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Making the Connection: A Guide to Social Media, Blogging, and Other Online Tools

Many PTs and PTAs are using social media and blogging for everything from networking to education. Here's what they're doing and how you can start.

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How the effects of the pandemic will permanently change physical therapist practice.

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“Social media has been a great way for patients to connect with us. It also has allowed us to connect with other providers and fitness influencers all over the world, and we have built some pretty cool relationships from it. We want to build a community, not a clinic.”

Ronald D. Peacock Jr., PT, DPT, in “Making the Connection: A Guide to Social Media, Blogging, and Other Online Tools,” on Page 26.

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APTA welcomes your opinions and encourages diverse voices.

Opinion

Personal Trainers vs. Physical Therapists

As physical therapists, we pride ourselves on being the movement experts. We constantly are defending our services against the services of personal trainers. While we have the diagnostic skills and the injury progression rehabilitation skills, I feel that the physical therapy profession lacks knowledge of appropriate exercise progression. The end of a rehabilitation cycle should look very similar to a gym session with a personal trainer, because that is usually the patient's goal.

No one's goal is to be able to do 100 clamshells on a table. Why are we so hesitant to relate ourselves to trainers? Trainers progress strength. Trainers assess mobility. Trainers encourage appropriate recovery between sets of an exercise, and good trainers also will incorporate nutrition and stress management into their systems. These are all concepts that parallel the goals of physical therapy, but trainers do it with heavier weights.

I'm not saying the professions are the same. Our physical therapy training provides advanced diagnostic skills, a proper understanding of how to load healing tissue, and how to load bones safely after injury. We have expert knowledge of the neuromuscular system, advanced knowledge of functional anatomy, and are skilled in using various modalities that aid the healing process.

If we want to separate our skill set from the personal trainers, we'd better be as good or better at doing the activities where we overlap. We claim the "expert" card when it comes to functional movements such as lifting, carrying, pushing, pulling, hinging, and squatting. And we should! But we'd better know how to teach someone to hinge and squat to perform a deadlift safely if we're the experts. Rarely do I see this type of training in a standard physical therapy clinic. Too often patients are restricted to bodyweight-only exercise when the body really needs a heavier load.

I propose that instead of saying the two professions are entirely different, we acknowledge our similarities and, in all aspects, become the better of the two. Train PTs to become more competent in the progression of functional movements. Train therapists how to appropriately progress heavy loads. Make physical therapy the go-to profession for rehabilitation and wellness instead of leaving it up for debate.

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Coming Out Made Me a Better PT. Your Journey, Whatever It Is, Can Do the Same

(This article is the opinion and experience solely of the author and does not reflect the position of her unit, the United States Army, or the Department of Defense.)

I'm transgender. Chances are, you're not. I'm a lesbian. Chances are, you're not. I'm also in the Army. Chances are, you're not. The thing is, none of that matters.

The bottom line up front, or BLUF, as we say in the Army, is this: We are all more the same than we are different. We all have challenges and defining moments. We all go through transitions. It's what we do with those experiences that matters.

Think back to the last time you experienced something difficult or something that just made you pause ever so slightly. It doesn't have to be a big dramatic event, just something that you noticed. What did you do with that experience? Really think about it. Did you learn from it? Did you grow? Did it change how you think about the world or how you interact with people? Did it change you?

It took a massive event in my life for me to change — my coming out as transgender. I'm going to share some of my story with you in hopes that it will stir something in you. Perhaps it will remind you of yourself: maybe your best self, or your worst. Maybe it will remind you of a patient. Or a friend.

My story is one of a big, public shift that resulted in me changing my life, but I strongly believe that the only thing required for us to meaningfully change is to pay attention. We don't have to have some dramatic life event; we just have to choose to be attuned to someone else's world.

Being a technically competent therapist is the easy part of our job. It's the emotional labor of truly knowing and caring for our patients that pushes our care from average to excellent. I think you already know this. I hope my story reminds you how much it matters.

I came out to the world as transgender in May 2017. Some people knew before then, but that was the first time it was public. As a kid I knew I was supposed to be a girl, but I had no language for that. It was just a feeling, a knowing in my gut. I couldn't find the words until my ex-wife encouraged me to go to therapy to sort through it.

That was in 2010, though, so when I figured it out, there was nothing to be done. I was in the Army, and at the time I could have been discharged for coming out.

Then, in 2016, just before I graduated from the U.S. Army-Baylor DPT program, the Department of Defense's policy changed to allow open service by transgender people. This was significant to me, because for the first time I would be able to serve in my chosen profession as who I actually am.

My story is one of a big, public shift that resulted in me changing my life, but I strongly believe that the only thing required for us to meaningfully change is to pay attention.

When I arrived at my first clinic, I came out to my boss (who was incredibly supportive) and began the administrative, medical, and legal process of transition.

Transition is difficult for a lot of people because of the systemic discrimination in and barriers to medical care, housing, social support, and employment. I mentioned before that my qualifications and experiences in the Army have granted me significant privilege in the system, and here is where it mattered: I was able to proceed through transition relatively quickly and easily. I had fewer hurdles to jump, and they were lower. It was more difficult for people to tell me no, or even for them to simply be rude or make things difficult for me.

For me, the difficulty in transition has been the internal reckoning. The increasing awareness of how big the gap is between the person I am becoming and the person I used to be. More important, transition was a

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trigger that has enabled me to be more attuned to the experience and context of those around me.

Most often, my awareness happened in little ways. For example, the first time after transition that I felt cold.

All my life, I have been hot far more often than I have been cold. After transition I realized that I instead was frequently cold: in public spaces, in my home, in other people's homes. I hadn't changed the temperature of my thermostat, and it was unreasonable to assume that everyone else had. The only logical explanation was that starting hormone replacement therapy (I began taking estrogen, as well as a medication to block testosterone production) had caused me to experience temperature differently.

Accompanying that realization was the deeply uncomfortable and embarrassing fact that in years past I had been wildly insensitive and dismissive to many women when I had written off their opinion or feeling that "it's too cold in here" as inaccurate or unimportant.

As I continued to have many more big and small epiphanies, I went back and apologized to the people I dismissed or ignored or even shamed. And I have chosen to be better: I have stopped acting that way and instead tried to channel these experiences into advocating for other marginalized groups — most often women and the LGBTQ+ community, but also (important in my context) young soldiers who may not be able to advocate effectively for themselves.

When I hear conversations about the experiences of marginalized communities, I am quite clear and vocal about agreeing with those communities, to say, "No, you should believe them, they're telling the truth."

Because of course they are. They've always been telling the truth. What I didn't realize prior to my transition was that I had been so attuned to my own experience or context (as a presumably heterosexual, cisgender male) that I just assumed it was "normal," and universal. I recognize this is cringe-y: It makes me sound arrogant, self-absorbed, and inconsiderate. As I look back, I am certain that I was arrogant, self-absorbed, and inconsiderate. As impossible as it seems, I somehow didn't realize that 50% of my peers experienced the world in ways that were radically different from the ways I did, even though I'm quite sure many of them told me so repeatedly.

I just wasn't listening.

So, I changed. I started listening. And, when you start listening, the world changes.

When people feel heard, they will talk. They'll tell you things that they've needed to say out loud but haven't dared. They'll ask for help. They'll tell you the things that matter most, the things they're most proud of, most ashamed of, most afraid of. As I listened, I realized there was a whole world I had previously missed. Everyone else had a "normal," too, and those normals weren't the same as mine. Here are just a few of the things I've heard, and observations I've had, once I really started listening:

"You're the first medical provider in my career who has believed me." (You mean to say that people haven't believed you all this time? What if my doctors hadn't believed that I am a woman?)

"No, it's not really better, but I feel better — I just needed someone to listen." (Me too — sometimes I just need to be able to say it.)

"I haven't been able to have sex with my spouse for a year, and I haven't felt safe telling anyone until you asked." (Whoa. That's a lot.)

"My sibling is transgender — how can I help them?" (This has nothing to do with why you're here! But somehow you feel safe enough to ask this. Let's talk.)

"No, you're right — I'm not the same guy I used to be. Nothing in my life has felt the same since that concussion on my last deployment. Can you help me?" (Oh, no. I mean, I suspected it. But I was really hoping I was wrong. I hope we can help you.)

I've found sexual harassment and assault to be so common that it is unusual when my female patients don't have that in their history.

I have yet to meet a woman in the Army who, when I ask, doesn't have a list of stories about how she has been treated unfairly because of her gender.

I have been surprised to find how many of my male patients are afraid to talk about what's really happening with them physically, medically, or emotionally. Yet when given the opportunity to do so, they are deeply grateful for the opportunity to safely talk.

As I look back, I am certain that I was arrogant, self-absorbed, and inconsiderate. As impossible as it seems, I somehow didn't realize that 50% of my peers experienced the world in ways that were radically different from the ways I did, even though I'm quite sure many of them told me so repeatedly.

These experiences have changed how I practice. Being open and authentic with my patients, being present and truly listening, has increased my awareness and my empathy.

When I showed up in the far north of Afghanistan to treat some patients, the first thing I asked the folks there was, "When do you want me to be available to treat you?" I could have showed up and announced what my clinic hours would be. But I knew there was a high likelihood they were on a reverse sleep schedule, working at night.

They were shocked that I was willing to shift my sleep schedule to accommodate them, and it meant the world to them. It meant that they actually showed up to get care.

I had a patient arrive one day and tell me during the subjective exam, "I haven't slept more than two hours a night for the last two days and I'm exhausted." After treating his back pain, I offered to turn the lights off and let him sleep in the exam room on the treatment table because my next patient had cancelled. He was asleep before I got out the door.

Another time, at the end of her appointment, a patient said to me, "I don't want to take up your time, but you're an older woman I trust — can I talk to you about something? I've heard bad things about the place I'm going next and I'm worried about getting raped." I told her she could have as much of my time as she wanted. There was nothing more important than being there for her in that moment.

So, here's the thing: Remember when I said that my being a gay, transgender woman doesn't matter? That this applies to everyone? My being transgender doesn't have a thing to do with my technical skill as a physical therapist. But becoming a better human being has everything to do with being a better provider: how I responded to that experience, my choice to reflect and change and become attuned to other people's worlds.

You don't have to be transgender, or gay, or have had cancer, or have lost a child, or any number of other difficult things to become a better human being. You just have to make the choice.

Come back to that experience I asked you about at the beginning. That thing that caused a brief flicker of something in you. Did it change you?

If it didn't, don't beat yourself up. Just get to work. When the next moment comes, pay attention. If you do, it just might change your world. If we all do, we can change the world.

MAJ. ALIVIA KATE STEHLIK, PT, DPT
BOARD-CERTIFIED ORTHOPAEDIC CLINICAL SPECIALIST

(Alivia is an active duty Army major currently serving in the 3rd Security Force Assistance Brigade at Fort Hood, Texas. A version of this originally appeared as "My Journey as an Army PT Who's Transgender Made Me a Better PT. Your Journey, Whatever It Is, Can Do the Same" on June 8, 2021, as a perspective piece on apta.org.)

No One Way To Be a PT

I still remember it: In my PT school interview, I was asked, "What do PTs do other than patient care?"

On that day, I had no answer. Now, many years later, the answers to that question are still revealing themselves.

Becoming a physical therapist would give me a skill set that was much broader than I realized at the time. The problem-solving abilities I developed have benefited me both personally and professionally, but it was recognizing what energizes me that has guided my less-than-conventional path as a physical therapist, from clinic to classroom and beyond.

From Physical Therapy Student to PT

In 1993, leading up to graduation, hanging outside the classroom was a sign offering internships in London, England, in law and health care. At the time I was looking for adventure, away from the town where I grew up, and saw it in that sign. I did not know where I wanted to practice, I wanted to travel, and I had no fiscal responsibilities yet. This three-month adventure allowed me to see how another health care system functioned and to meet and work with therapists from England, Ireland, and South Africa. I saw that much that I took for granted in the United States is not a universal experience. Attitudes that I thought were human nature were in truth U.S. attitudes. Work was not the central focus of everyone's lives, and taking a month-long vacation was a routine activity.

Helping a patient figure out how to safely get wood from a woodpile on the deck into his wood stove, when he had recently had a stroke and was alone most of the day, was one of my favorite problem-solving tasks.

I returned to the U.S. not only with a midwestern-British accent but also with the readiness to take the board exam and get a "real" job.

I moved three states away from the only town I had ever lived in. I did this to push myself out of my comfort zone. I located a hospital near the mountains in Pueblo, Colorado, and got a job in acute care. There I met a great group of therapists and, after two years of practice, applied for my first leadership position. I did not get it, but, in hindsight, I was not qualified yet. I was aware enough to ask why I did not get the role, and the answer was that I was less ready to lead than the other applicant who had more experience. It did not deter me from pursuing leadership positions, but I was beginning to learn that leadership is a behavior, not always a title.

Three years after arriving in Colorado, I moved to northern California, to a county that had 13,000 people and no stoplight. I worked in a small clinic and saw the full variety of patients — from loggers with worker's compensation injuries, to inmates in the jail with wrist injuries, to home health patients who lived with wood stoves for their only heat. Helping a patient figure out how to safely get wood from a woodpile on the deck into his wood stove, when he had recently had a stroke and was alone most of the day, was one of my favorite problem-solving tasks.

The years of patient care gave me a close look at patient participation versus nonparticipation and pushed me to think critically about patient goal achievement — their goals, not mine. I did not realize it at the time, but I was starting to look at individual factors that made a patient more or less likely to get better and how to best interact with them to encourage their engagement in the recovery process and enable their success.

Adding in Business Ownership

While I was seeing patients, I knew I also wanted to provide care that was not related to rehabilitation of illness or injury but instead related to prevention and to getting or staying healthy. So, I started a small business, Fifty Plus Fitness. It did two things for me: I could provide preventive health care by working with clients who wanted to be proactive about their health in the physical realm, and I could stop documenting to the liking of the insurance companies and instead only document the relevant information for the best client care. I have a small number of clients, due to the volume of activities I perform, and I focus on those with a chronic disease who want to prevent advancement of their disease process or just be more physically fit.

From Clinician to Management

I knew early on that I wanted to work in a larger capacity within health care — to influence organi-

zational processes and decisions that affect more than one patient at a time. Though I could not have articulated that at the time, I wanted the responsibility, knowledge, and growth that comes with formal leadership positions. By this time, I had moved to Kansas City and was working at a not-for-profit community hospital — where I still am today. Twelve years after I'd graduated from physical therapy school, I had grown in my leadership behaviors and skills and was now a home health rehab supervisor. My goal was to help elevate the care provided by the rehab staff to best serve our patients. I was and still am fascinated with leadership and how to lead people to meet the goal of improving patient care. At the time, I managed a rehab staff of 30 PTs, PTAs, occupational therapists, and speech-language pathologists in a home health department in North Kansas City.

I Think I'll Be a Teacher Now

As a supervisor, one of my responsibilities was to interview and hire new staff. My favorite interview ended with the candidate not taking the job we offered but instead connecting me with the owner of a continuing education company. Within a month I was hired as one of their instructors for weekend courses. Through this unexpected encounter, I discovered how much I love to teach. Sharing information with others that makes them a better therapist, employee, or person inspires me.

Another teaching opportunity presented itself at Rockhurst University. I was excited to accept a role as adjunct faculty teaching an undergraduate class on chronic disease and exercise. The students were

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primarily interested in becoming PTs and OTs. Teaching in person is fun and challenging, but teaching a full-semester class to undergraduate students is far different from teaching professionals in a weekend continuing education course. Learning how best to teach them is a work in progress. Throw in COVID-19 and the pivot to online education, and I have spent the last year learning all about didactic methods for remote learning.

But wait, there's more!

From Supervisor to Application Analyst

As I type this, I am on to my next (but not last) twist in my career: I made a left turn into information technology. In my supervisor role, I was integrally involved in our clinical software transition in 2009. It was important to me that the clinical staff had a resource in the office to answer questions and limit the impact on their patient care. I learned everything I could to become that resource. I applied that same skill set of problem-solving that I was taught in my physical therapy education.

The process of problem-solving is the same for treating a patient as it is for troubleshooting a computer. I have the best of all the worlds, remaining on the leadership team and supporting the home health field and office staff, but in a completely different way. I combine the joy of teaching, the fun of problem-solving, and the knowledge of behavioral motivation to teach software use, fix the software, and work with the software vendor. I have a continued focus on helping the staff with the software to enhance patient care while maintaining compliance.

Not Done Yet …

On a Sunday morning in early 2019, I was talking with a PT about her career and where she wanted it to go. She was talking to me because of all the different experiences my path has included. During our conversation, she noted that our talks had helped her clarify what she wanted and her accountability around next steps. She suggested in passing that I become a coach. I had no idea what she was talking about, but after a quick Google search and a couple days of reflection, I knew that coaching appealed to me. Helping people tap into what is important to them and identifying their personal motivating factors to move them toward their own goals is the very thing that interested me when working with patients and staff. So, I became a certified professional coach in January 2020.

Today, I am growing my coaching business, In Progress Coaching, where I help people discover what they really want and how to move forward to achieve it.

When asked now, "What do PTs do other than patient care?" my answer is "Anything they want."

VICKI LANDERS, PT, DPT

(Vicki is a certified professional coach and an Energy Leadership Index master practitioner. A version of this originally appeared as "More Than One Way To Be a PT" on June 10, 2021, as a perspective piece on apta.org.)

Our Experiences Matter When It Comes to Advocacy

It was my first day of work as a licensed physical therapist. I had my usual morning routine and made my commute to the kitchen, where I was going to be delivering services for the next several months.

I never thought I would see my first patient on a computer screen, but it has now become the new norm for me due to the COVID-19 pandemic.

Working as a pediatric physical therapist, I've seen the pandemic transform the parents and caregivers of my patients into teachers and therapists overnight. I know many parents who have quit their jobs to stay at home with their children, who currently work from home and balance the child's therapies during their workday, who have multiple children who receive therapies, or who have disabilities themselves.

Delivering physical therapist services through telehealth has come with its challenges, but it has also increased access to services that are critical for qualified students. Because of telehealth, children have been able to stay active and engage in their therapy sessions despite COVID-19 restrictions. I've been challenged to come up with daily physical activities that families can do together in or around their homes with limited living spaces to promote movement and continue to meet their goals.

But it's not just me. Across the physical therapy profession, we've all become more creative in what we do.

The past year has shown us what we're capable of, but it's also held up a mirror to some of our current federal policies and the ways they can be a help or a hinderance to pursuing those creative, effective approaches. The pandemic has shown the adaptability of physical therapists and the expanded ways we can deliver effective care. Now it's health care policy's turn to be adaptable. And the only way that's going to happen is through work on our part.

The 2021-2022 APTA Public Policy Priorities include a focus on advancing policies that will "increase patient access to rehabilitation services delivered via digital health and telehealth." Telehealth is important in giving patients access to the care they need — and our advocacy efforts are helping to get that message across to legislators. My representa-

tive, Rep. Mikie Sherrill, D-N.J., recently introduced The Expanded Telehealth Access Act of 2021 (H.R. 2168) to ensure that PTs can continue providing telehealth services under Medicare after the public health emergency ends.

APTA also is advocating for an increase in funding for the Individuals with Disabilities Education Act state grant programs. As a school-based and early-intervention therapist, I strongly support this and can speak to it. The IDEA state grant programs help children thrive with their peers, participate safely in their school environment, and achieve family outcomes. These programs help to identify children who qualify as early as possible in order to nourish their growth and participation in their classrooms and their homes. This not only helps the child, but it also helps the child's community and the entire school system.

As an APTA Key Contact in the New Jersey District, I called my legislators' offices and sent them emails with a copy of the APTA Public Policy Priorities, sharing my personal story on how increased funding for the Individuals with Disabilities Education Act state grant programs will help my practice and my patients.

The voice of the profession was heard, and the American Rescue Plan Act was signed by President Biden on March 11, which included funding for IDEA state grant programs. Most early-intervention and preschool programs have not received any additional funding during the pandemic, so this was a great win for early intervention.

But our advocacy efforts don't end there. I suggest taking a look at the APTA Public Policy Priorities and seeing how they align with your own priorities as a physical therapist, physical therapist assistant, or student. I know sometimes it may feel like you are just one person, but sharing your story with your legislators as part of this profession can have a huge impact on legislation on the state and federal levels.

Talking to your colleagues about new policy and legislation is also a part of advocacy because hearing about the different concerns in various settings can be a motivating force.

You also can use social media to spread awareness about legislative and public policy issues. For example, I use my blog and Instagram account to share the status of a new bill and ask my followers questions on how the bill will affect their practices. I have spoken at student special interest group meetings about how they can best advocate for topics such as the Physical Therapy Compact and other changes to their state practice act.

I know I am not the only physical therapist wrapping up work after a long day thinking I could have done more, or that there are public policy changes that need to occur for me to deliver the best services possible to change patients' lives.

What we prioritize as a profession needs to come directly from us, because we are the ones experiencing it. With everything that has been going on in the world, it is understandable to want to take a step back from these political issues, but don't let that become a permanent decision. It's up to us to use our voices and experiences to move the profession in the right direction through advocacy.

MERCEDES AGUIRRE VALENZUELA, PT, DPT

(A version of this originally appeared as "Our Experiences Matter When It Comes to Advocacy" on June 21, 2021, as a perspective piece on apta.org.)

APTA Asks ...

If you could say one thing to public and private payers to help them understand the value of physical therapist services, what would it be?

Physical therapy should not be seen as a modality but as a philosophy and a form of medicine for patients that is as beneficial as traditional or pharmaceutical medical treatments.

HOLLY PARSONS, SPT

Regardless of medical or surgical interventions, everyone will need to improve their function and mobility. Physical therapists are able to assist with differential diagnosis and medical monitoring, and they develop a plan of care that can reduce imaging costs, the need for pain medication, use of health care services, and unnecessary surgical intervention.

MEGAN MITCHELL, PT, DPT

Physical therapy guides patients to recovery and better self-care; it doesn't just put a patch on.

EWA CZAJKOWSKA, PT, DPT

Your beneficiaries will learn how to treat themselves and save money! Avoid those lifelong fees of passive care, such as medications, hospital visits, and monthly or weekly passive modalities.

LT ANDREW DOMINGUEZ, PT, DPT

What advice do you have for someone considering a career in physical therapy?

Think about what your life goals are and your intentions for pursuing the profession, because it is not for the faint at heart. It also is not a passive career, and it requires a personal commitment to self-growth, and a desire and passion for helping your patients.

HOLLY PARSONS, SPT

Individuals wishing to enter the profession should remember to be humble, caring, and empathetic. To accomplish this, continue to develop interpersonal communication skills. Communication is a foundational component to everything we do on a daily basis, whether interviewing a patient, presenting an in-service, or even ordering food at the local restaurant. Health care focuses on individuals, so it is important that we learn to be dynamic in the way we communicate with other.

ERIC TRAUBER, PT, DPT

Don't hesitate! It is a wonderful career with many avenues to pursue. It is rewarding and purposeful work.

CRISTINA FONTANEZ GARRISON, PT, DPT

Physical therapy is a field in which we are remunerated to help people help themselves. We educate people about becoming stronger, healthier, and better. I feel I've positively impacted at least one person's life every day!

SHARON GALITZER, PT, MSPT, DScPT

APTA encourages diverse voices. "APTA Asks ..." poses questions that all members are invited to address, and we'll publish selected answers. To participate, log in to the APTA Engage volunteer platform at engage.apta.org, find the APTA National — APTA Magazine Member Input opportunity, and click the Apply Today! button for a list of questions. Answer as many as you want. Responses may be edited for clarity, style, and space, and do not necessarily reflect the positions or opinions of APTA Magazine or the American Physical Therapy Association.

Things to Think About

TELEHEALTH. ARE YOU DOING IT?

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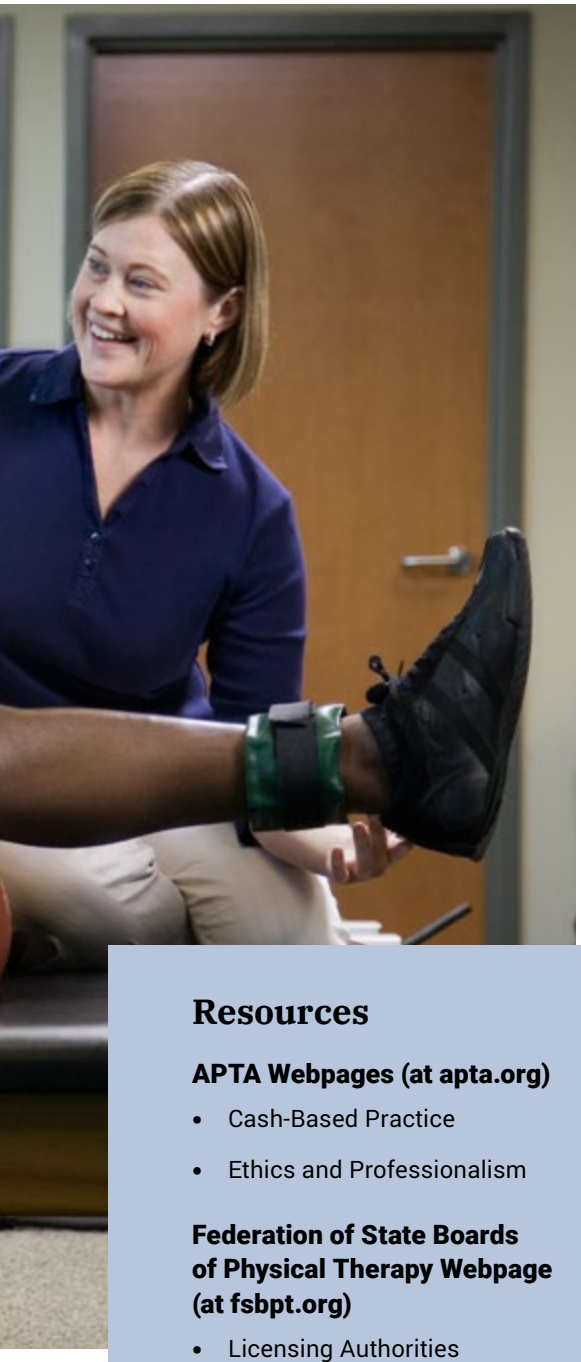
/ By Alice Bell, PT, DPT

Thinking about going cash-based? You still won't be completely free of restraints.

Cash-Based Practice: It's Complicated

Alice Bell, PT, DPT, is a senior payment specialist at APTA. She is a board-certified clinical specialist in geriatric physical therapy.



Payer policy may influence many aspects of physical therapist practice, such as which patients are able to seek covered services from a given provider, limitations on the amount or type of care you can provide, and service authorization and documentation requirements. Adopting a cash-based practice model may eliminate some — but not all — payment-related challenges.

Although adopting a full or partial cash-based model may be a viable option for your practice, providing services under such a model does not absolve you of all administrative burden and compliance responsibilities. Because payer requirements often are at the forefront of documentation considerations, it is possible to forget that there are other standards guiding our practice and that we must continue to meet legal and ethical obligations not associated with payer policy.

Let's explore the policies, regulations, and standards you must adhere to, regardless of who is paying for services.

Your State Practice Act

PTs are licensed — and PTAs are licensed or certified — in all 50 states and the District of Columbia, Puerto Rico, and the U.S. Virgin Islands. Licensure laws define the scope and govern the practice of physical therapy in each state. Regardless of the source of payment for the services you provide, you are required to know and comply with the requirements of your practice act. This includes direct access provisions, supervision standards, and documentation requirements.

State Laws and Regulations

Beyond the state practice act, other state laws and regulations may impact the practice of physical therapy. For example, your state may have specific requirements for telehealth, patient privacy, and areas such as infringement or inducement.

Resources

APTA Webpages (at apta.org)

- Cash-Based Practice
- Ethics and Professionalism

Federation of State Boards of Physical Therapy Webpage (at fsbpt.org)

- Licensing Authorities

APTA Code of Ethics for the Physical Therapist and Standards of Ethical Conduct for the Physical Therapist Assistant

All PTs and PTAs are obligated to comply with these documents, which define the principles of ethical practice and provide standards for professional behavior. Providing care under a cash-based model does not exempt you from any of your ethical obligations.

Payer Policy

Payer policy may limit your ability to bill certain patients for noncovered services if you are a participating provider. It is important to understand your obligations and liabilities based on the plan in which a patient is enrolled and your provider status with the plan. And if you submit a courtesy bill for a patient and accept assignment, you may be inadvertently entering into a claim-specific version of participation. These provisions are not always completely transparent,

Defining Cash Practice

The term "cash practice" can be confusing because it is often used to describe a variety of physical therapy business models, such as collection at time of service, limited or no insurance contracts, and noncovered services. Here are descriptions of each of these cash-based practices.

Collection at time of service. Your practice may participate with a variety of insurance plans, but you collect copays, deductibles, or other fees that are the patient's responsibility at the time service is delivered. This reduces the number of bills you have to send and increases the likelihood of collecting all patients' fees.

If your practice doesn't currently collect copays, deductibles, and other patient fees from the patient during their office visit, you can modify your policies and procedures to do so, without changing your status with insurers or making major changes in your business model.

Limited insurance contracts. Your practice owner may decide to participate only with third-party payers whose payment and policies make sense for their business model.

Perhaps you have insurance contracts that pay so poorly that they barely cover your costs. Other payers may insure a very small number of your patients and have procedures that are so burdensome to both your administrative and clinical staff that, despite attempts at negotiation, are not worth continuing. At the same time, you may have payers with whom you wish to continue to contract. If this is the case, you can retain the contracts that make sense for your practice and discontinue those that don't, adopting a hybrid model with some in-network contracts and some out-of-network patients.

No insurance contracts. Your practice may opt out of all private insurance contracts and become an out-of-network provider for all patients. You may have patients pay in full at the time of service or bill the insurer directly and bill the patient for the balance not covered by the plan.

As an out-of-network provider, you likely will save administrative costs by not having to deal with insurance negotiations, billing, and collections. You will be able to set your fee schedule based upon your actual costs, the value you ascribe to it, and what you determine the market will bear. You are able to make more decisions about the care you provide, such as the length of appointments, the number of visits, and the services you provide.

Noncovered services. Your practice may choose to provide services that are not covered under most insurance plans. These offerings may include fitness, wellness, and health promotion; prevention programs; educational seminars; weight-loss programs; and sports performance enhancement programs. For these services, your practice determines the value, establishes the fee, and, in most cases, collects the fee at the time the service is delivered. Some practices offer fitness memberships or enrollment in fitness classes, and those may have a different payment model such as a monthly membership fee or set price for enrollment in a series of sessions or classes.

and you need to understand all the conditions of accepting payment as an out-of-network provider. It is also important to be aware of any state restrictions on balance billing. Finally, as an out-of-network provider you do not have a relationship with the payer. The relationship is between the patient and the payer, therefore any requests for reconsideration or appeals must be made by the patient.

Medicare, Medicaid, Workers Compensation, and TRICARE

Each of these entities has complex billing policies and regulations that affect your ability to seek or accept upfront payment or to balance bill the participant. It is important to be fully versed in these policies and regulations before adopting a cash-based model.

Medicare. Federal law does not allow physical therapists to opt out of the Medicare program. If you are providing a Medicare-covered service to a Medicare beneficiary, you must be an enrolled Medicare provider and submit a claim to Medicare. If you are not enrolled as a Medicare provider and you accept payment directly from a Medicare patient for a service that is covered under Medicare, you could be subject to federal investigation and financial and other penalties.

If the service is not covered under Medicare, you can collect out-of-pocket payment from the patient. Before delivering the noncovered service, be sure to properly inform the beneficiary about their responsibility for paying for the service.

Questions often arise about possible exceptions to the laws that require physical therapists who treat Medicare beneficiaries to be enrolled and to submit claims for covered services to Medicare. The short answer is that no exceptions allow you to bypass these requirements. You'll find scenarios that help explain potential situations in APTA's online article "Cash-Based Payment and Medicare Services: No Exceptions to the Rules."

Medicaid. Medicaid laws and regulations vary from state to state. However, if you are a Medicaid provider, you agree to accept the payment provided by Medicaid for services to covered patients. Your ability to accept direct payment for noncovered services may vary by state. Whether or not you are enrolled in Medicaid, you should check your state regulations before you accept payment for services from Medicaid beneficiaries.

Many physical therapists are engaged in the provision of cash-based services either exclusively or as a component of their practice. There are definitely opportunities and advantages to these models.

Workers' Compensation. In workers' compensation cases, all but a few states ban the practice of balance billing — requiring the injured worker to pay for the portion of the bill that the employer or insurer will not pay. Because laws vary by state and can change, refer to your state law for guidance.

TRICARE. You may choose to be either an in-network or out-of-network provider for TRICARE, the government insurance for U.S. military and their families. However, TRICARE policies are complex and vary by region (East and West), so review current TRICARE policies before providing out-of-network services to this beneficiary group. In many situations, a beneficiary may access the services of an out-of-network provider if there are no in-network providers in a certain geographic area. For information on out-of-network providers, visit TRICARE's Non-Network Provider Directory.

Many physical therapists are engaged in the provision of cash-based services either exclusively or as a component of their practice. There are definitely opportunities and advantages to these models. At the same time, know that payers are not the only entities you must answer to — and eliminating the payer from the equation does not eliminate all your legal and ethical obligations.

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

The transition from hospital to school-based setting brings up questions of authority.

Who Is the Judge?

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.

PTs and PTAs often find themselves struggling to manage the various responsibilities and obligations they have to patients, their institution or employer, colleagues, and their profession. They sometimes forget the obligations they have to themselves to protect their right to practice.

Independent or Set Adrift?

Scott was one of those PT students who knew before he started school that he wanted to work in pediatrics. Still, he was grateful for the experience that he had in both subacute and outpatient care for the five years before he decided to take the plunge and pursue his dream of working in a school setting with children.

He considered himself fortunate that the large hospital system where he worked had a pediatric rehab facility. He rotated through the unit several times, reinforcing his pediatric skills and strengthening his desire to devote himself to the pediatric population.

He geared his continuing competence activities between improving his abilities in his current work environment and planning for his future pediatric career. He started investigating the requirements for earning his specialist certification in pediatric physical therapy. The disruptions in clinical practice that arose from the COVID-19 pandemic put his active pursuit of a school-based position on hold, but, as things sometimes happen, a school position arrived in the spring, and he decided it was now or never to make the change for the new school year starting in August.

While he was the only PT in the two schools he was assigned to, he easily connected with other PTs in the district and found them helpful with tips on the best equipment to outfit himself with and how to navigate the many nuances of the new school setting.

Considerations and Ethical Decision-Making

Licensure as a physical therapist permits the PT to practice in all settings, and it comes with the inherent responsibility to practice ethically and legally in any of those settings. Scott is receiving secondhand information about the legality of his treating children outside his jurisdiction, and he is obligated to do his own research into his practice responsibilities for both the clinical aspects of appropriate treatment and the legal limitations on his ability to treat. He needs to take the initiative to speak directly with the school's legal counsel to make sure he is practicing appropriately.

Realm. Per the Realm-Individual Process-Situation Model of Ethical Decision-Making, or RIPS (see "Resources at apta.org" box on Page 24), the primary realm is Organizational/Institutional. This realm is primarily concerned with the good of the organization and focuses on structures and systems, which facilitate organizational or institutional goals.

Individual process. Initially Scott demonstrates the moral motivation to question what he is being told. Now he must stand up to the directive he has been given. Refusing to treat children who are out of state until he is licensed in those jurisdictions, or directly receives clarification that under the circumstances is it legal to do so without being licensed in those states, will require moral potency, which includes moral ownership, courage, and self-efficacy.

Ethical situation. Scott is experiencing moral distress. He knows what he should do but he feels blocked by both the institution and his inexperience in navigating this new practice setting.

Ethical principles. The following principles of the Code of Ethics for the Physical Therapist provide guidance for Scott:

- **Principle 3A.** Physical therapists shall demonstrate independent and objective professional judgment in the patient's or client's best interest in all practice settings.
- **Principle 3C.** Physical therapists shall make judgments within their scope of practice and level of expertise and shall communicate with, collaborate with, or refer to peers or other health care professionals when necessary.
- **Principle 3D.** Physical therapists shall not engage in conflicts of interest that interfere with professional judgment.
- **Principle 5A.** Physical therapists shall comply with applicable local, state, and federal laws and regulations.

Still, some things took getting used to. Scott was accustomed to having a designated treatment area, and even when he had treated bedside in the hospital, the physical therapy gym had been a home base in the building. He found the school to be a maze of areas that he was welcome to use — if nobody else was in there at that time, a caveat that required a lot of flexibility on his part in the busy school environment.

His colleagues advised him to stake a claim early in the year to the multipurpose room; or to use the gym during lunch periods, the lunchroom during class times, and, if all else failed, a quiet stairwell with little traffic. Scott embraced the creativity and adaptability that was demanded by his new setting and realized that he was expected to be independent in his practice.

The first two weeks before school started Scott was busy reading the Individualized Education Plan or 504 Plan for each of his students — which dictated the legal requirements for the services the children were to receive — and negotiating for scheduled times to pull his students out of class or to work with them in the classroom setting, as dictated by their written plans.

Scott was no stranger to the importance of a structured care plan, but navigating the complexities of these documents initially was daunting. He contacted Gloria, one of the PTs in the district who had encouraged him to call if he had any questions, and she helped him negotiate the nuances of the school setting. The PTs in the district were working for an agency called Kids Plus, which was based in another state but contracted with PTs and OTs in school districts and early intervention.

With Gloria's help Scott found within the IEPs and 504 plans the guidelines he had to use to develop his treatment schedules, such as two individual sessions per week for 30 minutes, or one individual and one group session. Scott dug into the challenge of making sure he complied with the requirements outlined in the IEPs and 504 plans.

However, while his schedule looked good on paper, as Scott began seeing the children some of the plans did not seem to make good treatment sense. Based on his early assessments, some of the children needed more than the plan called for; others needed less. In some cases, Scott believed a child needed a different type of intervention or belonged in class when the plan called for them being pulled out, and vice versa. A call to Gloria confirmed that sometimes the plan was a bit outdated, as kids changed quickly — particularly during this past year where much of the instruction had been remote.

Gloria suggested that he speak with his occupational therapy and speech-language pathology colleagues in the building and with the Child Study Team for their thoughts on his difficulty in matching the prescribed plan with the child's needs. Her closing remark, "Remember, you are no longer in the medical model as a PT, you are an ancillary service," resonated with Scott as he tried to reconcile what he was finding with what he was obligated to do. Scott knew that his fellow therapists technically provided support services that were required by law to be available in the schools to help children reach their IEP goals, but he also felt strongly about the professional duty he had to his young patients.

The other therapists were collegial but seemed to accept passively what was in the IEP. This indicated to Scott that while the therapists made recommendations, often the final IEP was negotiated with the child's guardian with little input from the ancillary services providers.

The other therapists were collegial but seemed to accept passively what was in the IEP. This indicated to Scott that while the therapists made recommendations, often the final IEP was negotiated with the child's guardian with little input from the ancillary services providers. His predecessor in the position recently retired, and while she left him a nice welcoming note, she did not provide any contact information.

Scott's discomfort rose to a new level when he began to grapple with another issue. The district had given parents the option to continue remote learning with the beginning of the fall semester if they were not comfortable sending their children back to school. Scott had four children whose IEPs called for individual PT sessions twice a week, but they were not at school in person. While Scott felt comfortable with telehealth, having been immersed in it during the past year, he wasn't prepared for the realization that three of the four children were living with family in other states, and Scott was licensed in none of them.

A quick check revealed that the states were not yet part of the PT Compact, so Scott would not be able to use a compact privilege to treat these children, and it could take months to secure the additional licenses. Scott contacted the director of the Child Study Team to deliver the news and see what alternative plan could be made.

The director calmly told Scott that he had nothing to worry about — the attorney for the district had told him last year that it wasn't an issue; the children were registered in the school, and these were extraordinary times. Scott responded that he was aware that there were emergency orders in place during the pandemic that allowed for temporary licensure in other states, but to his knowledge most of these had expired. The director, glancing at his watch and obviously in a hurry, reminded Scott that the attorney said it was fine, and he also was okay with Scott treating these children. He reminded Scott that his role in a school setting was different from where he had been before.

Scott took the cue, leaving the office but not at all satisfied with the answer. This setting, or for that matter any setting, did not absolve him of his personal professional responsibility or legal obligations, did it? Scott considered whether he should be comfortable accepting the director's word about the advice from the attorney for the district — after all, the attorney would know the law, and his colleagues seemed OK with it. On the other hand, it is Scott's license on the line.

Scott considered whether he should be comfortable accepting the director's word about the advice from the attorney for the district — after all, the attorney would know the law, and his colleagues seemed OK with it.

For Reflection

Have you ever found yourself in a workplace setting where your understanding of your professional obligations or responsibilities conflicted with others in the work environment? Have you ever been asked to undertake your job responsibilities in a way that you did not feel comfortable doing, either ethically or legally? What did you do about it? What resources are available to you to help navigate a situation like this?

For Follow-Up

If you'd like to share your thoughts on this scenario, and/or recount a similar experience and how you responded, I encourage you to contact me at kirschna@shp.rutgers.edu. You also can share your thoughts with APTA Magazine (aptamag@apta.org), which publishes selected comments in the Viewpoints department of each issue.

Resources at apta.org

The APTA Ethics and Professionalism webpage features links to documents such as the Code of Ethics for the Physical Therapist, Standards of Ethical Conduct for the Physical Therapist Assistant, Core Values for the Physical Therapist and Physical Therapist Assistant, Values-Based Behaviors for the Physical Therapist Assistant, and Standards of Practice for Physical Therapy. Click on "Clinical Decision-Making in Physical Therapist Practice" under "Recommended Content" for an article describing the RIPS model referenced in this column. The webpage also links readers to related content in the realms of both ethics and professionalism.

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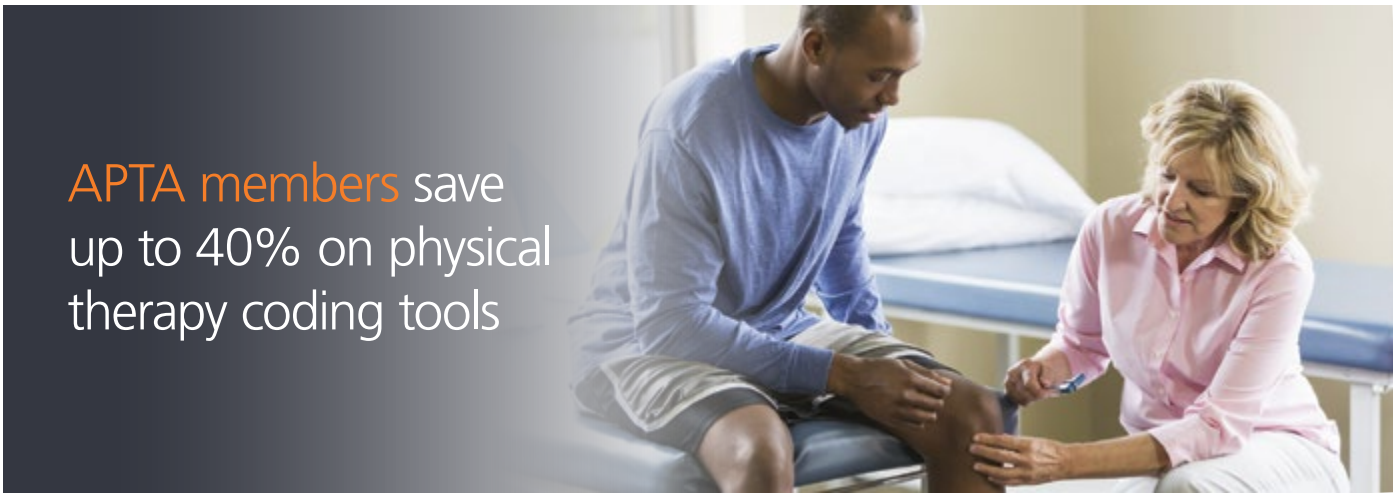

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Making the Connection:

A Guide to Social Media, Blogging, and Other Online Tools

Many PTs and PTAs are using social media and blogging for everything from networking to education. Here's what they're doing and how you can start.

By Michele Wojciechowski

APTA has a strong social media presence on behalf of its members and the profession. And it's being amplified many times over by PTs and PTAs who use social media for their own reasons.

Ronald D. Peacock Jr., PT, DPT, the co-founder and CEO of iMove Health (@imovehealth), says his practice uses social media posts and a blog to share condition-specific content to patients and to the public. "Our goal is to provide content that helps individuals understand their conditions and gives them dos and don'ts of rehab for their specific condition," Peacock explains. "We want our patients and the public to know the facts about pain, movement, and exercise, as there are a ton of misconceptions that lead to catastrophizing behaviors and overall cessation of activity for many patients."

Krystyna Holland, PT, DPT, (@krystyna.holland) primarily uses Instagram to educate people about treatment options, trauma-informed care, and normal anatomical and physiological expectations, "particularly as they relate to 'taboo' topics such as toileting, intercourse, and genitals," she says, and to help patients advocate for themselves in medical visits. As the founder of Inclusive Care in Denver, Colorado, Holland reports that

“I look at social media as a way to begin conversations.”

Jimmy McKay

she also uses Instagram “for marketing digital products such as “The Playbook for Painless Sex” and the “Trauma Informed Care” webinars she teaches.

If you haven’t begun using social media, or you have and just need some tips, we’ve got you covered — from what social media platforms many PTs are using to what they’re using them for.

APTA and Social Media

According to Amelia Sullivan, APTA’s senior new media specialist in digital and creative services, the association is active daily on the social media platforms Facebook, Twitter, and Instagram. In addition to these, APTA has a YouTube Channel as well as many other Facebook pages — some of which are for the consumer, such as ChoosePT, while others serve students, physical therapist assistants, and more. For this article, Sullivan is speaking about the main APTA approaches — to members and consumers.

“We publish daily news articles that are written by our staff — covering anything from payment issues to advocacy — that our members should know about. As for building awareness about the benefits of physical therapy, we put out daily information on our consumer side as well — whether those are tips, articles, or information on conditions,” Sullivan says. “APTA also hosts APTA Live events several times a month. These expert discussions are hosted on Facebook Live, and we stream them on Twitter and YouTube simultaneously. Whether it’s the latest research and new educational or networking opportunities or developments on Capitol Hill, we not only share these resources via our website and email, but we also will post them to social media.”

That said, APTA is a membership organization and has the staff to produce and share a lot of content daily. As for what smaller clinics or individuals can do in the social media arena, Sullivan says, “It’s beneficial for PTs and PTAs to be on social media, whether it’s them as a person or for their clinic. It’s a great way to connect with potential patients and clients or just to spread information about what PTs and PTAs do, who they are, and how they can help people.”

Don’t Try To Do It All

With all the available social media platforms, which one(s) should you use? Sullivan advises using what feels right to you. “I don’t think that all PTs and PTAs need to be in all spaces. If you’re not comfortable on a set platform, whether that’s TikTok, Instagram, Facebook, or Twitter, don’t feel like you have to force it,” she says.

Holland agrees. She says that she uses Instagram because she likes it best. “Trying to convince myself to spend time on platforms I didn’t enjoy wasn’t sustainable,” she says.

“I look at social media as a way to begin conversations,” says Jimmy McKay, PT, DPT, (@PTPintCast) director of communications for Mt. Sinai Hospital and host of the podcasts PT Pintcast and NPTE Studycast, which combined have been downloaded 4 million times. In the last year, McKay, who had been producing all the podcasts himself, brought on Juliette Dassinger, PT, DPT; Bridget Nolan, SPT; and Tayo Akinboboye, SPT, to work with him on PT Pintcast. “I have gone from liking creating content and episodes to loving it again. For more than four

Eight Quick Tips To Get Started

If you're just beginning to use social media, or you're already posting and blogging but believe you can do better, here's a summary of the advice from the PTs and PTAs who were interviewed for this article:

1. If you're uncomfortable plunging into social media — or even just dipping a toe in — find a PT student or another savvy professional who can help you.
2. Explore the various social media platforms and decide what one(s) you like best.
3. Decide what you want to share and why.
4. Think before posting.
5. Create and share content.
6. Post consistently.
7. When appropriate, share personal stories.
8. Build a following.
9. Have fun!

Still feeling hesitant? Krystyna Holland, PT, DPT, says, "The only way to start is to start."

years, it was mostly just me — a one-man band. Now I have diverse voices from different people within the profession, different backgrounds, with different likes and dislikes."

While most of the sources interviewed for this article do social media on their own, some have guests write posts or even pay for others to write posts for them. They suggest that the way you generate social media all depends on how much time and/or money you have. If you don't have the time, paying others to do your own or your clinic's social media can help you start or expand your online presence.

Content Is King ... or Queen

Before you choose which social media platform you want to use, decide why you want to use it. Margie Nguyen, PTA, BS, suggests that PTs and PTAs first ask themselves questions like "Why do you want a social media page? What is the purpose of your page? Do you want to increase the number of patients coming to your clinic? Do you want to connect with other PTs and PTAs? Are you promoting your business?" She says that deciding on your "why" will help you figure out the type of content you need. In 2019, a year after graduating from PTA school, Ngyuen launched @notjustapta on Instagram to connect with fellow PTAs.

"Everything you do should fit into your 'why,'" Peacock says. "Do not conform to trends and fads that do not fulfill your mission or your vision. You ultimately will create a great following, but you will burn yourself out trying to be someone you aren't."

McKay says that before you create content, keep the receiver of your message in mind. "Leaving bits of information that are easily digestible about the things they want or need to know is a great way to show how you could potentially solve someone's problem or improve their lives," he says.

Another suggestion: Be aware of the type of content that you're sharing. "Content that holds something personal seems to get more engagement than anything else — whether a photo or video," Peacock says. "Our engaged followers love some degree of longform text on posts. This allows your personality to shine through a little more, especially if you're just posting an image or demonstrating a movement. It also gives a richer explanation of your content and intention."

Meredith Castin

Lindsay Durand

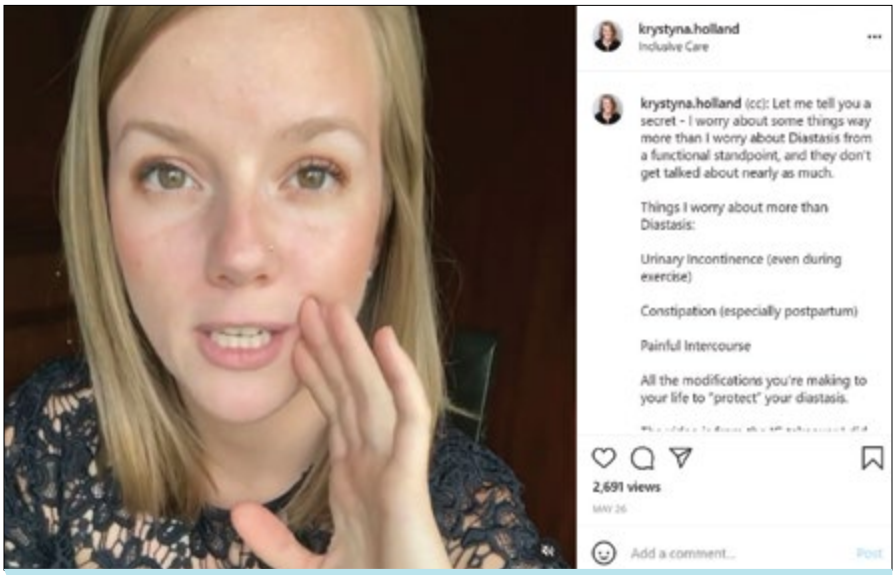
Jasmine Marcus

Jimmy McKay

Margie Nguyen

Ronald Peacock Jr.

Krystyna Holland's posts are designed to help patients advocate for themselves.



Peacock says he's found that followers will interact on posts to offer congratulations or celebrate a success. "People want to be involved in community and relationships. We create content specifically for people we know. When we do this, we always tag people and let them know, 'This is for you! Would love to hear how it goes and how else I can help,'" he says. "Another mechanism is to get personal, get real, and get raw with your viewers. There is power in that."

Holland, meanwhile, says her content and posts have two things in common, "The post itself is meant to have a hook, and then the captions are long and full of medically accurate information written without judgment, shaming, or fear mongering," she explains.

> "The post itself is meant to have a hook, and then the captions are long and full of medically accurate information written without judgment, shaming, or fear mongering."
>
> Krystyna Holland

Lindsay Durand, PT, DPT, (@LindsayDurandFitness) and the clinic she works for, OrthoPelvic Physical Therapy in Sterling, Virginia, use social media to help educate people about pelvic health physical therapy, as many people may not know that it even exists. "We also use social media to reach new patients and build rapport in the community and with other providers," she says. "For marketing, patient information, or distribution of research, I tend to do informational posts on Instagram. I create them on Canva.com, always providing my sources and giving potential new patients clear instructions on next steps for contacting me or the clinic."

Durand adds that she finds that "educational content does best as an infographic or Instagram Reel that can easily be digested, shared, and saved." And, as Peacock said about posts being personal, she says, "Photos of me also do well, especially when paired with a personal story or struggle."

Finally, Durand suggests that PTs and PTAs keep it simple. "One of the biggest mistakes I see PTs making on social media is not making things simple enough! I see a lot of great posts, but the language is too complex and does not highlight why someone should care," she says. "Sure, some people want to know the anatomy and mechanics of the shoulder joint, but the majority want to know what you can do to get them back to throwing or golfing pain-free. We need the general public to

> "Content that holds something personal seems to get more engagement than anything else — whether a photo or video. This allows your personality to shine through a little more, especially if you're just posting an image or demonstrating a movement."
>
> Ronald Peacock Jr.

know more about what physical therapists do and how we treat — so that's what we should be doing on social media."

Think Before You Post

McKay points out a truth often noted about electronic communication: "Social media is permanent. There's always a permanent electronic record. It's also worldwide."

Sullivan agrees. "Be mindful of what you're putting out there and how you're presenting yourself. This is your professional persona, whatever you determine that is," she says. "Know that people are watching. The biggest thing about social media is that once it's out there, it's out there." While you can delete a post, it's never really completely gone.

In addition, Sullivan suggests, "make sure you're consistent in the amount that you post, in your tone, and in your presentation." For example, she says, if you decide to do an Instagram Live post once a week, don't do them for four straight weeks and then stop without notice. People will have come to expect it.

Social Media During the Time of COVID-19

Before March 2020, Sullivan says that other than student-led monthly discussions on a variety of topics, APTA had not been streaming regular video discussions. That all changed when the initial shutdowns and quarantining signaled the early stages of the pandemic.

APTA was trying to get vital information out as quickly and on as many venues as possible — using similar content and putting it on social media, YouTube, on podcasts, and in emails. That's when the association began doing APTA Live events — expert discussions on various topics. The APTA blog, which existed prior to the pandemic, changed a bit in format. Staff began using it to describe "what members were experiencing amid the pandemic, whether that was transitioning to a telehealth model, working in a hospital setting, or moving to remote learning," Sullivan says.

Everyone on social media suddenly had something they needed: a captive audience. As time passed

Succeeding in Social Media

Social media can be an effective tool for networking with colleagues, staying informed, or promoting yourself or your brand. Here are some things to keep in mind. (Taken from APTA's website at apta.org/social-media/succeeding-on-social-media.)

Risk Management

Inappropriate behavior on the internet can be damaging to your personal and professional reputation. Consider these recommendations for successful social media use:

Ethical conduct. Use social media in a manner consistent with the Code of Ethics for the Physical Therapist and Standards of Ethical Conduct for the Physical Therapist Assistant.

Professionalism. Remember that errors and omissions in communication, harassing statements, and unprofessional language presented via social media may have long-lasting negative effects on others, you, or the physical therapy profession. As in the workplace, professionalism is the best approach.

Patient and client protection. Remember that the principles of patient and client privacy and confidentiality extend to social media. Be cautious about when and how to interact with patients and clients on social media; consider creating separate social media accounts for personal and professional use.

Verification before amplification. Understand that social media is often prone to inaccurate information. Do your best to verify the accuracy of information before sharing it via social media.

Accountability. You should know the published policies on social media set by your employers, educational institutions, or clinical training sites. Never misrepresent when you are speaking for yourself or your employer, or other organizations. It may be appropriate to consult legal counsel before engaging in social media. Remember, just because other people or organizations are doing something on social media doesn't mean it's appropriate or legal. (For example, stock photography is often downloaded from the internet and then inappropriately reused without licensing, permission, or credit.) APTA cannot provide members with specific legal advice.

Collegiality. Alert colleagues if you discover that they have posted content to social media that appears inaccurate or unprofessional. Ask your peers to do the same for you.

Thoughtfulness and patience. Avoid impulsive social media behavior. While the constantly updating nature of social media platforms creates the impression that speed and immediate responsiveness are important, harmful social media behavior can be avoided simply by pausing to be thoughtful. Don't post in anger. If you're in doubt about whether you should say something, the best course is to probably not say anything. Take a 30-minute break or get a second opinion. Remember that single social media posts are more likely to harm a reputation than strengthen it.

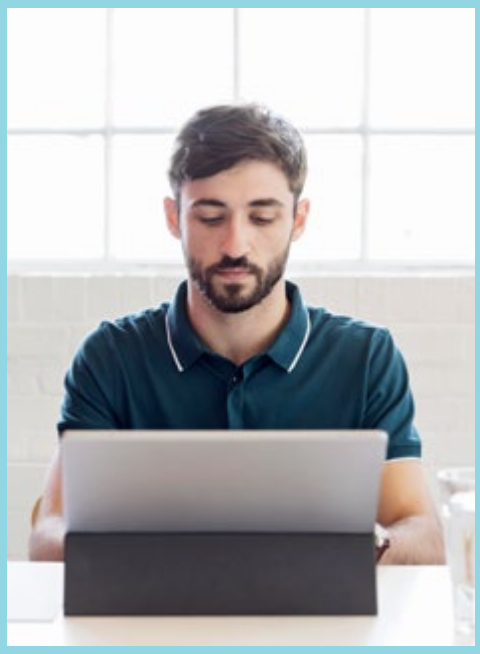
Building Your Brand

Many people engage in social media for personal use only. But if your goal is to use social media to promote yourself, your business, or your organization, here are some useful tips.

Identify specific goals. The more specific your goals (to generate new patients and clients, to raise awareness, to advocate, etc.) the better you can define a strategy to meet them.

Be realistic about your social media investment. Typically, it's free to create a social media account. But successful social media use will require an investment of time and (potentially) money. Be honest with yourself about how much effort and money you are willing to invest, and then build your social media strategy accordingly. For example, some of the most successful social media users regularly engage with their followers. Will you have the time and energy to maintain that level of involvement? Be realistic about your ability or willingness to engage.

Identify your primary audience. Social media thrives when it's based on shared interests. Knowing who you're trying to reach will help you create the right messages to appeal to them. Are you using social media to network with other professional peers or to interact with the general public? It's possible to do both via the same social media account, but it is more challenging. Likely the topics that are of interest to your peers will not be the same as those that are of interest to the general public.



Measure your success. If you dedicate time or money to developing a social media presence, you want a return on that investment. Create a definition of success based on your goals. Success metrics might include the number of followers you gain, the amount of engagement your posts receive, or the amount of social media referral traffic to your website.

Find your best social media fit, and consider taking a gradual approach. If you're not sure whether Twitter, Facebook, Instagram, Snapchat, or other social media platforms are best for your goals, you will need to better understand your preferred platform before you can create a strategy.

Start small. A common mistake is to try to develop a social media presence across multiple platforms simultaneously. Instead, pick one social media platform, get comfortable with it, and expand from there.

with people confined indoors, many turned to social media platforms for everything from entertainment to education — and even just to connect with others.

Nguyen began interviewing PTs and PTAs on Instagram Live in what became #TherapyTalkThursday. "Currently, I have more than 50 interviews on my page," she says.

Both Holland and Durand grew their followings during this time. "I created a community that is interested in learning more about women's and pelvic health physical therapy," says Durand. "I found social media to be a great way to connect with individuals and even find potential patients."

Holland says, "I discovered that people are paying more attention than you might think, and that while it can sometimes feel like you're shouting into the void of the Internet, often someone is being changed by what you said. During the pandemic, I had more time to interact with individuals in direct messages who thanked me for what I was creating. I had no idea so many people were being positively affected by it."

If You Post It, They Will Come

There are many ways to increase your following, those interviewed for this story said. On Twitter, it may be as simple as "following" people in your own profession. In fact, they often will follow you back. But if you want to attract more potential patients and clients, you may need to do something different.

For example, Nguyen says that PTs and PTAs can learn to build a following by doing research, watching videos on YouTube, taking classes, following and using relevant hashtags, posting consistently, and using features the social media platform offers. For example, "Instagram has posts, stories, reels, and lives — use them all," she advises.

Boon of the Blog

Blogs are usually parked on websites or webpages, and links to those pages often are shared on social media.

In 2017, Meredith Castin, PT, DPT, (thenonclinicalpt.com) began to blog. Since then, her blogging activities have grown. Her site now offers in-depth nonclinical career courses, job application materials, a weekly jobs newsletter, and free content

> "You can write about interesting topics, and people might enjoy your articles, but if you aren't solving a problem for them, they won't become loyal readers."
>
> Meredith Castin

on nonclinical career paths. "I began the blog as a free resource for other PTs who felt isolated and even ashamed for not wanting to practice direct patient care," says Castin. Her blog topic has turned into her business.

Castin publishes one blog post each week — often spotlighting a PT, OT, or SLP who works in a nonclinical role. She also releases longer blog posts every two to three months.

"From a business perspective, writing these free articles helps me in my Google rankings, which attracts people to my site to discover more of my free content as well as my premium and paid content," Castin says. "The popularity of my posts varies per current events and trends. For example, at the beginning of the pandemic, my telehealth physical therapy post was popular. However, as people developed fatigue after months of uncertainty and furloughs, my post about work-from-home and remote physical therapy jobs spiked in popularity."

Jasmine Marcus, PT, DPT, (JasmineMarcus.com) practices per diem as a PT and is a freelance writer. She uses her blog to promote her writing and editing services. "I use blogging as a way to help those applying to PT school," she says. "When I was applying, I often felt lost and didn't know anyone else applying at the time." Marcus blogs weekly, posting on her website and sharing her posts on social media.

"I write by answering the questions I get asked most often. I don't like being constrained by having to write a certain amount so, since it's my own blog, I write as much as I see fit," she says. "I tend to be a concise writer, so my posts aren't too long. This appeals to more people as well."

Marcus says that a mistake PTs and PTAs make when blogging is the same mistake mentioned for social media — not posting consistently.

Castin points out another mistake she sees new bloggers make: not solving a problem. "You can write about interesting topics, and people might enjoy your articles, but if you aren't solving a problem for them, they won't become loyal readers," she says.

Biggest Benefits of Social Media

McKay says that since he graduated PT school, every job he's had has come from a social media connection. He's made countless connections and friends. "I found a purpose combining my radio broadcaster background with physical therapy and my new curiosity for the profession," he says.

Durand says she has had many people confide in her about their pelvic health conditions, "and although I cannot offer advice or treatment over social media, it is nice to know that because of my posts, people are asking for help. My goal was to

APTA's Social Media Platforms

APTA on Social Media

Facebook: /AmericanPhysicalTherapyAssociation

Twitter: @APTAtweets

Instagram: /APTApics

YouTube: /APTAvideo

APTA Students on Social Media

Facebook: /APTAStudents

Twitter: @APTAStudents

Instagram: /APTAStudents

APTA's PTA Caucus on Social Media

Facebook: /PTACaucus

Twitter: @APTAptac

Instagram: /ptacaucus

ChoosePT on Social Media

Facebook: /ChoosePhysicalTherapy

Twitter: @Choose_PT

YouTube: /ChoosePTvideo

APTA Specialization, Governed by ABPTS

Facebook: /ABPTS

use social media to build a future patient pool, and that is exactly what I am doing now," she says.

"I've met incredible providers whose work I've respected for years, Holland says. "Social media allows me to interact with these folks in ways I previously wouldn't have had a chance to. Using social media has tested my ability to take complex and nuanced ideas and speak about them briefly and succinctly. That's a great skill to have for effective patient education. Finally, I've really found my voice, and it has increased my confidence to show up as myself."

For Nguyen, she's been able to connect with many PTAs across the country. But she's also been sought out to be interviewed by other social media outlets and to collaborate with others in the field. Best of all, "I turned @notjustapta into a business — Notjustapta, LLC. I provide mentoring, consulting, resume services, virtual anatomy tutoring, mobility workshops, and more," she says.

"Social media has been a great way for patients to connect with us. We have had patients both reach out and schedule via Instagram. It also has allowed us to connect with other providers and fitness influencers all over the world, and we have built some pretty cool relationships from it. It also has allowed us to connect with outpatients for the distribution of individualized exercises. We want to build a community, not a clinic," says Peacock. "If you feel you have something worth saying, then share it. You never know whose life you might change."

Michele Wojciechowski is a freelance writer based in Maryland and a frequent contributor to APTA Magazine.

A Long-Term View of the Profession Following COVID-19

How the effects of the pandemic will permanently change physical therapist practice.

By Keith Loria

Physical therapists responded quickly when the COVID-19 pandemic began, installing safety protocols and changing the way they worked with patients. Now, more than 18 months later, a lot of these short-term changes remain, and many believe that physical therapy is forever altered — for PTs, PTAs, patients, and students who seek to enter the field.

Michael Martin, PT, MPT, believes the coronavirus pandemic has affected and will continue to affect the practice and profession of physical therapy in predominantly positive ways in the long term.

"To start, I believe the pandemic and subsequent response further cemented the notion of a physical therapist as an essential health care provider, regardless of practice setting," says Martin, a board-certified clinical specialist in orthopaedic physical therapy at The Ohio State University Wexner Medical Center. "From acute response and intervention for patients diagnosed with COVID-19 to the long-term care of patients experiencing post-COVID-19 symptoms and dysfunction, physical therapy has been an integral component of the care of patients. This can open the door for our profession to be considered and consulted when addressing similar conditions in the future."

DeAndrea Bullock

Monique Caruth

Kayla Covert

Lisa VanHoose, PT, PhD, MPH, notes that the coronavirus pandemic provided insight into how connected practice patterns are to societal events and other professions.

"We do not exist in a vacuum," VanHoose — doctor of physical therapy program director at the University of Louisiana Monroe — says. "Although it is easy to lose sight of our interconnectedness when we are busy with the demands of practice, education, and research, we always will have an increased awareness of the 'what if' and the need to plan for the unexpected as it relates to infectious diseases."

From a home health perspective, Monique J. Caruth, PT, DPT, Southern District chair of APTA Maryland, asserts that the pandemic had at least one positive aspect by highlighting the true value of clinicians going into the home.

"Prior to March 2020, when the Patient-Driven Groupings Model — PDGM — hit, many agencies were making therapy cuts because they didn't see the value in reimbursement and believed the value was in nursing," she says. "Patients affected by COVID-19 who didn't want to or couldn't get into a SNF were debilitated. PTs were the ones to help manage their conditions and comorbidities and get them back to safe and optimal function in their homes."

PTs and other health care providers in many settings — from acute care to subacute care and even outpatient rehab — began to recognize the true value of home health physical therapy for both patients and caregivers. That's something Caruth expects to be a long-term positive for the profession.

Krissa Reeves, PTA, program director at Chippewa Valley Technical College, foresees another long-term impact of the pandemic: a shift in the role of the physical therapist assistant. "I believe there will be a push to better integrate PTAs into a more integral role in the delivery of physical therapy," she says.

"We've also seen the benefit of physical therapy for systemic conditions through manual interventions, postural interventions, and active interventions for patients. In this setting, I hope that the role of physical therapy in related conditions will be recognized."

MICHAEL MARTIN

Changes in Practice Settings

The impact of the pandemic has been felt in various practice settings in many ways, Martin says. For example, in an acute rehabilitation setting, it has become clear that physical therapist intervention and a dedicated hospital mobility program can improve patient outcomes, reduce negative sequelae or unanticipated negative patient events, and improve hospital throughput and related metrics.

"We've also seen the benefit of physical therapy for systemic conditions through manual interventions, postural interventions, and active interventions for patients," he says. "In this setting, I hope that the role of physical therapy in related conditions will be recognized and that physical therapists and PTAs will grow in their roles and influence within multidisciplinary care teams."

In inpatient rehabilitation, skilled nursing, and outpatient settings, Martin believes the primary impact will be the development of technology used for virtual and ongoing patient, family, and caregiver education or intervention.

"As in-person patient visits and family visitation for patients were limited in the past year, clinicians had to turn to virtual communication strategies to intervene with patients and to educate family members and caregivers," he says. "While we may continue predominantly with more traditional in-person or 'high-touch' interventions, we also must leverage this technology as another strategy in reaching our patients and meeting their evolving needs."

Overall, as the proverb says, "Necessity is the mother of invention." The coronavirus pandemic may have further enhanced the notion of convenience, access, and cost of care and may indeed expedite innovation in virtual or on-demand services.

Whether the setting is a hospital, clinic, or the patient's home, VanHoose is hopeful that the profession will commit to the growth of telerehabilitation as a primary delivery system of rehabilitation practice regardless of the emergency state.

"Telerehabilitation has allowed us to address access issues for some individuals and communities," she says. "It allowed us to provide care in a mode that, for some consumers, was their preferred method."

However, DeAndrea Bullock, PT, DPT, founding member of the National Association of Black Physical Therapists, raises a concern with telehealth. Is internet access becoming a sixth social determinant of health?

Social determinants of health, as explained by the federal Healthy People 2020 initiative, are conditions in places where people live, learn, work, play, worship, and age that affect a wide

Michael Martin

Remi Onifade

Lisa VanHoose

Hallie Zeleznik

range of health and quality-of life-risks and outcomes. Healthy People 2020 organizes the social determinants of health into five key domains: (1) economic stability, (2) education, (3) health and health care, (4) neighborhood and built environment, and (5) social and community context. (Learn more on the Healthy People webpage: healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health.)

"With an increase in the use of telehealth, are we furthering the divide of adequate health care and access to health care?" Bullock asks. "It is our responsibility to look into resources to equip our patients as we look for more creative ways to provide care."

"The pandemic's glaring statistics of how it affected Black and brown communities and people of lower socioeconomic status was a shameful highlight for our country. Because of this spotlight, it is important to finally get this right. This will require policy changes in health care as well as a shift in our personal approaches to treatment."

DEANDREA BULLOCK

COVID-19 also resulted in an opportunity for personal and organizational reflection by many. "It required us to stop and prioritize what is really important in our care delivery," VanHoose says. "We had to address the practice or mission drifts that often occur. I hope that we structuralize these opportunities from COVID-19 to become part of our normal processes."

Covert agrees that changes across the continuum of care may be accelerated further by the adoption of telehealth into various practice settings. While providing physical therapist services via telehealth increasingly has been recognized as a method to serve rural and isolated communities, it has been difficult to implement due to legislative and payment barriers, both regionally and nationally.

However, during the pandemic, federal and private insurers saw the benefit of telehealth as a strategy to continue to provide health care services while limiting exposure from the coronavirus. Some private payers, including giant UnitedHealthCare, have recognized the ongoing value of telehealth PT services, making them permanent even after the public health emergency ends. APTA is leading efforts to continue this trend with more private payers as well as Medicare. (Read more at apta.org/advocacy/issues/telehealth.)

"Due to its convenience and feasibility" — and if they are permitted to and are paid for the services — "more physical therapy practice settings may be inclined to continue providing telehealth services to certain patient populations," Covert says.

As for other protocols that became essential during the pandemic, it is highly likely that mask-wearing will become commonplace in hospital settings, she suggests. Policies and procedures on use of personal protection equipment, hand-washing, and mask-wearing may be stricter, especially during cold and flu season.

Impact on DEI

Remi Onifade, PT, DPT, MEd, co-founder with Bullock and president of NABPT, says it's no secret that more marginalized groups contracted COVID-19 at higher rates. This, she suggests, perhaps opened people's eyes to discrepancies of health care in minority communities.

"I think for PTs there was a realization of their worth in different cities, in different communities, and more into their representative communities," she says. "We already were seeing the numbers of marginalized groups being not realized in the physical therapy realm, even though more Black people are trying to get into the medical profession. We need that representation in physical therapy and need to do a better job advocating as professionals."

Bullock believes the pandemic placed a spotlight on social issues that have been imbedded into health care and society in general.

"There always have been health care disparities. There always have been social determinants of health. However, the pandemic's glaring statistics of how it affected Black and brown communities and people of lower socioeconomic status was a shameful highlight for our country," she says. "Because of this spotlight, it is important to finally get this right. This will require policy changes in health care as well as a shift in our personal approaches to treatment."

That means, she says, factoring in how SDOH affect every patient and having resources readily available to provide an inclusive environment for patients.

"There should be a system that assists students of color with a track to academia and leadership to improve the diversity of thought among our leaders and change makers," Bullock says. "We should leave treatment sessions, the classroom, and our board meetings asking, 'How have I factored in other voices today?'"

VanHoose says, "The pandemic unearthed additional dirt from the hole the profession has dug for itself as humans and PTs and PTAs.

"We have chosen to cover the structural and systemic barriers in our society," she continues. "We have supported the -isms with our silence and our busyness. The pandemic has shown us that we

all live on one planet. We can slice this planet up however we like into continents, countries, states, counties and parishes, cities and neighborhoods. Regardless, hurt and disease will remain isolated within a certain area for only so long."

Furthermore, she adds, the profession can continue to dig and remove the items that are buried, or it can cover them up — but these items are weighing down the profession of physical therapy and society as a whole.

"People will recognize that we made a choice — consciously, subconsciously, or unconsciously," VanHoose says. "It still will be considered an active decision. Then our health care partners and organizations, prospective students, current PTs and PTAs, and patients get to make a choice on what their relationships will be with us as a profession and as providers."

One big change Caruth would like to see long-term is full payment for telehealth visits and services. "Many older adults have issues with transportation, and historically many Black and brown patients use public transportation services and work multiple jobs; hence, they have missed appointments in certain settings," Caruth says. "Telehealth is one way to bridge that gap and provide access to all."

Effects on Patients

There undoubtedly are long-term effects on survivors of COVID 19 and on those who did not contract the virus. Many PTs are starting to see some of those impacts on their patients.

For instance, Bullock reports encountering more patients who are at higher risk of falling simply because they did not move enough during the pandemic.

"As a profession, it is our obligation to push the importance of mobility more than ever," she says. "I think there is a fear and distrust of the medical field. So, from a physical therapy perspective, we must be transparent about the treatment that we provide. We need to focus on the individual as well as the science to build trust with our patients. We also must have compassion for patients who do not trust the medical field and hone our teaching and learning skills to provide patients with all the information they need to make an informed decision."

(APTA is collaborating with the American Board of Internal Medicine Foundation on the Building Trust initiative to identify and promote practices that foster trust and trustworthiness in physical therapy. Find examples of trust-building physical therapy practices at buildingtrust.org/partner/american-physical-therapy-association.)

Onifade practices in a predominantly Black community and, with the bonds she had with her community, helped patients avoid the traps of depression and physical ailments that many dealt with during the pandemic.

"As PTs and PTAs, we are advocating for improving mental health and encouraging exercise. We're advocating for improving conversations. We want people to understand how physical therapy can be involved in bettering their day-to-day life," she says. "During the pandemic, a lot of those in marginalized groups were defined as essential workers, and they definitely appreciated physical

therapy. I think long-term that our communication and action is only going to improve the relationships between these communities and physical therapy providers."

"Whether that is caused by fear of exposure or self-imposed social distancing, it is likely that members of the public will view outpatient physical therapy clinics, especially those who honor direct access, as primary care visits," Covert says. "As a result, clinicians should be strongly encouraged to review patient safety recommendations, take routine vital signs, and perform thorough screening measures to assess involvement of other body systems."

Courtney Witczak, PT, DPT, supervisor of physical medicine and rehab services at the critical care and emergency center for Beaumont Health, reports seeing many patients who have recovered from COVID-19 coming back with problems, including chronic long-term cardiopulmonary issues, blood clots, and stroke.

"A lot of patients and families don't understand that if you had the virus, you may have a long-term need for medical supervision from us," she says. "From a physical therapy standpoint, we have to focus on cardiopulmonary interventions and education regarding energy conservation and safety of mobility. We have to prevent patients from having to be readmitted to the hospital with other issues related to the virus."

Physical therapists across all settings of care and within all specialties need to continue to follow the evidence as it emerges regarding the effects that people who have had COVID-19 may experience.

Hallie Zeleznik, PT, DPT, board-certified clinical specialist in neurologic physical therapy at UPMC Centers for Rehab Services in Pittsburgh, notes that patients may be referred to or seek out services for symptoms that may or may not be related to PASC — post-acute sequelae of SARS-CoV-2, commonly referred to as "long COVID."

"The responsibility may be on the therapist to identify whether the symptoms could be driven primarily by PASC or be impacted by an overlay of PASC onto the condition for which they are seeking physical therapy, and whether that patient is having other symptoms of PASC that may call for coordination with other members of an interprofessional team — for instance, mental health symptoms such as increased anxiety," she says.

This will require the PT to understand the symptoms of PASC and realize that it can affect anyone who has had COVID-19. It's not specific only to people who had severe infections or who were hospitalized.

"As PTs and PTAs, we are advocating for improving mental health and encouraging exercise. We're advocating for improving conversations. We want people to understand how physical therapy can be involved in bettering their day-to-day life."

REMI ONIFADE

"Additionally, patients who did have more severe infections and required a stay in an ICU also may be experiencing symptoms of post-intensive care syndrome, which includes a variety of physical, cognitive, and/or mental health problems following ICU care," Zeleznik said.

Defining Role in Emergency Management

While there has been an ongoing conversation about the underuse of PTs and PTAs in disaster response, VanHoose feels the profession needs to champion physical therapy roles in the broader context of emergency management.

"There is a role for us in building healthier communities that might be more resilient to human-made and natural disasters," she says. "We can partner with individuals and organizations in preparedness activities. We can identify and define our roles in response and recovery. COVID-19 paralyzed us temporarily as a profession due to perceived and actual reimbursement barriers. However, there was a missed opportunity for us to fully engage as emergency management partners beyond clinical care delivery. We waited on others to define our roles in all phases of emergency management."

Caruth notes that, as has been seen from field hospitals and during the vaccination process, the PT's role can be expanded to allow them to assist in providing vaccines and become more involved in cardiovascular and pulmonary rehabilitation in acute and subacute settings.

COVID-19's Effect on Academia

Academia has opportunities to reflect on how the profession will define current and future educational practices.

"The pandemic provided us with a 'playground' to explore different instructional and curricular strategies," VanHoose says. "We were able to observe that some learners and faculty thrived in that environment. As we consider our next steps, we have the opportunity to provide diversity in our training programs through admission policies and procedures, instructional methods, workplace environments, meeting structures, and other educational practices."

Since so many students were displaced from their clinical affiliations during the pandemic, delaying graduation for many of them, Caruth believes universities and colleges should have their own clinical setting and offer pro-bono services to members of the communities.

"Not only does this provide practice for students but it also is a great way to promote our profession's value," she says. In addition, Caruth believes program curricula needs to incorporate treating patients with PASC.

Janice Howman, PT, DPT, MEd, associate clinical professor and director of clinical education at Ohio University's division of physical therapy, says because so much was postponed last year, clinical experiences have been backed up, making it difficult to find placement for students.

"We'll get through this, but it's going to be a struggle for a while and it's going to be hard on the students and academic programs in the clinic site," she says. "Hopefully in two years, that will fade away."

Additionally, she feels APTA Acute Care "was absolutely incredible" in terms of the learning

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> LISA VANHOOSE

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>
> KRISSA REEVES

opportunities it made available on the APTA Learning Center (learningcenter.apta.org) in getting students ready to be on the frontlines.

"That information about both COVID-19 and PASC has been helpful to students and our faculty to ensure that students are better prepared to be in the health care environment," she says. "It will become part of our curriculum for the long haul."

One major shift that many in academia expect to become permanent is more hybrid education. What was necessary during the pandemic, they say, will continue to demonstrate value in the long term.

"The consensus used to be that you could only provide successful physical therapy education in a face-to-face format. We found that's just not true," Reeves says. "A lot of virtual options work great, and I think a combination of the two is the wave of the future."

That will allow PT to be accessible to more students and include a greater variety of learning strategies, which will be extremely helpful since all people — including students — display a range of learning preferences.

(Read more about the immediate impact of the pandemic on physical therapy education, and the long-term implications and opportunities, in APTA Magazine's special June 2021 issue on the future of PT education, available at apta.org/apta-magazine.)

Martin feels that physical therapy education currently prepares the professional well for addressing the long-term needs of patients with COVID-19. He cites training and study in various body systems and functions, including cardiovascular and pulmonary, the effects of long-term illness or autoimmune disorders, chronic pain or fatigue syndromes, and related conditions, signs, symptoms, and functional implications.

"PTs and PTAs also tend to demonstrate a level of emotional intelligence and professional preparation that allows them to be versatile and adaptable providers and caregivers. That serves them well in responding effectively and efficiently to changes in patient condition," he says. "PT researchers and clinicians would be well-served to continue to study and produce ongoing research on long-term effects of COVID-19 on individuals as more data become available, and the relation of conditions affecting various body systems to overall daily function."

Keith Loria is a freelance writer.

Health Care Headlines

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

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

Study: Falls Responsible for 90% of Injury-Related ED and Hospital Visits Among 65+

The U.S. Centers for Disease Control and Prevention estimates that in 2018, 2.4 million emergency department visits and more than 700,000 hospitalizations across the U.S. were due to unintentional injuries among people 65 and older — and of those injuries, more than 90% were related to falls. Researchers believe that number could be reduced significantly if health care providers took a more concerted approach toward falls-prevention interventions, including referral to physical therapy and adjusting or eliminating certain prescribed medicines. Rates of both ED visits and hospitalizations for falls were higher for women than for men, with women recording an ED visit rate of 5,003 per 100,000 compared with the men's rate of 3,530, and a hospitalization rate for women of 1,494 per 100,000 versus 1,035 for men.

UnitedHealthcare Makes Telehealth Permanent for PTs

In a major win for the profession and patients, UnitedHealthcare has become the first of the country's large private health insurers to adopt a permanent telehealth policy that includes PTs. UnitedHealthcare has updated its Telehealth/Telemedicine Policy, Professional for providers who bill services on a 1500 claim form, now including physical therapists as eligible providers. UHC will cover certain physical therapy, occupational therapy, and speech-language pathology telehealth services rendered through interactive audio and video technology. APTA has made educating insurers on the value of permanently covering telehealth furnished by PTs and PTAs a central focus of its advocacy efforts.

Study: Better Risk Adjustment Needed in THA, TKA Bundled Care Models

As the use of bundled care models increases, providers may be motivated to "cherry pick" less complicated (and thus more profitable) patients. Authors of a recent study published in the Journal of the American Academy of Orthopaedic Surgeons took what they believe is an important step toward developing better risk stratification for total knee and hip arthroplasties: identifying additional costs associated with specific comorbidities and demographic variables.

By analyzing data from some 6,500 patients, researchers were able to attach a price tag to the amount by which conditions such as overweight, heart disease, and stroke can increase the total cost of TKA and THA. A few of the findings: Among Medicare beneficiaries, the comorbidities associated with the highest increases in care costs were congestive heart failure ($3,937), history of stroke ($2,604), and chronic kidney disease ($2,478). In the private insurance group, coronary artery disease was identified as the comorbidity with the highest impact on care costs, at an additional $4,764. High BMI was associated as a cost-generator for both groups, with a $105 increase associated with every BMI point above healthy for the Medicare group and $148 for the private insurance group. Age also increased cost.

"Without appropriate risk stratification of patients, current payment models introduce the possibility that low-risk patients will be preferentially selected to abate financial risk, thus creating inequality in access to care for patients that would otherwise qualify for arthroplasty procedures," the researchers write, describing current Medicare risk-adjustment models for TKA and THA as "primitive."

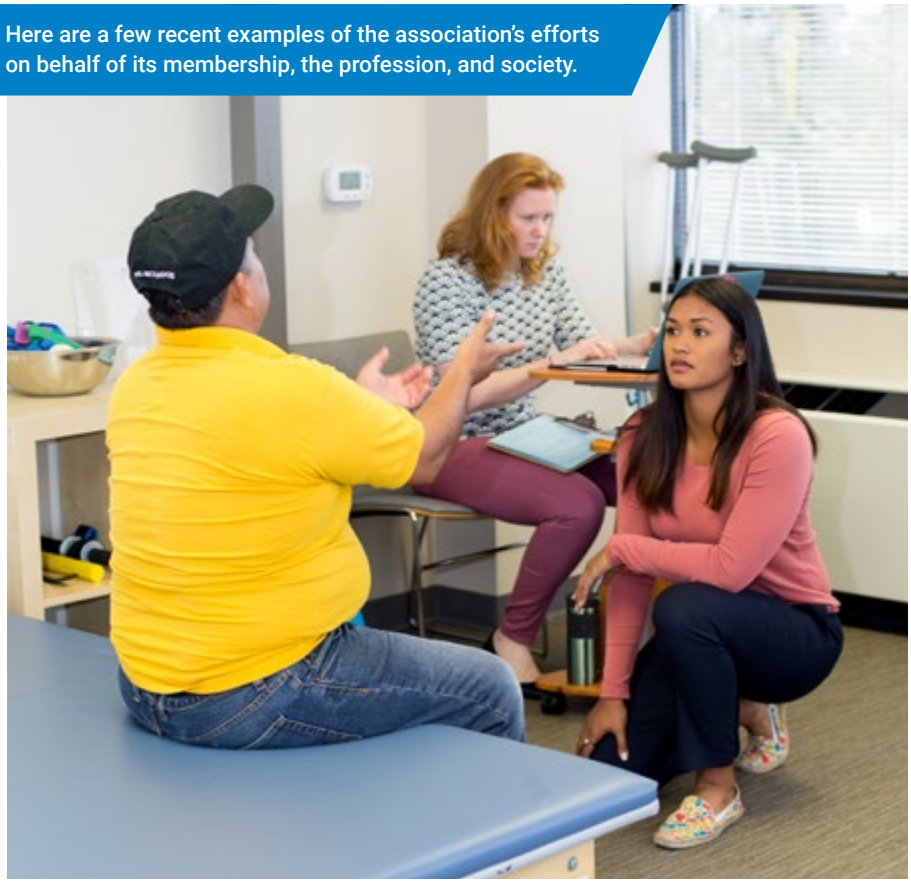
Individualized Rehab Effective for Frail Elderly With Acute Heart Failure

Frail elderly patients with acute decompensated heart failure and multiple comorbidities often are excluded from rehabilitation studies precisely because of those characteristics. But a new study focused on this population found that physical rehab incorporating strength, balance, mobility, and endurance components not only is feasible, but also can lead to significant improvement in physical function and mood — as long as the approach is tailored to individual patient needs.

Researchers studied outcome measures from 349 older patients (aged 65 and above) who were hospitalized for acute decompensated heart failure and received either "usual care" that included telephone calls and clinic visits at one and three months after discharge, or a progressive rehab program focused on increasing endurance by addressing deficits in balance, strength, and mobility. After three months, the rehab intervention group significantly outscored the usual care group on the Short Physical Performance Battery, the six-minute walk test, and self-assessments of self-efficacy and function. The intervention group also reported lower levels of depression than the usual care group.

APTA Leading The Way

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



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

Bipartisan Group of House Members Takes on PTA Differential, Offers Options

A bipartisan group of five members of the U.S. House of Representatives has joined APTA and other groups in criticizing a plan to reduce Medicare payment to providers when therapy services are delivered at least in part by a PTA or occupational therapy assistant. In a letter sent to HHS Secretary Xavier Becerra, the lawmakers warn that the system will be particularly harmful for providers in rural and underserved areas, and offer possible solutions to avoid the worst of the damage. The lawmakers press the Department of Health and Human Services to either create a class-specific geographic index to offset the differential in rural areas, or to establish targeted incentive payments.

"The payment reduction puts at risk the financial viability of physical and occupational therapy businesses in rural and underserved areas," the letter states. "Absent action by the Centers for Medicare & Medicaid Services, the therapy assistant payment reduction will exacerbate the growing problem of limited access to medical care throughout much of rural America."

APTA-Backed Bill Presses for Medicare Advantage Prior Authorization Reforms

APTA-supported bipartisan legislation taking aim at misuse of prior authorization in Medicare Advantage plans has arrived on Capitol Hill. Known as the "Improving Seniors' Timely Access to Care Act" (H.R. 3173) the bill in the House wouldn't completely eliminate the use of prior authorization but would put up guardrails around MA's prior-authorization practices.

Specifically, the bill would establish an electronic prior-authorization process, require the implementation of a "real-time" decision system for items and services that are routinely approved, mandate that MA plans provide more detailed reports on use of prior authorization to the U.S. Centers for Medicare & Medicaid Services (including their rates of approvals, denials, and average time for approvals), and press MA providers to do a better job of incorporating input from health care providers in their authorization programs and decisions. Easing administrative burden is a central policy goal for APTA.

ABPTS
American Board of Physical Therapy Specialties

New From APTA: A Fresh Look at Specialist Certification Opportunities

Think specialist certification might be right for you? There's a new gateway to exploring the possibilities. This spring, APTA launched a retooled website for its specialist certification program governed by the American Board of Physical Therapy Specialties. The changes aren't just about the look and feel of the site: In addition to adapting content to APTA's brand, the new resource makes it easier than ever to find out what certification means, learn the details of the process, and track your certification application. The streamlined resources also help already-certified PTs understand how to maintain their credentials and monitor their progress.

'DEI Is Not New': A Brief Q&A With 2021 Woodruff Lecturer

Charlene Portee, PT, PhD, who in June delivered the second annual Lynda D. Woodruff Lecture on Diversity, Equity, and Inclusion in Physical Therapy, isn't looking to tread lightly around the topic. You can guess that much by the title of her presentation: "The Road to Success: Are We Ready To Change Direction?"

The lecture, presented on June 17, was followed by a panel discussion to provide even more insight and context. Recordings of both are free and available at **apta.org/apta-and-you/diversity-equity-and-inclusion/2021-woodruff**. Shortly before the lecture, APTA caught up with Portee — dean of the College of Health Sciences, interim director of the Physical Therapy Department, and a tenured associate professor in the Physical Therapy Program at Alabama State University — to get a sense of what to expect. Here's what she had to say.

APTA: How would you describe the physical therapy profession's understanding to date of what diversity, equity, and inclusion mean?

Portee: Over the last year, I have observed an increased effort by physical therapy to "understand" DEI; however, sustainable change and measurable action are what is needed.

APTA: You might be talking in more detail about this during your lecture, but what are the barriers that the profession may face as it changes direction — and are those barriers solely within the profession, or are there larger challenges that need to be addressed?

Portee: One barrier that I will discuss is the lack of racial diversity in APTA. Many other organizations face this same challenge. It is a microcosm of what is going on in society.

APTA: What are you hoping attendees to come away with after your lecture?

Portee: I hope attendees will come away with a few strategies for increasing DEI in the profession and recognize why fostering DEI in physical therapy is necessary.

APTA: Unlike McMillan or Maley lecturers, who can look back on years' worth of content, you have only one previous lecture as a point of reference. Do you feel like a pioneer charting new territory? What guided you as you prepared for this lecture?

Portee: "Minority issues" in physical therapy are not new; therefore, when preparing for my lecture, I did review several McMillian lectures and the previous Woodruff DEI lecture, which provided some insight. I do not consider myself a pioneer; diversity, equity, and inclusion are not new concepts. Recently, they have become the buzz words and have received much more attention. I have looked to the past for answers. The answers are there. Now, we must be committed to change and take action.

The Second Annual Lynda D. Woodruff Lecture on Diversity, Equity, and Inclusion in Physical Therapy is sponsored by APTA, the American Council of Academic Physical Therapy (**acapt.org**), American Academy of Physical Therapy, APTA Academy of Education (**aptaeducation.org**), National Association of Black Physical Therapists (**nabpt.org**), and Physical Therapy Learning Institute (**ptlearninginstitute.com**).

Student Focus

Students are frequent contributors to our blog at apta.org, and most of their essays hold interest for everyone in the profession. The following is excerpted from a 2020 post by Darren Joffe, SPT, a student at Temple University, who recounted experiences in transitioning from in-person to remote learning during the COVID-19 pandemic.

Adapt and Thrive: Becoming a Professional in the Age of COVID-19

The patient I was meeting on the computer had sought out our care through Temple University's pro bono clinic. He had been experiencing knee pain since the pandemic started, after he took up running.

As I listened to his weekly reports of how his knee pain was progressing, with my supervising instructor also on the computer, I began to formulate a patient education and exercise program. I explained how he shouldn't push past his envelope of function as a beginner runner. I talked through different lower extremity exercises such as bridges and clamshells. We discussed different ways that he could perform the exercises at home since he didn't have any resistance bands with him.

As the session was wrapping up, I felt a sense of relief that even during a pandemic, a time when human contact and physical interaction was limited, I was still able to provide care.

I think back to the beginning of my first year, in cadaver lab on a hot summer day, riding the subway with my classmates to our podiatry building, Vaseline under our noses to mask the smell of formaldehyde, stomachs empty to avoid potential nausea, and not knowing what to expect. That experience and sensation of starting something new as a future physical therapist was exhilarating but terrifying at the same time.

As we dissected the cadaver and learned about all the intricacies of the human body, our minds started to delve deeper into the complexity of our species. I used this information in learning how to measure range of motion, perform manual muscle tests, and compile objective data into treatment plans.

At times the transition to online classes and clinic was difficult. I wasn't able to practice many of the manual skills and other hands-on skills that we were being taught. I had to alter the way I treated and integrated the material I was learning to adjust to a remote environment.

However, I found that I could still be involved and deliver patient care through communication, by working on patient-provider dialogue. I've come to believe that, while so much of physical therapy is grounded in touch, when we bring all of our senses into the experience, as we are now in the age of COVID-19 and the use of telehealth and e-visits, we are better able to make a connection.

When we experience something with all our senses, we are better able to make a connection. However, with more stressors and issues in this world than ever before, the importance of our words and the impact that communication and a conversation can have on a patient is vital.

Read the full story from Dec. 15, 2020, at **apta.org/adapt-and-thrive-becoming-a-professional-in-the-age-of-covid**

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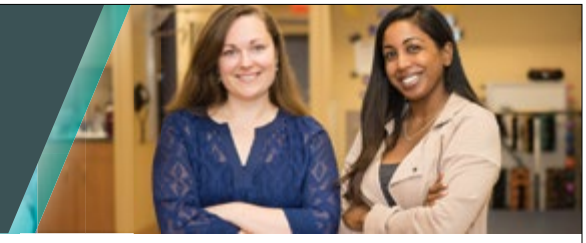

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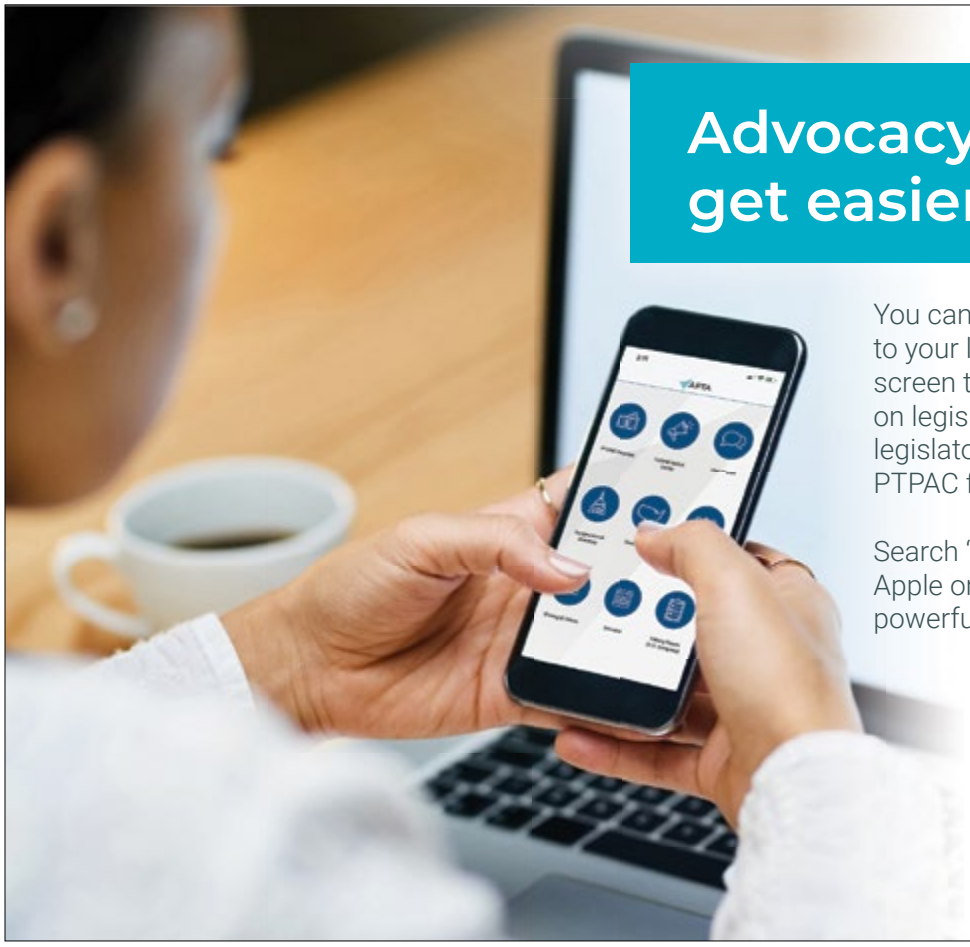

Advocacy doesn't get easier than this!

You can send prewritten messages to your legislators with a few screen taps, view talking points on legislative issues, and find your legislators. You can even donate to PTPAC from the app.

Search "APTA Advocacy" in your Apple or Google app stores. This powerful advocacy tool is free!

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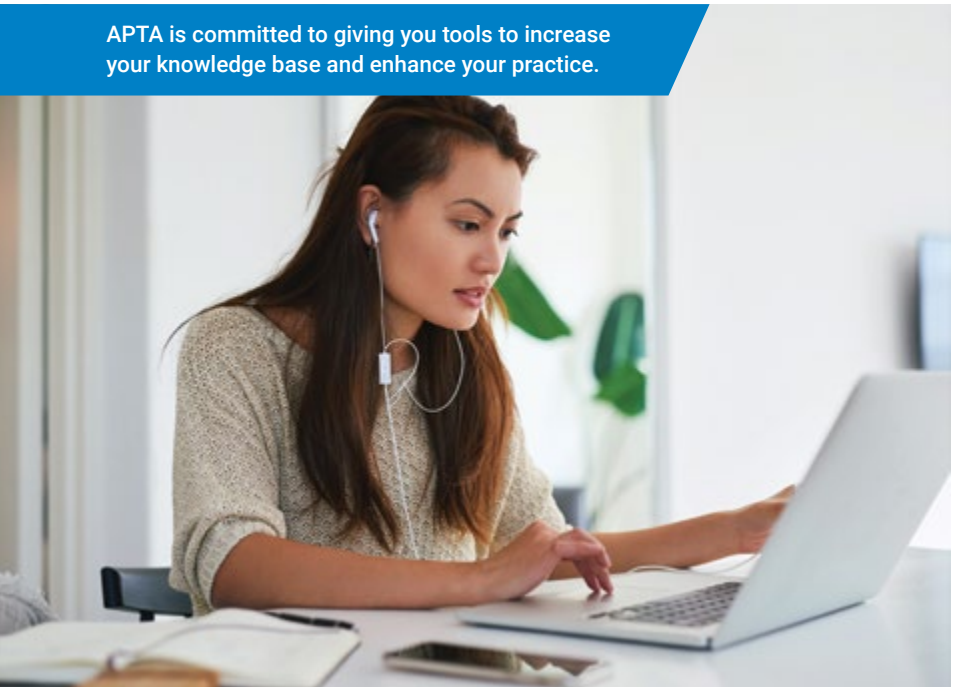
APTA Member Value

APTA is committed to giving you tools to increase your knowledge base and enhance your practice.



Access the APTA Learning Center at **learningcenter.apta.org**

APTA Learning Center — Your Access to Trusted Continuing Education

Whether it's time to focus on your CEs for licensure renewal or learn about a new area of practice, the APTA Learning Center is your place to begin. With free and significantly discounted courses for APTA members, the Learning Center helps you expand your knowledge. Here are five examples:

1. Centennial Lecture Series. Celebrate 100 years of our association by participating in APTA's Centennial Lecture Series that runs through October. Earn 0.8 CEUs (eight contact hours) with each two-day lecture. The August lecture will be offered virtually, and the final two monthly lectures and labs are scheduled to take place in person at the new APTA Centennial Center in Alexandria, Virginia. Upcoming lectures will focus on concussion assessment and management, treating the injured runner, and physical therapist management of the bicyclist. Missed a prior lecture? Recordings are available for purchase.
2. APTA Telehealth Certificate Series. APTA developed this six-part series to ensure that PTs, PTAs, and students are prepared to provide excellent care via telehealth. Learn best practices and tips covering ethical and regulatory considerations, administration and marketing, technology, and clinical application, while you earn 1.2 CEUs (12 contact hours). Tiered pricing is available for bulk registration by organizations or education programs. NEW: See newly added electives with real-world cases about the provision of telehealth services in specific clinical settings such as acute care, geriatric, neurological, orthopedic, and vestibular disorders.
3. Free member courses. APTA members have access to 32 complimentary courses, plus free access to 150 CE modules from the CINAHL information system via APTA's Rehabilitation Reference Center — all a part of your membership.
4. Need more continuing education this year? Purchase a Passport to Learning. With one annual subscription, you can get more than 20 prerecorded webinars and many other CE opportunities for the price of two webinars. Normally $279 for nonmembers, an annual subscription is just $198 for members.
5. Special offers from APTA affiliates. APTA has teamed up with continuing education affiliates to bring you the most trusted CE content in physical therapy. These include a discounted MedBridge subscription, free offerings from CMS, and other courses from APTA sections and chapters.

Get all your annual CEUs in one place, at a discount. Take advantage of the APTA Learning Center and start earning your CEUs today.

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APTA
American Physical Therapy Association

It's our centennial, and here are some of the ways we're celebrating.

APTA Centennial Celebration

Multiple activities will be held in our nation's capital in September to celebrate APTA's past 100 years and look forward to the next century. While the plan is to hold events in person — consistent with CDC, state, and venue guidance and restrictions — the following will be livestreamed to allow for remote viewing. Visit the Celebrate page on the APTA centennial website for details, and if you can't be on-site, tune in!

Sept. 10

The annual John H.P. Maley Lecture will be delivered by Tim Flynn, PT, PhD, board-certified clinical specialist in orthopaedic physical therapy.

Sept. 11-12

The APTA House of Delegates will conduct its annual session.

Sept. 10

A President's Forum will feature APTA President Sharon Dunn, PT, PhD, board-certified clinical specialist in orthopaedic physical therapy, who will join past presidents in discussing the past, present, and future of the association and profession.

Sept. 13

The Future of Physical Therapy Summit will feature thought leaders from within and outside the profession.

APTA Centennial Lecture Series

The APTA Centennial Lecture Series features recognized leaders on topics in clinical practice, practice management, payment, and innovation. We're continuing to offer one course every month through October, with the August course scheduled to be hosted virtually and later ones tentatively to occur in person at APTA Centennial Center in Alexandria, Virginia. (We are monitoring health recommendations related to COVID-19, and dates and formats may change if needed to ensure everyone's safety. Check the centennial webpage for updates.)

Recordings will be available if you miss a live course, but to earn CEUs you must attend the live events. Here's what's coming up:

- **August:** Get Your Head in the Game: Basic Concussion Assessment and Management (live virtual lecture and lab Aug. 27-28), with lecturers Lt. Col. Carrie Hoppes, PT, PhD, board-certified clinical specialist in neurologic physical therapy and in orthopaedic physical therapy; and Karen Lambert, PT, DPT, board-certified clinical specialist in neurologic physical therapy.
- **September:** Treating the Injured Runner (live tentatively in-person lecture and lab Sept. 24-25), with lecturer Eliza Szymanek, PT.
- **October:** Physical Therapist Management of the Bicyclist (live tentatively in-person lecture and demo Oct. 22-23), with lecturer Eric Moen, PT.

Recordings of the lectures from March through July also are available. Go to **centennial.apta.org/celebrate** to register or learn more.

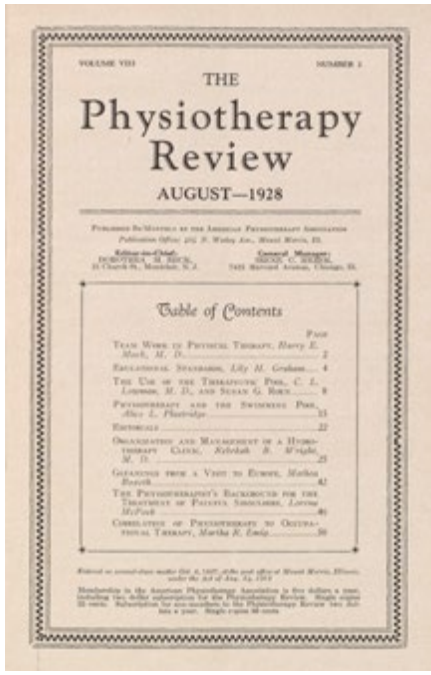
Find out more at **centennial.apta.org**

This Month in APTA's History

Here are some notable dates in August from APTA's past 100 years.

- In August 1928, the association's journal, Physiotherapy Review, transitioned from a quarterly publication to bimonthly.
- On Aug. 1, 2008, the Physical Therapist Centralized Application Service launched PTCAS, which allows PT applicants to use a single web-based application and one set of materials to apply to multiple physical therapist education programs.

Visit centennial.apta.org to see how you can join in the celebration and view the top 100 milestones of the association's 100 years. Read more about the milestones in "A Century of Movement: Milestones of the American Physical Therapy Association's First 100 Years," for sale in the APTA Store at store.apta.org.



THE
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AUGUST—1928

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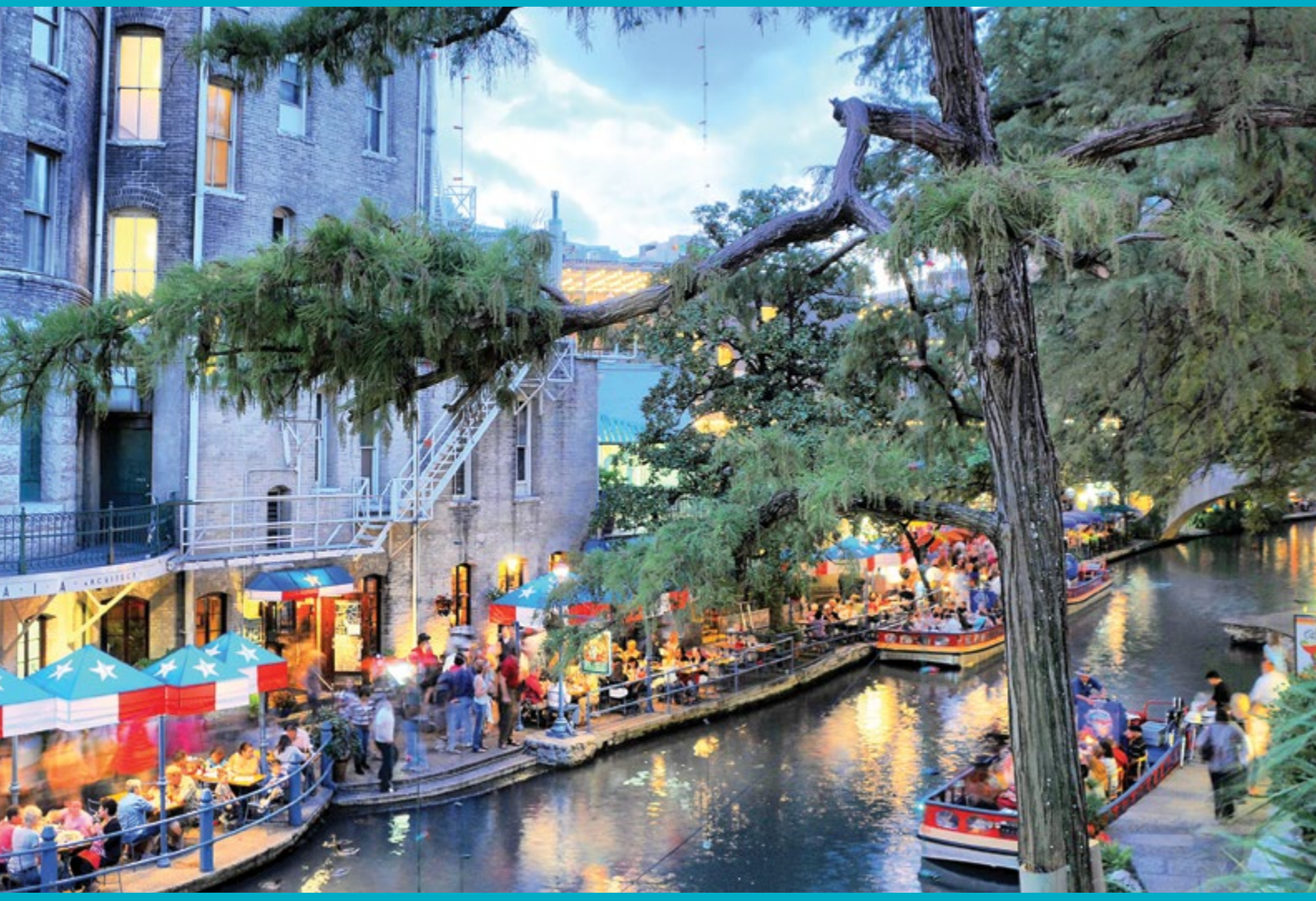
Table of Contents page of the August 1928 issue of The Physiotherapy Review.

Better together.
Together again.



APTA Combined Sections Meeting

Feb. 2-5, 2022 / San Antonio, Texas

Registration opens early September.

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Learn more about physical therapy research at **Foundation4pt.org.**

/ By Wendy Wagner, PT, MPT

It wasn't until she saw patients with the same rare condition that a PT realized what had been plaguing her own body for years.

A Lucky Patient Encounter Provides Answers

My parents marveled at my "adorable" foot braces to fix feet that turned inward at birth. My bendy body was recruited for the local circus because it could twist in such entertaining ways. Ribs dislocated after a car accident took 10 years to find their way back home where they belonged.

I thought, "I guess I'm just unlucky."

My right shoulder popped out during the state finals of a record-setting high school swimming competition. My left shoulder popped out during the state finals of a championship high school water polo game. On a tiny ski hill, my ACL snapped.

I thought, "I guess I'm just unlucky."

My jaw dislocated and locked up on my wedding day — how would I smile or talk? I spent time in a wheelchair during pregnancy due to a sacroiliac joint that slipped out of position. My stomach slowed to a stop once, putting me in the hospital for weeks until it woke up.

I thought, "I guess I'm just unlucky."

I couldn't stand in a line without feeling dizzy, I lost my vision when I stood up quickly, and I had constant underlying nausea. My ankles would forget how to be ankles walking down the stairs, or even walking down the street. Stitches never held, and wounds dehisced. My hands and wrists required splinting to write, type, sleep, or drive.

Oh, and as an adult I had a disabling, eight-out-of-10 headache nearly every single day.

Growing up and as a young adult, I asked myself: Didn't everyone's body behave that way? Don't most high-level athletes spend large percentages of their seasons in pain and in physical therapy? Wasn't I just unlucky?

I assumed the answers were yes and pressed on through my pain to complete my undergraduate degree in business at the University of Illinois. I then started a career as an advertising executive. The hours were long, but the job was dynamic, the travel was fun, and the perks were glamorous.

I shagged balls for Michael Jordan before a media event because my client was a sponsor for the Chicago Bulls. I sat at conference tables and planned ad campaigns with magicians Penn and Teller, Bill Nye the Science Guy, and execs from McDonald's and Miller Brewing Company. I had a visible and important role in bringing Target stores to Chicago. It was fun. It was sexy. But it burned me out. My 27-year-old body hurt all the time.

After getting married and thinking about starting a family, I realized that my job was not compatible with my desire to work part time while I raised my children. It also left me feeling empty on the inside: I realized I was in the business of persuading people to buy stuff they didn't know they wanted or

Wendy Wagner, PT, MPT, owns Wendy4Therapy, a private specialty practice in Naperville, Illinois, that serves patients with hypermobility-related disorders and POTS. She is also co-founder of EDS Illinois, a nonprofit support and resource group for patients in that state. You can reach Wendy at wendy@wendy4therapy.com, @Wendy4Therapy on Facebook, and @EDSIllinois on Facebook and Instagram.

Wagner works with a patient who has hEDS and POTS — and is the mother of three girls with a similar diagnosis. Because they have excess range of motion, these patients require close supervision on form to make sure they are not using compensatory patterns to execute desired exercises.

Defining Moment spotlights a particular moment, incident, or case that either led the writer to a career in physical therapy or confirmed why they chose to become a physical therapist or physical therapist assistant. To submit an essay or find out more, email aptamag@apta.org.

Wagner sits with the three young patients who helped her identify her own diagnosis of hypermobile Ehlers Danlos syndrome.

probably didn't need. And I wanted to know more about why my body seemed to behave the way it did and how to make it feel better. So, I decided to change course to something that I suspected would bring more meaning to my life — I went back to school to become a physical therapist.

Having been in business school as an undergraduate, I did not have a single required science prerequisite. After quitting my ad job, I spent a year at my local community college studying anatomy, physiology, chemistry, physics, biology, statistics, and calculus before applying to and entering Northwestern University's physical therapist program. The Department of Physical Therapy and Human Movement Sciences prepared me to be a physical therapist, and I felt privileged to have graduated from such a well-respected school.

Working on and off and part time when my kids were young, I practiced in a community hospital, a public school, a home health setting, and a residential pediatric intensive care facility.

Then, 25 years after graduation, I had a mother and three daughters come though my outpatient pediatric clinic with conditions that I had never heard of: hypermobile Ehlers Danlos syndrome, also referred to as hEDS, hypermobility spectrum disorder, and HSD; and postural orthostatic tachycardia syndrome, known as POTS.

The children were excessively flexible (they could walk on the tops of their feet and bend their bodies into pretzels), they had complex medical histories with vague symptoms and complaints, and they struggled with pain and joint instability at very young ages. They had GI distress, felt fatigued all the time, and had injuries that were difficult to explain given the mechanism of injury they described and the lack of corresponding radiographic evidence to support their clinical complaints.

One day their mom saw me clutching my forehead as I came to get the girls for their treatment session and asked me if I had ever considered that my 187-day headache may not be a migraine but might be caused by the instability in my upper cervical spine. She had seen my overly flexible fingers and wrists and heard me relate to the girls with the "party tricks" I also could do with my flexible body. As I got to know the mom and her daughters better, their stories started sounding familiar to me. I realized that I had a similar history of presenting symptoms. These little girls were frequently injured and discounted their physical complaints. They pushed through their pain, struggled

to tolerate a full day of being upright, and felt different from their peers.

Before the girls' diagnoses, their mom hadn't been able to get an explanation from the school system, previous therapists, or physicians as to why her daughters complained so much. She was told they were "anxious" and just needed "to exercise more."

I spent the next year reading everything I could about hEDS and POTS (both of which have limited clinical research). I sought out professional conferences and traveled around the country to be evaluated by industry experts. I participated in online learning modules. After a visit with a neurosurgeon and geneticist, I was ultimately diagnosed with hEDS — and came to my defining moment. This is what I was meant to do with my exceptional professional education and my personal gifts of compassion and healing. I wanted to help other people connect the dots that I had just connected. A lifetime of seemingly unrelated "accidents" and vague complaints of pain and fatigue had an explanation.

Before I knew it, word got out in the Chicago area, and I went from being the PT who has hEDS to being the PT who treats patients with hEDS and its comorbidities. My pediatric practice quickly transitioned from treating children with developmental delays to specializing in adults and children who have hEDS and POTS. I have since attended specialty conferences, connected with professional colleagues, and consumed large volumes of material to learn all I can about these conditions.

Although considered "rare," it is estimated that up to 30% of the patients who present to outpatient orthopedic physical therapy clinics likely have some form of hypermobility as a contributing factor to their injury or disease process, whether or not it is their presenting symptom. I believe connective tissue disorders such as hEDS are underrecognized, underdiagnosed, and poorly understood in the medical community. I am engaged in research to survey all DPT programs to determine the amount of time dedicated to teaching students about systemic hypermobility and connective tissue disorders, as it is believed to be at least as common as rheumatoid arthritis or fibromyalgia but receives much less time in didactic and clinical instructional settings.

Because collagen is found in nearly every tissue in the human body, connective tissue disorders can have varied and complex presentations. EDS affects nearly every organ system: the GI system ("leaky gut" and gastroparesis), skin (excessive stretch, poor wound healing), and the pelvic region (prolapse, incontinence, and complications with pregnancy). Most commonly, hEDS presents with generalized joint hypermobility and associated chronic pain. Patients are unaware of their excessive range of motion and create "microtrauma" each time the joints are loaded at end range. As collagen is found in highest density in ligaments and tendons, these primary stabilizers do not resist tensile load as

As I got to know the mom and her daughters better, their stories started sounding familiar to me. I realized that I had a similar history of presenting symptoms.

Most come to me after “failing” traditional therapies. Nearly all have felt discounted by their health providers, friends, and family. Most have cried during their initial examination because it is often the first time they feel seen and understood.

effectively as they should in people with hEDS, causing pain and dysfunction when muscles, the secondary stabilizers, are asked to work harder than they should. Because these conditions effect multiple body systems, they tend to puzzle primary care providers and seem, at first glance, to be unrelated.

Called the “trifecta,” most patients with hEDS experience the comorbidities of POTS and mast cell activation syndrome, in which the body mounts an inappropriate immune response to what should be benign stimuli (think hives, flushing, GI distress, and wheezing). Symptoms from the comorbidities can be as disabling as hEDS. I am passionate about advocating for better understanding in the medical community and improved treatment options for patients with these conditions.

As physical therapy is often presented as being the first — and best — line of defense in preventing injury and limiting disability related to systemic joint hypermobility, I would like to educate clinicians to better recognize symptoms related to hEDS, POTS, and MCAS and work toward better quality of health delivery. Due to the disabling nature of their physical pain, patients with these conditions often spend a great deal of time in physical therapy. Many of my patients report having been injured by past experiences with physical therapists who were unfamiliar with hEDS, because their bodies were being asked to do more than they were capable of doing. Physical therapy for this population must begin at low levels due to compensatory patterns, exercises must begin in supine and prone positions before progressing to upright due to the patients’ orthostatic intolerance, and progression must be slow to allow new neuromuscular patterns to be learned.

With the multiple body systems affected, the chronicity and severity of presenting symptoms, and the complex and interrelated musculoskeletal issues to understand and rehabilitate, I spend a great deal of time, and form deep personal bonds, with each of my patients. Most come to me after “failing” traditional therapies. Nearly all have felt discounted by their health providers, friends, and family. Most have cried during their initial examination because it is often the first time they feel seen and understood. I have been told that I saved a life. I have been told that hope was being experienced for the very first time.

I would say the same things right back to my patients. I am honored to be in partnership with them and am grateful to have them with me on my own journey. We all learn from each other. I often turn to this quote from Maya Angelou for inspiration: “We need joy as we need air. We need love as we need water. And we need each other as we need the earth we share.”

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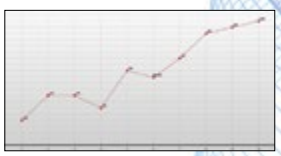

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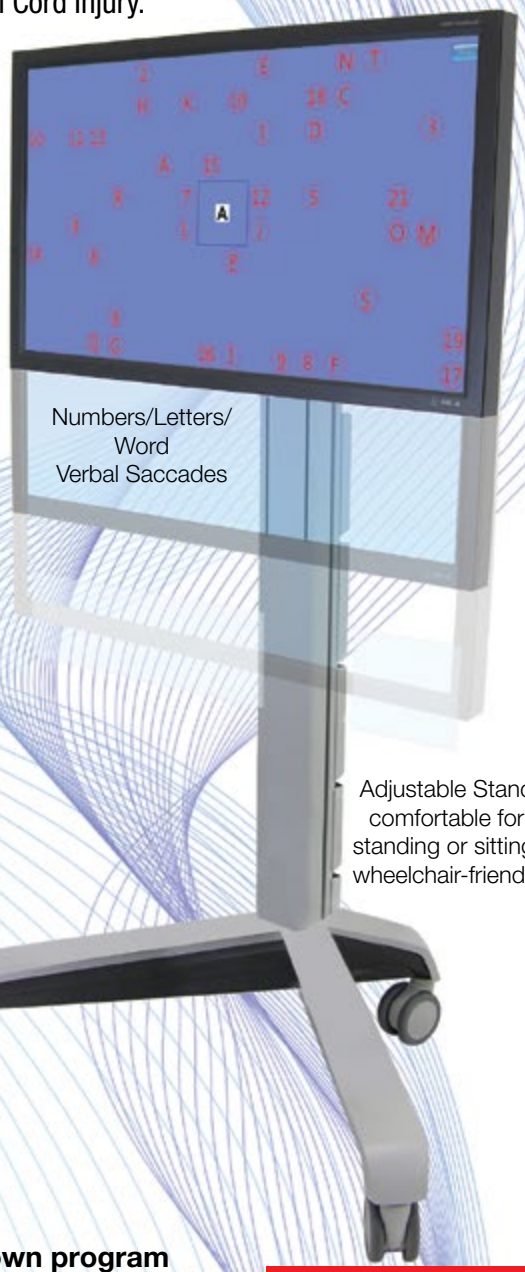

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