundraising efforts through a "Campaign for Future Generations," creating a new "Dimensions of Diversity" fund, and outlining a new APTA director of inclusion staff position, set to begin in 2021.



PTJ "Virtual issue" Fast-Tracks COVID-19 Research and Perspectives

APTA's scientific journal is a platform for sharing its latest COVID-19-related research and perspectives at a rate not possible through the normal PTJ publication process. The journal is free to members, and the virtual issue contains open-access work that is free to everyone. The virtual issue isn't a static resource; PTJ regularly adds new accepted manuscripts. The result is a collection of articles that, while not in final copyedited form, are as fresh from authors as possible.

Components Compile Collection of COVID-19 Resources

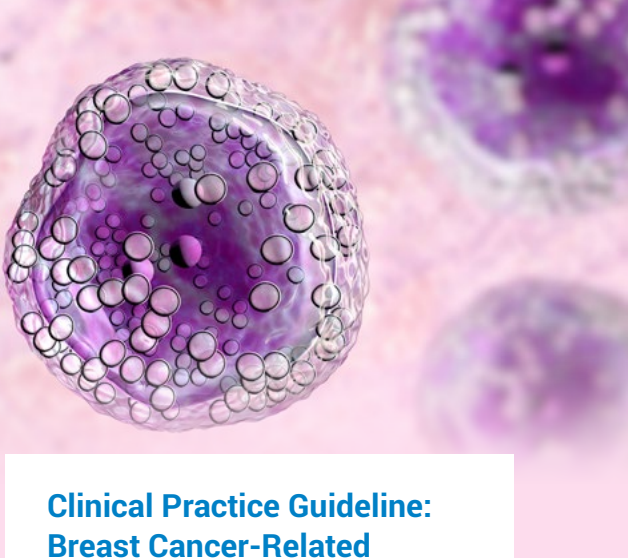
The COVID-19 pandemic triggered an unprecedented effort among APTA components to provide resources that deliver expert perspectives and insights on a wide variety of topics. Sometimes from a single component and at other times through collaboration, the offerings are proof that the physical therapy profession is committed to responding to the health emergency with tenacity and compassion, through a unique set of skills and expertise.



Find the full text of these stories and more at
apta.org/APTANews

PTJ's Editor's Choice

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



Clinical Practice Guideline: Breast Cancer-Related Lymphedema

Some data suggest that as many as one in five breast cancer survivors may develop breast cancer-related lymphedema, significantly lowering quality of life and interfering with participation at home and in the community. In a follow-up to "Diagnosis of Upper Quadrant Lymphedema Secondary to Cancer: Clinical Practice Guideline From the Oncology Section of the American Physical Therapy Association," PTJ in July publishes "Interventions for Breast Cancer-Related Lymphedema: Clinical Practice Guideline From the Academy of Oncologic Physical Therapy of the American Physical Therapy Association" by Davies and colleagues.

A work group from the Academy of Oncologic Physical Therapy, supported in part by funding from APTA, developed evidence-based practice recommendations and assigned a grade based on the strength of the evidence for each intervention. To help clinicians apply the guideline to patients, recommendations are presented by modality throughout the care trajectory and according to International Lymphology Society stages of cancer.



Find these and other articles at academic.oup.com/PTJ

Also in July: COVID-19

Some of the first articles about how physical therapists are responding to the COVID-19 emergency are published in the July issue. They provide insights from colleagues — across the globe and at home — who are on the front lines. (Some of these articles were mentioned in this space last month in APTA Magazine's predecessor, PT in Motion, when they were accepted manuscripts but not yet published. The published versions now are available.)

From Italy — one of the countries hardest and earliest hit.

Pedersini and colleagues share examples of physical therapist intervention and contribution to multidisciplinary teams in the acute hospital phase of COVID-19. They also describe efforts to create a "PT task force" to quickly improve skills and knowledge and to take action, even as therapists live with the fear that they and their families are at risk of infection.

From Portugal. Alpalhão and Alpalhão describe strategies to preserve safety and other practice adaptations in situations in which regulatory rules mandate that only urgent care should be provided for the duration of the pandemic. Each physical therapist has the discretion to determine which cases could benefit the most from intervention, resulting in asymmetrical access to care.

From the Digital Physical Therapy Practice Task Force of the World Confederation for Physical Therapy. Lee shares recommendations on digital physical therapist practice and guidelines on future directions in advancing digital practice, telehealth, and education in the physical therapy profession in the wake of COVID-19.

From the ICU and beyond. Smith and colleagues report on the prevalence and clinical presentation of post-intensive care syndrome. Many individuals recovering from COVID-19 could benefit from physical therapist services after hospital discharge; the authors provide recommendations for physical examination and outcomes measures, plan of care, and intervention strategies for PICS, aimed at rehabilitation services outside of acute and postacute inpatient settings.

From the public health arena. Community physical therapist services are reduced during the pandemic. Falvey et al argue that home- and community-based physical therapist services should remain open and available, as substantial evidence supports their role in decreasing new hospitalizations. Likewise, use of physical therapists in emergency departments has been associated with shorter wait times, less overcrowding, and lower rates of admissions for acute musculoskeletal conditions.

Student Focus

APTA's student blog, The Pulse, is written for students, but it includes worthwhile reads for everyone in the profession. The following is excerpted from a post by Sarah Rice, PT, DPT, a recent graduate of Northwestern University.

Adapting to Navigate Uncertainty

We all know that whenever a physical therapist is presented with the question of what to do in a patient care scenario, the answer is "it depends."

It depends on the patient's ability, available resources, and personal desire. These things aren't always clear at the outset of a session, so we go in with plans A through F, then use patient feedback, clinical reasoning, and outcome measures to identify the plan that best enables our patient to progress toward their goal. We also know that the first thing you try often doesn't work. So the process of navigating "it depends" is as much about adaptation as it is about preparation.

One day, I got called into a room and told that my clinical experience was over due to COVID-19. Just like that.

I was stunned and scared, like everyone else in the class of 2020, when clinicals ended abruptly. I spent about a day scrolling Facebook and the news. One friend posted a picture of her colleague, an emergency room doctor, who had put a plastic container over his head to intubate a patient because he had no face shield. That image had a profound effect on me.

Three weeks ago, my husband and his colleague from DePaul University gained permission to run DePaul's 3D printers at home to join a nascent worldwide effort to quickly manufacture personal

protective equipment, or PPE, items that throughout this pandemic have been in short supply.

We converted our house into a factory and simultaneously founded the Illinois PPE Network, a large distributor network making 3D-printed face shields and cloth masks. To date, the network has made more than 25,000 face shields, with more than 2,000 produced in our home.

We have sent face shields to emergency rooms, hospitals, rehab clinics, nursing homes, fire departments, shelters, and other locations where personnel work with COVID-19 patients, both in Chicago and beyond.

I have never worked harder in my life than I am now. My days are spent fielding requests from desperate clinicians, repairing 3D printers that have broken down from being run 24/7 for weeks on end, and sanitizing and packaging face shields for delivery.

Adaptation, reflection, and more adaptation are the hallmarks of this effort — skills that I learned in physical therapy school.

PPE is lifesaving technology that is simple but often inaccessible at the moment, and this is exactly the problem that chronically faces medically underserved populations. This experience has left me motivated to devote my future physical therapy career to the medically underserved.

I am proud to be a physical therapist. We are professionals who can hack together solutions to help individual patients surmount barriers to activity, address health disparities by making best-practice physical therapy available when the best resources aren't, and even help provide a solution to a global health crisis full of unknowns.



Read the full story from April 29, 2020: "Adaptation, Reflection, and More Adaptation"

Sarah Rice



APTA Member Value

APTA offers value for your membership in any number of ways. Here are just a few examples.



3 Quick Ways to Use APTA to Your Advantage

1. Advocate Your Way

Have you been moved to action these last few months on a federal issue affecting the way you practice? Maybe you've been working with telehealth as an option during the national health crisis and would like it to be considered a permanent care option. If you have five or ten minutes and want to make a difference, APTA makes it easy to contact Congress with pre-written letter templates and quick access to your legislators. Visit the APTA Legislation Action Center, download the APTA Action App, and place this information at your fingertips. To get started learning about current activities and how you can make your voice heard, go to apta.org/Advocacy.

2. Share ChoosePT.com With Your Patients and Clients

APTA's award-winning website helps the public understand the benefits of physical therapy and what PTs and PTAs do for patients and clients, and for the health of society. For just one example of what's available, check out the Symptoms & Conditions tab if you're looking for digestible guides on how a physical therapist can help with various conditions. Also, in response to the national health emergency, APTA has added consumer-friendly information on staying physically active during social distancing, and on how PTs and PTAs can furnish telehealth services — something patients likely will continue to ask for even after the health crisis passes.

3. Participate in the APTA Community

Are you interested in gaining new leadership skills? Do you have a story or success to share and don't know how to share it? Check out APTA Engage for ways to get involved. APTA Engage is a volunteer portal where you can search and apply for a wide range of opportunities. Even if you're not ready to volunteer today, you can sign up, indicate your expertise or interests, and opportunities that match those will be sent to you as they arise. Get started by visiting engage.apta.org to view current opportunities to get started.

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Food for Thought — and Action



Ann W. Jackson, PT, DPT, MPH, is a senior fellow at the University of Chicago's MacLean Center for Clinical Medical Ethics.

As we move through life, we are confronted by moments, unexpected and unplanned, that can change us forever, if only we allow them to do so.

My mom spent a lot of time during the summer driving us kids to our various activities—swimming, music lessons, and the like. The summer before I turned 11, I started noticing along our route an older couple who were sitting on their front porch every day. Within a few months I began waving to them. Soon they were waving back.

Things went on like this for nearly a year. What struck me about the waving couple on

the porch was that their clothes seemed to be more or less the same whenever we drove by, even when we were out running errands along their road on crisp fall days or in the winter. I became more and more curious about them. One day, nearly a year after I'd first noticed the couple, I asked my mom to stop the car.

When she did, I bounced onto their porch and introduced myself. Up close, I immediately saw, they were thinner and frailer-looking than they'd appeared from the road. Over the course of that visit and several subsequent ones, I learned not only their names,

but also why they spent so much time on the porch, and why their wardrobe changed no more than sometimes adding a thin jacket to the mix.

They were a brother and sister in their 70s who had no other living relatives. Sitting on the porch was cooler than was sitting in their non-air-conditioned house during the hot Georgia summers, and the scene from the porch was a lot more interesting than from the confinement of their sparsely furnished dwelling in the colder months. I learned that arthritis limited both their self-care abilities and their confidence to venture into the world beyond their porch.

Over the next two years, our family stopped in frequently to share food, clothing, and company. Becoming their friend and seeing and understanding the challenges they faced each day was a spark that ignited my trajectory toward becoming a physical therapist and an advocate for people in vulnerable populations.

During high school and college I worked with the American Red Cross and other organizations that serve people in need. While preparing myself academically to enter PT school, I regarded my subsequent PT education as an extension of my commitment to service.

A few years later, having given birth to twins with developmental challenges, I changed my clinical focus from adult neurology to pediatrics, seeing opportunities there to better help meet the needs of children and their families.

In fall 2015 I was diagnosed with cancer. As I was sitting with my head down, trying to get through my second three-hour chemotherapy treatment, I started watching and listen to others who were navigating this frightening and unsettling space. What I soon found was that many of my fellow cancer patients also faced collateral losses associated with lost or reduced wages.

One mom, having just started a four-hour chemotherapy session, looked over at her son and asked if he was hungry. He was, so she reached into her purse and withdrew five \$1 bills and some change. They conferred and decided on five items from the oncology

floor's vending machine. That ragtag collection of snacks constituted their shared lunch.

Another time, an older gentleman said he was hungry, reminding the woman who I assumed was his wife that the early start time to chemotherapy had precluded breakfast. In a hushed tone, she told him she was sorry, but she barely had enough money in her pocketbook to cover their parking. So, as the chemicals filled his veins, his stomach remained empty.

These overheard conversations caused me to sit up from my own discomfort, lift my head, and resolve to do what I could to turn this challenge into an opportunity to effect change. It was my defining moment. Combining my training as a PT with my experience as an advocate for vulnerable populations and my scientific interests, I became — per the words of Mahatma Gandhi — an agent for the change I wished to see in the world.

Over the next 12 months, I worked with a team of dedicated professionals from across the University of Chicago's health care system, where I'd been receiving my cancer treatment, to conduct a strength-based assessment of the food-related issues I'd identified. We concluded that a great deal of education, training, advocacy, and research would be needed to address these problems. Along the way, I learned there was a name for what my fellow cancer patients were experiencing: food insecurity.

A series of events ensued that provided me with the opportunities and tools I needed to address this challenge: I was appointed to the University of Chicago's Comprehensive Cancer Center Patient and Family Advisory Council; was accepted into the University of Chicago's MacLean Center for Clinical and Medical Ethics' fellowship program; and attended an eye-opening lecture on food insecurity by Stacy Lindau, a physician and University of Chicago professor who long has been deeply involved in seeking solutions to issues of social injustice that impact patients and communities.

The Patient and Family Advisory Council advocated to add healthier offerings to the

Defining Moment spotlights a particular moment, incident, or case that either led the writer to a career in physical therapy or confirmed why he or she chose to become a physical therapist or physical therapist assistant. To submit an essay or find out more, contact Associate Editor Eric Ries at ericries@apta.org.

food cart that travels throughout the cancer center. We further asked that food cart vouchers be provided to all those in need who were there receiving care for at least four hours.

The council's actions spurred opportunities to educate medical staff on how to identify signs of food insecurity and what to ask patients to obtain needed information. Medical staff were encouraged to share with social services personnel instances or reports of patients and caregivers skipping meals, lacking the money to buy food, or being unable to eat balanced meals.

As this was happening, I sowed the seed planted by the Lindau lecture, designing my fellowship research project around analysis of food insecurity rates among individuals with cancer who were receiving care at the hospital and in the surrounding community. The research found that this subset of people was experiencing greater food insecurity than was the general population.

The most profound change arising from the efforts of many people connected with the University of Chicago, led by its Feed1st team, has been the creation of a food pantry of shelf-stable items — including canned goods, nuts, rice, noodles, supplemental nutrition drinks, and broths — that's located in a quiet, easily accessible location within the infusion area. Like the preexisting food pantries that Feed1st supports throughout the university's health care system, it is open access — meaning the food is free and available to all patients and their families at any time of day or night, with no limits on how much food anyone can take.

The food pantry within the infusion area quickly became the most utilized of the six now available. Since opening in November 2017 and

based on self-reported numbers, the cancer center's food pantry by early this spring had served approximately 2,575 households, representing 7,534 individuals. It's been so gratifying to have played a role in this initiative.

As my advocacy and pursuit of practical solutions has continued, my colleagues and I have worked to raise awareness at the national level. Earlier this year, my PT colleague Betsy Campione and I gave a two-hour presentation at APTA's Combined Sections meeting in Denver titled "Obesity, Food Insecurity, Nutrition, and Functional Impairment: What is the Role of Physical Therapy?"

Now with the COVID-19 pandemic, the need for food assistance has grown exponentially. Job losses and associated loss of income, increased need from families sheltering in place, and limited family participation in federally subsidized food programs all have conspired to increase

food insecurity. PTs and other frontline health care providers are ideally positioned to help mitigate this growing crisis by including food insecurity screening questions in our initial assessments, knowing where to find food and nutrition resources within our community, and, where possible, creating scalable, open-access food pantries within our work spaces to help fill the most immediate needs of patients and community members.

The recurrent thread throughout my life experiences — from befriending those siblings several decades ago to truly hearing the words of that hungry chemotherapy patient — has been the truth that it is within our power, and that it is incumbent upon each of us, to recognize the opportunities that lie within the challenges we identify.

We all are confronted with unexpected moments that can alter the course of our lives. It's up to us to accept their call. ■





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