APTA® Magazine

/ Future of Physical Therapy Summit

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February 2022 / Vol. 14 No. 1

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Something To Run Toward

New APTA President Roger Herr, PT, MPA, talks about moving from clinician to manager, how his parents were role models, and his plans for the future of the association.



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A View From the Summit: Physical Therapy's Promising Future

APTA's Future of Physical Therapy Summit offered inspiration — and a challenge to take risks to help the profession achieve its potential.



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Blood Flow Restriction Training Becoming Standard Practice

A novel treatment not long ago, blood flow restriction training is rapidly being used by more and more physical therapists.

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Ethics in Practice
What do you do when professional decision making clashes with professional requirements?

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Defining Moment
A light came on not only in a dark hospital basement but in a future PT's head that this was her ideal career.

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Balance Graph

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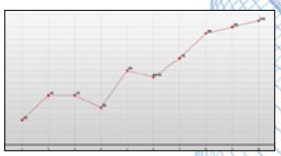

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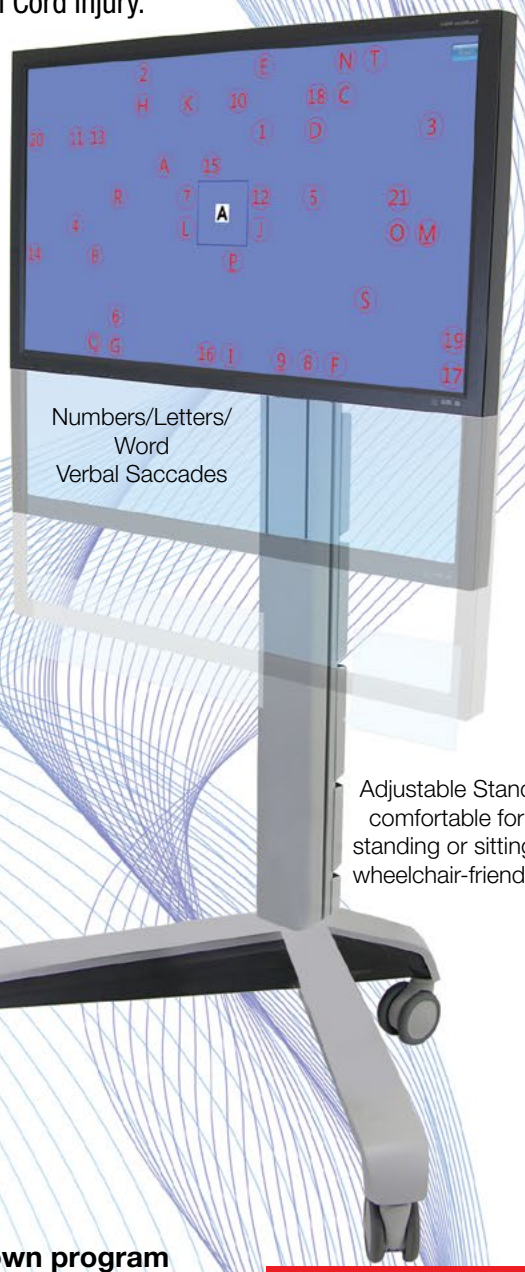


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“When I worked for the nursing home, it was faith-based. I’m not. But the nuns were thinking I wanted to convert because I asked so many questions.”

— Roger Herr, PT, MBA, in “Something To Run Toward” on Page 30.

APTA American Physical Therapy Association

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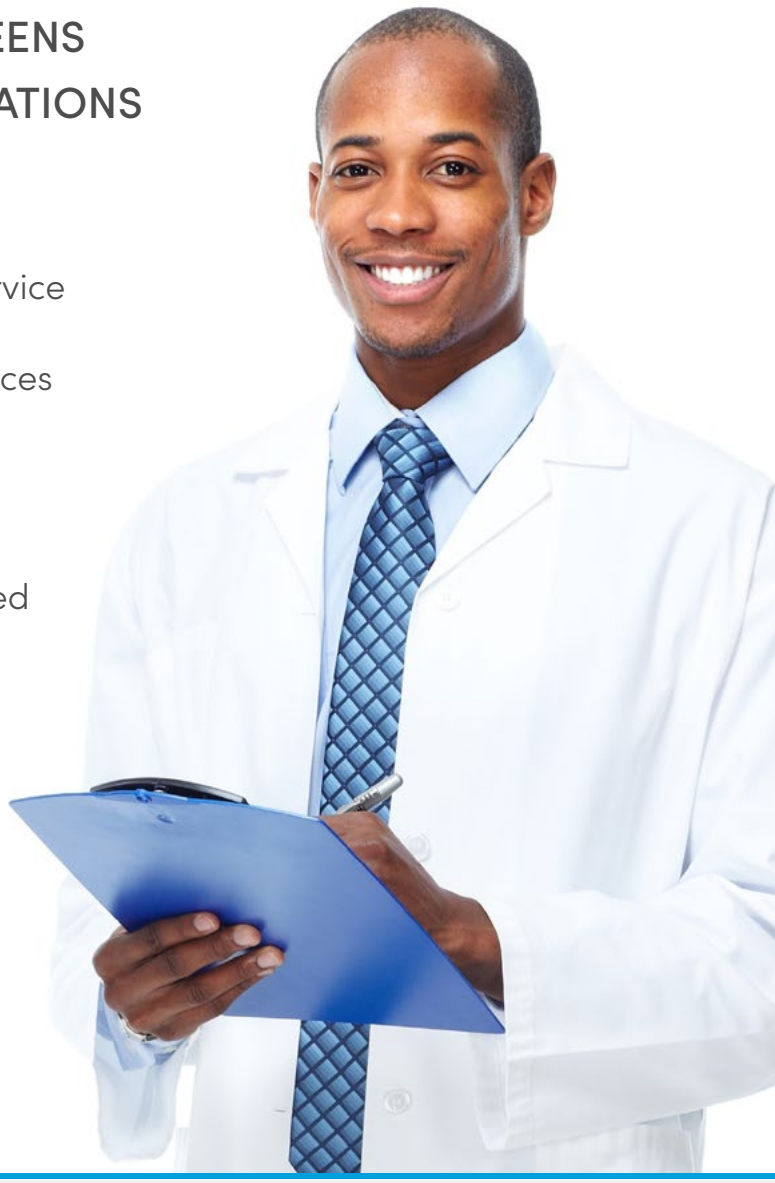
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Opinion



Physical Therapists See an Increase in Post-Lockdown Exercise Injuries

One unfortunate effect of the necessary COVID-19 lockdowns has been the decrease in physical activity among the population. People had good reason to stay away from gyms and physical therapy clinics for most of 2020. While this helped prevent the spread of COVID-19, it made it much more difficult for people to exercise regularly or conduct their treatment plans with their physical therapists. However, people are returning to gyms, and PTs — including my colleagues and me — are seeing a new issue. Exercise-induced injuries have become common in PT clinics across the country as people are overtraining after long periods of inactivity.

Extended periods of detraining make exercise-induced injuries more likely. A year of working from home on our couches, beds, and dining tables without frequent exercise is taking its toll.

Our clinic has seen the impact of detraining firsthand. We have experienced an influx of patients with common overtraining injuries in the shoulder, back, neck, feet, hamstrings, knee, and hip.

We're seeing back injuries from deadlifting too much weight too quickly and foot injuries from trail running. Both are caused by overexertion and a lack of knowledge of proper mechanics. This is exacerbated by many patients' assumptions that they immediately can return to their prepandemic level of intensity. Just starting with squatting body weight and walking their favorite hiking trail would be better ways to gradually get back into their fitness activities.

Treating exercise injuries along with the return of patients dealing with chronic pain issues and the addition of patients physically limited by COVID-19 will make any physical therapy clinic, including our own, exceptionally busy.

As our team sees more of these exercise-induced injuries, we are taking the time to educate our patients on how to properly build up a training routine. It is in our patients' best interests to get out of the house and get healthy again but not if they hurt themselves in the process. The best thing a PT can do when working with a patient dealing with an exercise injury is to establish good habits

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within the treatment plan. Treat them so they feel better, but also instruct them on what a proper warmup looks like and how they can slowly ramp up the intensity of their exercise routine. Help the patient establish a feel for what full range of motion feels like in their knee, shoulder, ankle, or wherever their injury occurred.

At our clinic, we take our patients through a proper warmup and then move them into a more challenging exercise. When we keep taking them through the proper process and they consistently find themselves feeling better after a warmup, they are more likely to buy into the treatment plan.

Help the patient understand signs of overexertion. Let them know that muscle soreness after exercise is fine, but irritation in one joint means the patient must take the foot off the gas and instead stretch or rest.

The decrease in physical activity over the last year is not a good thing. It is important to help our patients prevent exercise injuries so they continue to remain active.

Finally, we should urge more preventive physical therapy sessions. So much of our model is helping people after they get hurt. It is important that we advocate for prospective patients to have greater access to our services when they are healthy. By doing this we are able to understand a healthy patient's muscle function, strength, and flexibility as well as point out areas where we think a patient may be at risk for injury.

The opportunity to guide healthy patients through a proper warmup plan will go a long way to minimize injuries caused by overexertion. The best tool a PT can give a patient is the education to stay healthy. Advocate for us to educate healthy patients as well as injured ones.

NOAH ARENSON, PT, MPT
CONTACT PHYSICAL THERAPY
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Helen Hislop's Vision of Clinical Specialty: Where Are We Half a Century Later?

"Are we there yet?" my 5-year-old son asks from the back seat every five minutes during our weekly long drives to the beach. That and "Where are we now?" are questions all too familiar for a lot of parents traveling with children.

As I review the contents of the board specialty documents of the American Board of Physical Therapy Specialties, I ask the same questions to myself and to our profession; reflecting on Helen Hislop's 1975 lecture in Anaheim, California (cue images in my head of the past APTA Combined Sections Meetings with the Mickey Mouse Ferris wheel in the background), titled "The Not So Impossible Dream."

Hislop's vision for the profession included structured programs to develop clinical specialists to advance the clinical sciences and improve the quality of care. She stated, "It is only natural that the explosion of knowledge should outstrip the capacity of each practitioner to encompass the entire field." In 1985, a decade after Hislop delivered her lecture, the first clinical specialists were credentialed in the cardiopulmonary specialty area.

Almost half a century later — yes, 46 years and over 32,704 board-certified clinical specialists after her address to the profession — the amount of evidence and research literature in the profession of physical therapy has exploded exponentially. The proof of clinical competence that she requested for clinical specialization has given rise to the evolution of 10 board specialty areas in physical therapy and eight advanced proficiency pathways for the physical therapist assistant. ABPTS and its 10 specialty councils have been essential in realizing Helen Hislop's vision of providing a formal pathway to develop our professions' growing army of clinical specialists. The need for further structured programs to train clinical specialists has given rise to 348 accredited residency programs and 46 fellowship programs accredited by the American Board of Physical Therapy Residency and Fellowship Education.

In her lecture, Helen Hislop was worried that clinical specialization may turn out to be a double-edged sword.

»

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Want to read and save Helen Hislop's "The Not So Impossible Dream" and the other 49 Mary McMillan Lectures delivered 1964-2019? APTA has published "50 Visionaries: The Mary McMillan Lectures," a six-volume series containing the full text of each lecture. Buy the books from the APTA Store at store.apta.org.

On one side, she envisioned a high quality of care backed by research being provided by clinical specialists. On the other side, she acknowledged the risks of specialization becoming so compartmentalized that it would promote a "myopic" view of patient care and lead to studying the human being on a piecemeal basis, with each specialty concentrating in their respective anatomical areas and organ systems.

As it has played out, Hislop's prophesy of specialization advancing the clinical sciences is spot on with our profession supporting evidence-based practice in all its board specialties and almost all clinical practice settings. The "explosion of knowledge" that Hislop projected gave birth to knowledge translation and the continuous development of clinical practice guidelines to assist in our clinical decision making.

Her fear of the specialties creating a myopic lens turned out to be unwarranted. As we look more closely at the clinical specialties, the amalgam of evidence from the different specialty areas is like a set of gears moving together propelling physical therapist clinical expertise forward. Take, for example, the specialty of geriatrics: Advancement of knowledge in this specialty overlaps with that of the other specialty areas. This overlap of evidence ensures that the different branches of our profession provide the same best care to our older adults. As Aristotle and Ida Rolf once stated, "An effective human being is a whole greater than the sum of its parts."

The view from where I sit has shown me how the specialty of oncology was born out of the need to treat the whole human being, instead of the individual specialty areas working on individual organ systems, such as orthopedics for bone and muscle, neurology for the brain, and cardiopulmonary for heart and lungs. The active collaboration among APTA's sections and academies in development of clinical practice guidelines is proof that specialty areas are not working in silos. The current frameworks of ABPTS and ABPTRFE ensure that our modern clinical specialists do not lose sight of the forest for the trees.

Looking back it seems that our profession has heeded Helen Hislop's trifecta of warnings in the pursuit of specialization:

Prevent its inhibition by too much teaching. The heart of board specialization as well as residency and fellowship training are geared more toward clinical practice and gaining clinical experience, with a smaller, albeit equally important, portion dedicated to didactic instruction.

Prevent its submission by too much dogma. The evolution of physical therapist clinical practice from using historically important and traditional treatment approaches to continuously evolving best available research evidence is emphasized in the Academy of Neurologic Physical Therapy's position paper titled "Moving Forward."

Prevent its extinction by too much ritual. The scheduled practice analysis in the different specialty areas that assess the current practice patterns of specialists in the field consistently redefines the meaning of each specialty as it evolves with practice and evidence. The conversations on whether to include the newer Olympic games such as sailing, sport climbing, karate, and surfing in the sports practice analysis, or the addition of medical and surgical considerations and content reflecting the advancement of direct access in the latest pediatric description of specialty practice, show that the different specialty areas continuously evolve to reflect current practice standards. The clinical specialty will never be extinct and will not fall in the peril of doing the same rituals repeatedly, because it continuously responds to the changing needs of our times.

We have achieved Helen Hislop's vision of clinical specialization and avoided the perils that she projected. Our colleagues in the profession know the inherent value of specialization, but the current challenge that we face is ensuring that other professions, health care organizations, and third-party payers know the value of our specialty practice. This is an area where the specialty of clinical electrophysiology has been a pioneer in leading the charge.

"Are we there yet?" my child asked me again as we pulled into the beach parking lot. Looking at sunscreen, beach chairs, towels, and toys that still need to be set up and carried, I answered, "Finally, we are here. But there's still work left to do."

MORRIS "RICK" BEATO, PT, DPT
ASSISTANT PROFESSOR FOR THE UNIVERSITY OF CENTRAL FLORIDA SCHOOL OF KINESIOLOGY & PHYSICAL THERAPY, AND RESIDENCY DIRECTOR OF THE UCF & ORLANDO HEALTH NEUROLOGIC RESIDENCY PROGRAM

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Forum

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IEPTs Face Barriers To Obtaining US Licensure

The article "Internationally Educated PTs in the United States: A World of Experience" (November 2020) shed light on unique obstacles that IEPTs must overcome to practice in the United States. One specific barrier involves licensure by endorsement.

All states require a credential evaluation of the internationally educated PT's education, and most require verification of English language proficiency to sit for the National Physical Therapy Exam. This initial process of credential review, establishing English proficiency, and passing NPTE ensures that PTs meet requirements to practice in the U.S. But it is costly and time-consuming for us.

And when an internationally trained PT transfers their license to another state, rules differ from those for a U.S.-trained PT. Although they are already licensed and have been practicing in the U.S. — perhaps also having obtained higher degrees and/or clinical specialist certifications — they must repeat the credential evaluation and English proficiency exam.

Francesca Raponi, PT, DPT, practiced in Rome for nine years before immigrating in 2010 when her husband got a job in Maryland. The credentialing process cost her around $4,000, and she was given permission to take the NPTE in 2017. She practiced for three years in Baltimore, and then her husband's job moved them to New York. Because the New York Board works with a different credentialing agency from Maryland's, she had to restart the entire process. She says: "I have an active Maryland license but am working as a technician in New York City. This has not only impacted us financially, but the burden and undue stress of having to re-prove that I am competent, despite having a valid license to practice, feels unjustified."

Nadine Booysen, PT, PhD, MRes, MCSP, shares a similar story. She completed her PT education in South Africa, and a master's degree in clinical research and PhD in health sciences in the United Kingdom. She moved to New Jersey in 2018 and decided to obtain a license there and in New York due to their proximity and professional opportunities. She received her New York license first and now is applying for licensure in New Jersey. She must re-establish English proficiency through formal assessment, even though she completed her entry-level education in English.

Despite writing to the New Jersey licensing board with evidence of her English proficiency through her New York license and her master's and PhD degrees from the U.K., her waiver request was declined, and she had to pass the Test of English as a Foreign Language. She says: "I was disappointed that my request was denied. The focus was on my entry-level PT degree obtained over 18 years ago, while disregarding my education and my clinical and research experience achieved since."

For many internationally educated PTs, the process of licensure by endorsement is emotionally taxing and feels demoralizing and discriminatory. It discounts the clinical development, education, and experience they have garnered. The long process of credential evaluation for each state is a significant hurdle to being able to interview for jobs and accept employment. The current system perpetuates the negative stereotype that non-American individuals are not proficient in English, which is untrue and humiliating. It also impedes diversity within the PT workforce rather than celebrating contributions of PTs from different educational and cultural backgrounds.

"The current system perpetuates the negative stereotype that non-American individuals are not proficient in English, which is untrue and humiliating. It also impedes diversity within the PT workforce rather than celebrating contributions of PTs from different educational and cultural backgrounds."

There is a need to move toward more consistent licensing regulations that adhere to regulatory boards' mission of maintaining standards of practice and public safety, reduce the unnecessary time and cost of licensure by endorsement to these PTs, and lighten the administrative burden of regulatory boards.

To achieve these goals, regulatory boards could consider the following:

- Is the American public truly safer because of redundant, nonuniform, and confusing standards?
- What is the negative impact on patients if experienced and competent PTs, already vetted by a regulatory body, are limited in their professional mobility because of inconsistent standards?
- Are the costs incurred by internationally educated PTs to repeatedly prove their English proficiency and take courses in college-level science and humanities justifiable?

Once initial competency is established, internationally educated PTs should not be held to standards different from U.S.-trained PTs. The California State Board recognized this when it discontinued the English proficiency requirement for internationally educated PTs who received a bachelor's degree or higher in a PT program in an English-speaking country recognized by the board.

Former APTA President Sharon Dunn's statement in May 2020 on racism and systemic inequality in America called for ensuring that "within our profession and association no one feels like an outsider anywhere within our bounds." This resonates with us as internationally educated PTs. We share the goal of providing safe and competent services to the public. We also strive for equitable treatment and fair rules that do not discriminate against us based on the country of our entry-level education. We hope that our viewpoints highlight the need for advocacy in asking regulatory boards to create more equitable, meaningful, and effective standards that benefit both patients and PTs across the U.S.

NADINE BOOYSEN, PT, PHD, MRES, MCSP; KRIPA DHOLAKIA, PT, DHSC, MA, BOARD-CERTIFIED PEDIATRIC CLINICAL SPECIALIST; SHRUTI JOSHI, PT, DPT, BOARD-CERTIFIED PEDIATRIC CLINICAL SPECIALIST; AND FRANCESCA RAPONI, PT, DPT; WITH CONTRIBUTIONS FROM BEN AGUILA, PT, DPT; AND HEIDI KOSAKOWSKI, PT, DPT, PHD

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APTA Asks ...



How are you educating the public about physical therapy and wellness?

I persistently seek to facilitate opportunities for professional growth for therapists in my setting, which expands our opportunity to reach those in the community. Diverse skill sets among physical therapists on a team help build bridges to those who may not have otherwise entered the health care system via physical therapy.

DUSTIN REX, PT, DPT, MS

From the inpatient perspective, I think health and wellness are under-addressed, but I try to include this education for my patients. I am also a wellness champion for the inpatient therapy department and a wellness team lead for a nonprofit disaster response organization. I advocate at different levels including the hospital system, regional health care coalition, and state disaster planners; and I am trying to get more involved at the national level for inclusion of the broad scope of care and value that physical therapy can add to programs.

MEGAN MITCHELL, PT, DPT

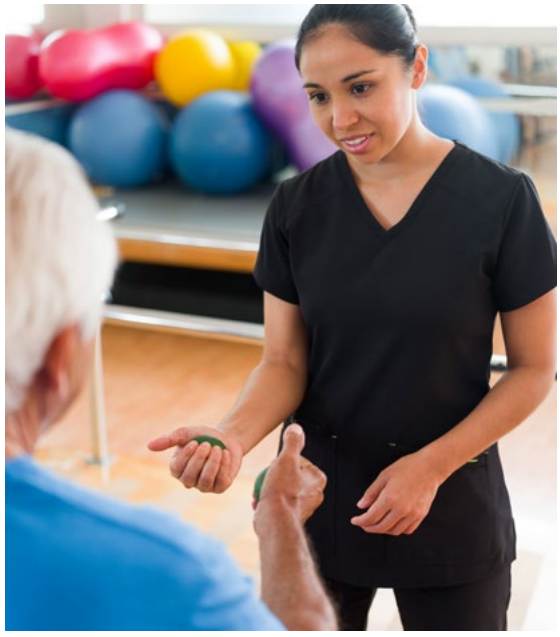
What trait, quality, or skill do you most look for when hiring a PT or PTA?

Professional humility. We have all become familiar with the term "cultural humility" as it encompasses self-reflection, lifelong learning, equity, and accountability. Those traits are just as important in professional competence. I look for a PT or PTA who understands the value of what they know and do and believes there is even more value in continuing to learn and grow in the profession.

SUSAN REYNOLDS, PT, DPT

PTs and PTAs who are confident, caring, and understanding. I look for complex and analytical thinkers who are willing to grow and cater their treatment plans specifically to a patient's needs and experiences.

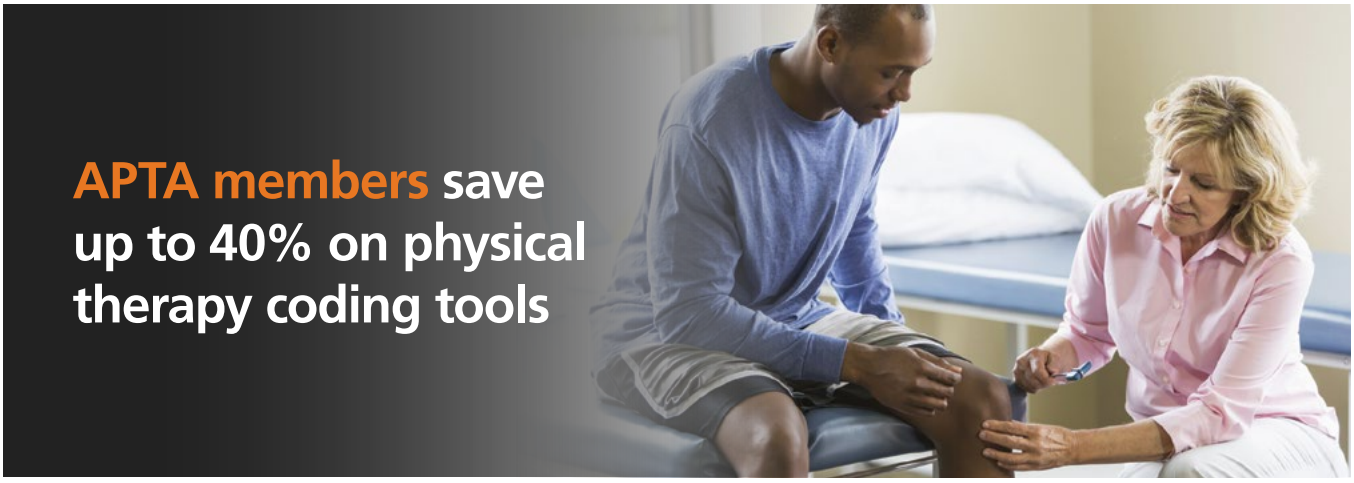
ROBIN BAKER, PT, DPT



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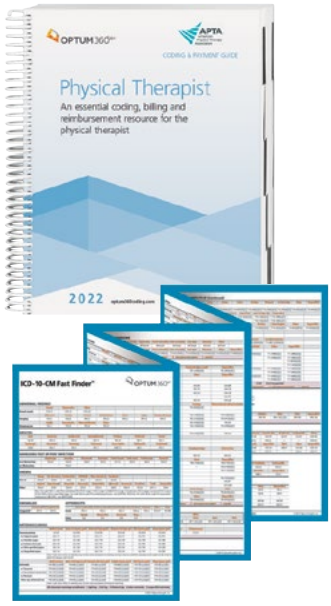
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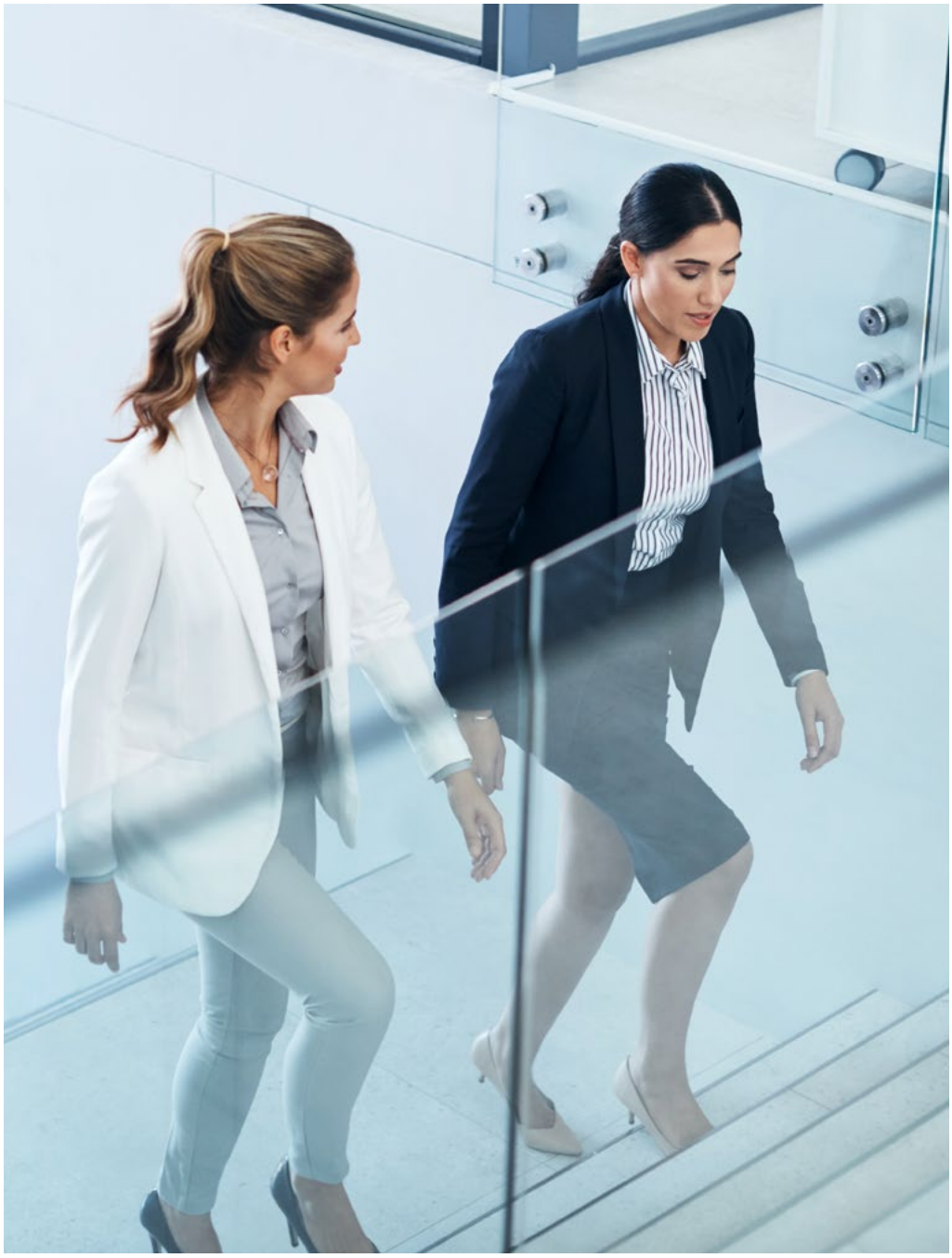
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/ By Nancy R. Kirsch, PT, DPT, PhD, FAPTA

APTA Magazine's "Ethics in Practice" column appears quarterly in February, May, August, and November. You also can find dozens of archived columns on apta.org by searching for "Ethics in Practice."

Professional Decision Making on the Line





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, and her book "Ethics in Physical Therapy: A Case-Based Approach" compiles some of the best of her magazine columns.

Every practice setting has its own innate challenges and special circumstances, but they all share similar professional expectations and responsibilities. The school setting is often quite different from the medical setting, but the requirements to adhere to the core values of excellence, integrity, and collaboration are the same.

Gail has been a school-based physical therapist for most of her professional career. She is in a small district and treats in the preschool, elementary school, and high school. She loves working with the children and watching them grow from the time they enter school until they graduate from high school.

Gail has been working with Melodee since she was 3 years old, and now at age 9 she continues to receive physical therapy, occupational therapy, speech-language pathology, and, of course, classroom instruction. Melodee is medically fragile and cannot safely attend school, so she receives all these services at home. She is nonverbal and does not ambulate, and as part of her individualized education program, Gail has been positioning her at a standing table for a portion of the session that she shares with the teacher in an attempt to improve her attention during the session. This aspect of the program is important to the family, but Gail sees little value in it therapeutically, as the time to get Melodee into her orthoses for standing seems to be far more than the benefit gained from the activity. She was planning to bring it up at the next IEP meeting.

On Wednesday, Gail arrives at Melodee's home for her regularly scheduled physical therapy session and is surprised to find that the girl is in a nightgown and not dressed as she normally is for school. Her mom explains that Melodee was out of sorts starting Friday evening and appeared to be in pain when her left leg was touched. They contacted the physician, who suggested taking Melodee to the emergency room for an X-ray — which revealed a left femur fracture. It was a clean fracture, so they decided not to cast it but rather to immobilize it, using a soft splint to protect the site.

On Monday, Melodee saw the orthopedist, who concurred that it did not need to be set and sent a note for "PT and OT to continue and to avoid any aggressive movement of the left leg." Gail is concerned, as this was Melodee's second fracture this year and for both there wasn't a precipitating incident noted; this type of spontaneous fracture could indicate underlying medical issues. Gail is happy

APTA Resources

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, 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. Go to apta.org/your-practice/ethics-and-professionalism.

Considerations and Ethical Decision Making

Gail can easily apply all three ethical frameworks to her decision making in this case. She knows the virtues that are guiding her actions are altruism and integrity, and she is respectful of the collaboration with her colleagues in education and in medicine. From a principle's perspective, she is concerned about doing no harm to her patient. She can anticipate the consequences if she does not consider the potential risk to Melodee of another fracture, not to mention some of the professional consequences that may occur beyond the immediate impact to Gail, such as losing the trust of the family or the trust of her colleagues on the child study team.

Realm. Per the Realm-Individual Process-Situation Model of Ethical Decision-Making, or RIPS (see "APTA Resources" on Page 15), the primary realm is organizational. The institutional/organizational realm is concerned with the good of the organization and focuses on structures and systems that will facilitate organizational or institutional goals. Gail is aware of the pressure from the school and from her colleague in medicine to influence her professional judgment.

Individual process. Gail requires moral courage. She knows that she must make a decision in the best interest of her patient, based on her professional judgment. This requires her to have an uncomfortable conversation with her colleagues in education and medicine. She is ultimately responsible for the decision to treat or not to treat a patient based on their needs.

Ethical distress. Gail is faced with an ethical distress. She really believes she should put Melodee's treatment on hold until she has a better idea of what is happening medically with her, but she has two barriers to negotiate: the physician who is only considering the medical impact on the child, and the school that is trying to align all the services under the IEP. Gail knows the right thing to do, but she has to consider whether or not she feels empowered to do it within the system that employs her.

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

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

to hear that apparently the orthopedist was concerned as well and had referred Melodee to the endocrinologist for an evaluation. The appointment is several weeks off, so there is going to be little change in the plan of care until that visit occurs. The standing table is certainly no longer part of the PT program, and Gail is questioning whether physical therapy can really be justified during this time. She attempts to reposition Melodee and begin range-of-motion movements for her right leg, but it's apparent that Melodee is very uncomfortable. Not wanting to get Melodee any more upset before the teacher arrives for the rest of the session, Gail stops any lower extremity treatment and position changes, just attempting to find a position that would be functional for the "school session."

At the next visit, on Friday, Gail hopes that Melodee's discomfort has diminished and she will be able to do more with the child. Unfortunately, after lying in bed for almost a week it seems that almost every movement makes Melodee uncomfortable. With the endocrinologist consult over a month away and Melodee unable to cooperate much with treatment, Gail decides the appropriate course of action is to put treatment on hold until the leg heals and Melodee has had the consult, so they can determine where this tendency to fracture is coming from and how to decrease the risk of her having another.

Gail is comfortable that her decision is medically sound. She cannot get Melodee into a position that supports the educational plan, so she is not impeding any school-based goals that are part of the IEP. She sends a quick email to the case manager outlining her plan to hold on treatment and readjusts her schedule accordingly. She is surprised when the case manager responds that Melodee should not be placed on hold, and, as long as the physician says it is OK to treat, she does not need to stop providing services. The case manager reminds Gail that the treatment plan is in the IEP, legally requiring her to continue to provide treatment.

Gail understands the perspective of the case manager. She also appreciates that the physician probably does not have a very good understanding of the nature of school-based rehab services and the need for educational relevance in the plan. But Gail is concerned, because she does know that the plan in place for Melodee is not consistent with the intent of the IEP. In addition, she believes that continuing to treat is not helping Melodee and could potentially be harmful. Just where is the line between professional judgment and professional requirements?

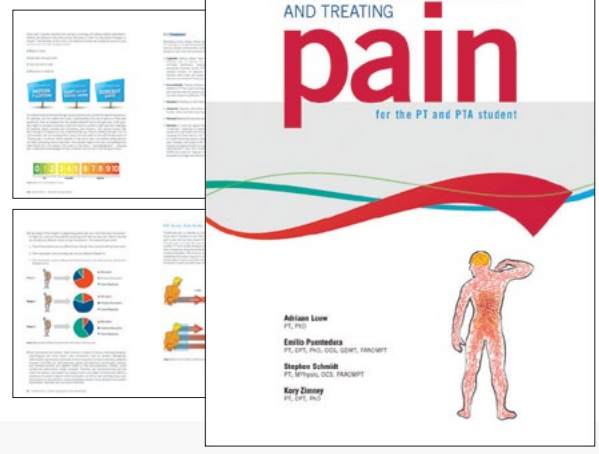
For Reflection

It is not uncommon, regardless of setting, to be caught in a situation in which we know what is best based on our professional judgment, but there are conflicting obligations that we have to acknowledge that impact our decision making. Ultimately, the responsibility for taking action is ours, as "no action" is by default an action, and often not the best one.

NEW STUDENT TEXTBOOK ON PAIN FROM ADRIAAN LOUW

Based on current guidelines for PT school curriculums, **Understanding, Evaluating, and Treating Pain for the PT and PTA Student** provides a foundation for PT and PTA students to learn about pain and provides tools to help them be part of the solution to this global epidemic. The book includes must-know information about the history of pain, the current neuroscience of pain based on the latest research, the biopsychosocial aspects of pain, how to effectively assess patients, and most importantly, how to treat pain.

Written by Adriaan Louw, Emilio Puentedura, Stephen Schmidt, and Kory Zimney. 224 pages.





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A VIEW FROM THE SUMMIT:

Physical Therapy's Promising Future



APTA's Future of Physical Therapy Summit offered inspiration — and a challenge to take risks to help the profession achieve its potential.

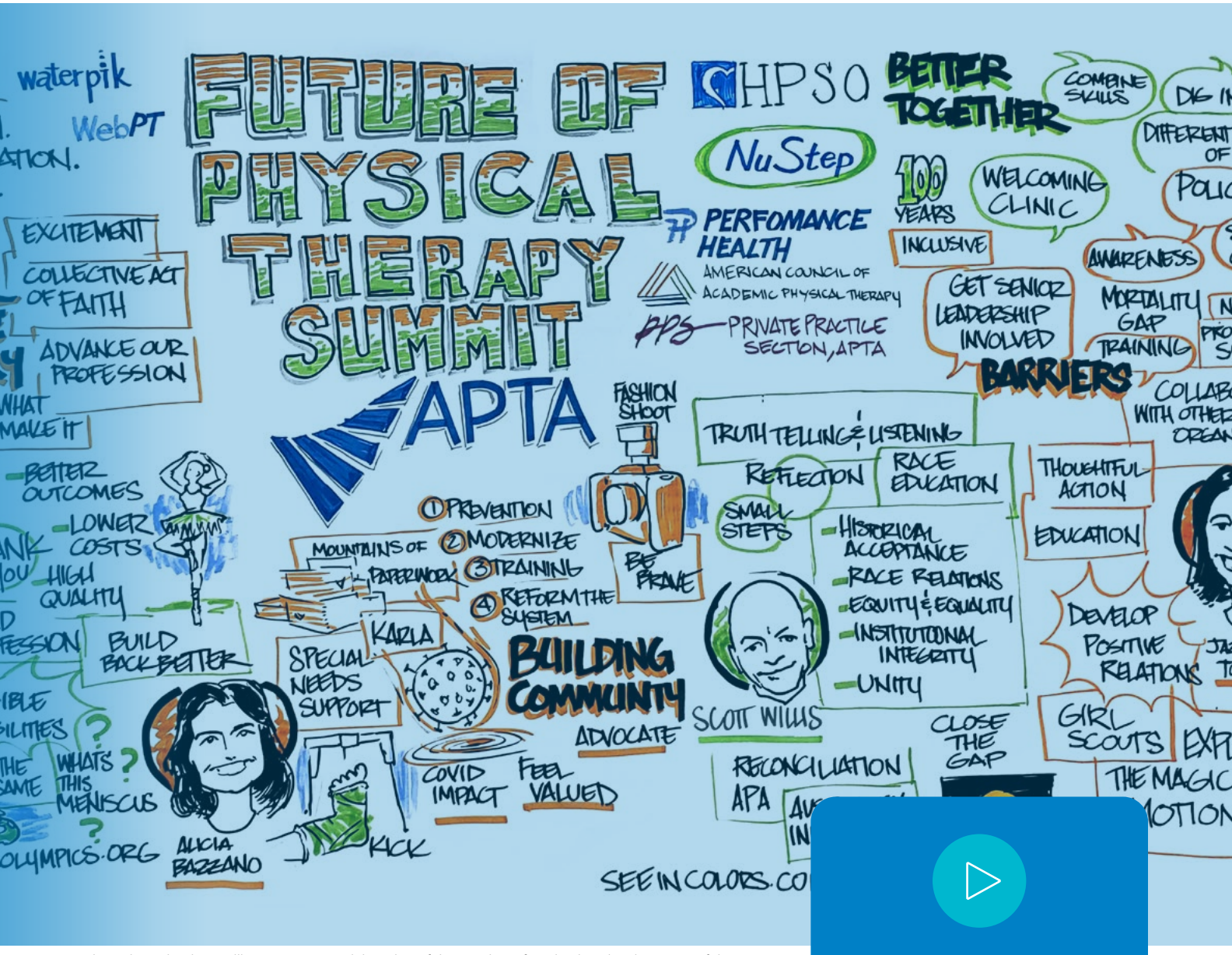
It was hard to walk away from the APTA Future of Physical Therapy Summit without feeling optimistic about the potential for PTs and PTAs to make a difference in society, and to be more convinced than ever that physical therapy can and will play an even more critical role in the health care system over the next century.

You certainly wouldn't get any argument about that from the chair of the Special Olympics international board of directors or the U.S. Secretary of Commerce.

Or First Lady of the United States Jill Biden, for that matter.

All three delivered comments to attendees of the Sept. 13 event broadcast live from the Capital Turnaround in Washington, D.C. The daylong experience was sponsored by Waterpik, WebPT, HPSO, Performance Health, NuStep, the American Council of Academic Physical Therapy, and the APTA Private Practice Section.

Structured around the APTA mission of "building a community that advances the profession of physical therapy to improve the health of society," the summit broke down that statement into its component parts, exploring what the future might hold for efforts to strengthen connections, advance the profession, and make a positive difference in society as a whole. To accomplish that, the summit engaged an international group of participants from as far away as Australia and the United Kingdom in an event that went from inspirational storytelling to philosophical exchanges, to discussions around the nuts-and-bolts of seizing opportunity.



Throughout the day, an illustrator captured thoughts of the speakers, for a lasting visual account of the event.

"Clinician," "collaborator," and "citizen" were the watchwords for the summit, appearing frequently on the stage and emblazoned on t-shirts commemorating the day.

Also appearing frequently on the stage was the event's master of ceremonies, Tara Jo Manal, PT, DPT, FAPTA, and APTA's senior vice president of scientific affairs. Because she was behind the scenes as well while participating in the program's development and rehearsals, Manal had a unique vantage point. "I could see the groups evolve as they prepared to discuss their perspectives," she said, "and then I was able to witness the culmination of the alignment and the impact of their words."

Manal says she was struck by how much the day's presenters had in common with the profession's leaders of 100 years ago. "While the leaders of the past may not have imagined what physical therapy would look like today," she said, "there was a singular passion shared over the last 100 years of wanting to improve the lives of others through expanding clinical excellence. I was inspired by the summit and have confidence that our profession is in great hands."

Watch the Video

The Future of Physical Therapy Summit was recorded, and the full video is available for watching. Use the QR code below, or go to **https://www.apta.org/future-of-pt-summit**



Surprise guest First Lady Jill Biden addresses the audience.

"Thank you for leading the way. You are here today because you have decided to be the strength that so many of us need in our most difficult moments."
– Jill Biden

High-Profile — and Unexpected

The summit had a couple surprises up its sleeve: an in-person visit from Biden and a virtual address from U.S. Secretary of Commerce Gina Raimondo.

The first lady accepted APTA's invitation to speak as a way of saying thanks to the positive impact physical therapy has had on her life.

"We often think of healing as a science, and it is — but we're not just a collection of parts to be treated and tested," Biden said. "Health care providers must recognize the wholeness of who we are." That's what PTs and PTAs are all about, she added.

"You pioneered the treatment of chronic pain," Biden said, asserting that amid the current state of health care, where systems can seem overly bureaucratic and patients reduced to little more than a repository of data, "you remind us that there is a person behind every number, a person who is unique and vulnerable."

"Thank you for leading the way," she told the attendees. "You are here today because you have decided to be the strength that so many of us need in our most difficult moments."

Raimondo, also speaking in recognition of her own experiences with physical therapy, said she had "lived it" and knows just what a difference care from PTs and PTAs can make.

"People are waking up to the power of physical therapy," Raimondo said. "Thank you for the life-giving work you do every day."

Special Olympics, an official APTA partner, added its voice to the event as well. Chair Tim Shriver addressed the summit, telling the audience that PTs "have been a lifeline for people with intellectual and developmental disabilities." Special Olympics representatives Loretta Claiborne, a Special Olympics athlete and member of the organization's board, provided remarks, and Chief Health Officer Alicia Bazzano, MD, PhD, MPH, delivered one of several keynote addresses.





From left: Jasmine Tooles, Alicia Bazzano, and Amy Smith Hamel share ideas on building community within the profession. Also joining the discussion, via video feed, is Australian Physiotherapy Association President Scott Willis, shown above with master of ceremonies Tara Jo Manal in the foreground..

Building Community

Want to build a community? Then you'd better be willing to listen, learn, and, in the words of panel moderator Amy Smith Hamel, PTA, BS, "settle in" to do the slow, steady work.

Hamel, regional director of operation for Restore Physical Therapy, was joined by Special Olympics' Alicia Bazzano; Scott Willis, BAppSC, president of the Australian Physiotherapy Association; and Jazmine Tooles, PT, DPT, director of Explore the Magic of Motion, for the portion of the summit that explored making connections — both within the profession and among the public at large.

In their individual remarks prior to the group discussion, panelists provided their own perspectives on how they dug in — and are still working — for change that brings people closer together.

Bazzano shared her personal experiences discovering the power of physical therapy after her son was diagnosed with cerebral palsy at age 2. She described their relationship with her son's PT as "the engine that got my son going, and got me going," and cited physical therapy as a major factor in her son's continued progress and love of physical activity, which has included rock climbing, swimming, and, most recently, ballet.

"Millions of families with children and adults with intellectual and developmental delays and diagnoses and disabilities are grateful to you for the work you do every day, under the hardest of circumstances," Bazzano said. "I hope you hold that in your heart."

Bazzano pivoted from her own story to larger issues of creating connections that help to address health inequities that she said were brought into sharp focus with the coronavirus pandemic, and praised the 20-year relationship between APTA and Special Olympics as an example of how organizations are coming together to address health inequities. She urged the profession to get more involved with Special Olympics' newest initiative, a five-year push to improve the health of communities.

"If we can do this for people with intellectual and developmental issues," Bazzano said, "we can do it for everyone."

The concept of addressing inequities as a first step in building community was echoed and expanded by Willis, who described the Australian Physiotherapy Association's ongoing reconciliation efforts with Aboriginal and Torres Strait Islanders, efforts that have included difficult discussions about the country's mistreatment of that population.

"We believe that as one of the country's largest health bodies, we need to step up, educate, lead, and assist in adding to the improved outcomes of Australians," said Willis, the first indigenous APA president. Those efforts begin with honest self-reflection, truthful conversations with previously marginalized groups, and genuine efforts to identify and dismantle racism.

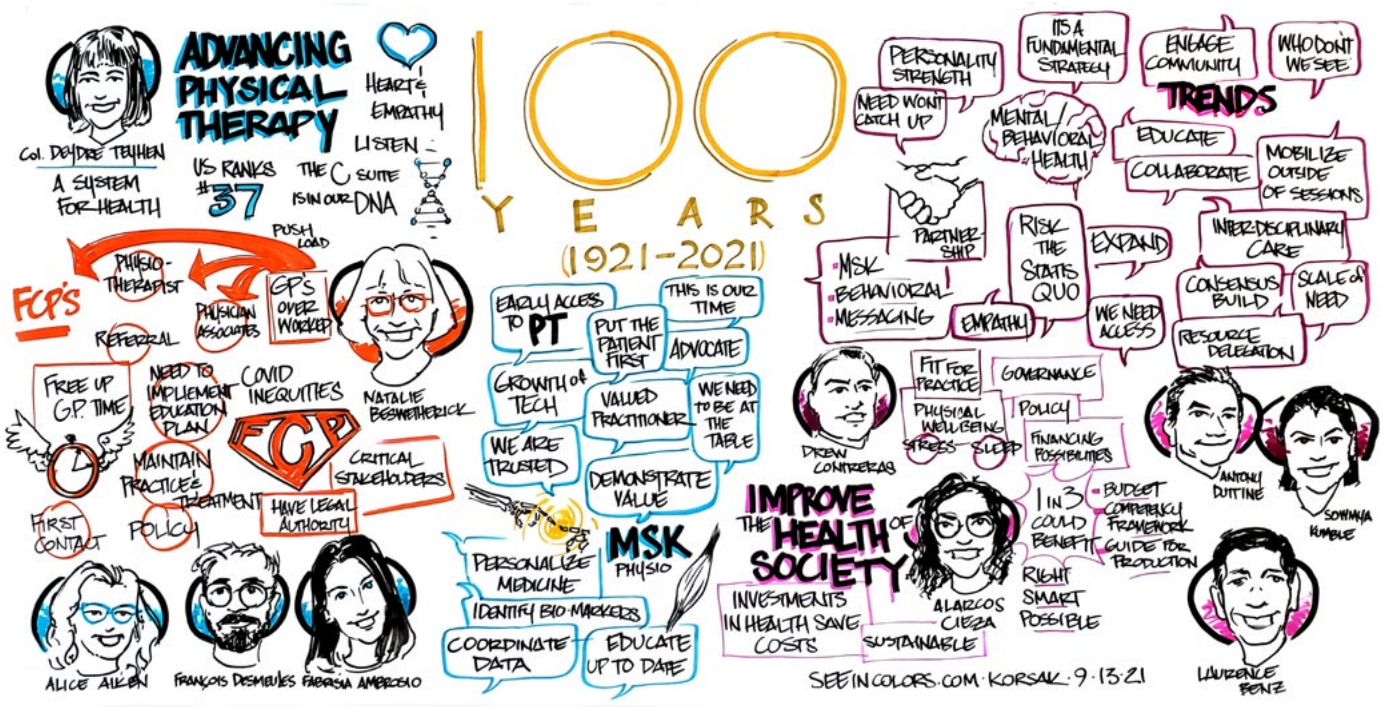
“We have a vision of community that is free of racism, and where justice and healing has occurred through acknowledgement and acceptance of the wrongs of the past and their intergenerational effects.”
– Scott Willis

Willis described how those beliefs have been put into action through adoption of an organizational strategic plan that makes reconciliation one of the central pillars of APA. He described the process as a journey that moves through five broad and overlapping dimensions: historical acceptance for past wrongs, an analysis of current and future race relations, conversations about equity and equality, efforts to increase the “institutional integrity” of entities beyond APA, and, finally, true unity.

“We at APA have a collective vision,” Willis said. “We have a vision of community that is free of racism, and where justice and healing has occurred through acknowledgement and acceptance of the wrongs of the past and their intergenerational effects.”

Tooles’ presentation reminded attendees that the profession’s leadership role in community-building is dependent on a broader understanding of physical therapy and what PTs and PTAs do, as well as the love those PTs and PTAs have for what they’re doing — or as she put it, “the reach of our profession and APTA is only as far as the reach of our engaged members.”

About 10 years ago, Tooles came to realize that generating understanding of and excitement around the profession would be key to physical therapy’s overall societal impact. To that end, she turned to Girl Scouts USA and founded a three-step physical therapy-related badge called “The Magic of Motion.” The program, which can begin as early as sixth grade, exposes Girl Scouts to the basics around the importance of movement, gradually evolving into an exploration of the physical therapy profession in its third component, aimed at high school juniors and seniors.



A second illustration covered the panel discussions on advancing physical therapy and improving the health of society.

The program's events reach more than just the Scouts: activities involve families and friends, and create opportunities for wider exposure of the profession, Tooles said.

The key, she explained, is to help people understand what PTs and PTAs do before they're in need of a PTA or PTA. "We must develop positive relationships with members of diverse communities before they are sick if we are to build trust," Tooles said. "We cannot continue to be strangers to the communities we serve."

And those benefits go both ways, she added. PTs and PTAs owe it to themselves to interact with the communities they serve while members of those communities are healthy, because "a bad experience with a client disgruntled by illness or injury can influence a provider's entire perception of a demographic."

Tooles described her Magic of Motion program as a small but impactful step in the right direction and encouraged attendees to think creatively about engaging with communities to build an even larger, more inclusive one.

"We need to peel back the layers that not only limit the expansion of our profession, but also our willingness to take the steps to do so," Tooles said.

During the panel discussion that followed the presentations, Bazzano, Willis, Tooles, and Hamel discussed barriers to building community, including the effects of health care and other disparities that can make connections difficult. All four agreed that dismantling those barriers requires not just stronger clinical education, but attention to health policy details that create built-in stumbling blocks.

Hamel stressed that achieving stronger communities requires patience and perseverance, likening the process to "settling in" to an uphill climb on a mountain bike, where consistency, perseverance, and pacing make all the difference.

"When you're climbing, if you go really hard and really fast, you'll tire out — but if you settle in, and you're constant and consistent, you're going to get to the top quicker, and you won't be as exhausted when you get there," Hamel said. "I think within our association and our profession, we have to settle in. We have to work together, side by side. We have to build our community and move forward."

Advancing Physical Therapy

When you think of health care, you probably picture a system that could be better. As voiced by Col. Deydre Teyhen, PT, PhD, to get away from being a health care system to being a system for health, the second group of panelists were clear on what advancing physical therapy entails: promoting physical therapists as first-contact practitioners and as executive leaders, and using technology and evolving knowledge to increase patient access to services.

With Teyhen, chief of the Army Medical Specialist Corps, panelists were Alice Aiken, CD, PhD, MSc, BScPT, BSc, vice president of research and innovation at Dalhousie University in Nova Scotia; Fabrisia Ambrosio, PT, PhD, director of rehabilitation for UPMC International in Pittsburgh; and François Desmeules, PhD, associate professor at Université de Montréal. Terry Nordstrom, PT, EdD, FAPTA, of California's Samuel Merritt University, facilitated the discussion, and Natalie Beswetherick, OBE, MBA, director of practice and development for the U.K.'s Chartered Society of Physiotherapy, delivered a keynote address.



Natalie Beswetherick delivers a remote keynote address before the panel on advancing physical therapy.

Teyhen encouraged PTs to strive for executive leadership positions, where decisions are made that can drive the needed changes in our health care system. "What drove me to become a good PT is wanting to help patients," she said. "What drove me to be a health care executive is wanting to create a system that allows us to be more efficient in creating those outcomes for our patients."

Beswetherick described initiatives in the U.K. that have established PTs as first-contact providers, offering advice for similar efforts in the U.S. She described a growing urgency about general practitioner capacity, and musculoskeletal conditions that were

"We know how to run a health system. It's a golden time for us to show our broad value, and we need to rethink how we interact with patients."
– Alice Aiken





From left: Terry Nordstrom facilitates the panel on advancing physical therapy, with Deydre Teyhen, François Desmeules, and Fabrisia Ambrosio. Above, Alice Aiken joins the panel discussion via video feed.

"What drove me to become a good PT is wanting to help patients. What drove me to be a health care executive is wanting to create a system that allows us to be more efficient in creating those outcomes."
– Deydre Teyhen

a major demand on primary care. GPs were overreferring patients to specialists — often "because they didn't know what else to offer," she said. Since PTs have been embedded as first-contact providers within a GP team, referrals are reduced, money is being saved, and patients "are highly satisfied with a provider who can advise them on self-care," Beswetherick said.

Aiken and Desmeules shared insights from Canadian health care. Aiken continued the discussion on the advantages of PTs as first-contact providers, especially within her country's numerous rural areas. "With COVID-19, we've seen the value of PTs being first contact," she said. "We know how to run a health system. It's a golden time for us to show our broad value, and we need to rethink how we interact with patients." To that end, Aiken asked: "Do we always need one-on-one interaction with patients?" With new technologies such as sensors and superconductors, there could be "a community of practice" with the PT monitoring multiple patients with the same condition in local area.

Desmeules described local musculoskeletal clinics that have helped unburden overscheduled medical specialists. Ambrosio discussed ways that technology, such as telehealth, regenerative rehab, and artificial intelligence, can provide better patient access and opportunities to personalize care.

Improving the Health of Society

Is physical therapy being provided to the patients who most need it? The consensus was "no" among members of the summit's third panel, "Impact the Health of Society." The causes, they said, include failure in messaging, lack of engagement, and lack of personalization.

The keynote speaker was Alarcos Cieza, PhD, MSc, MPH, of the World Health Organization, where she drives WHO's agendas on rehabilitation, disability, vision, and hearing. She was followed by a panel comprising Larry Benz, PT, DPT, MBA, president and CEO of Confluent Health in Kentucky; Antony Duttine, regional advisor, disability and rehabilitation of the Pan American Health Organization/World Health Organization; Sowmya Kumble, PT, MPT, clinical resource analyst in acute care at Johns Hopkins Hospital and a board-certified neurologic clinical specialist; and facilitator Efosa Guobadia, PT, DPT, CEO



Via video feed, Alarcos Cieza begins the panel discussion on improving the health of society.



Efosa Guobadia introduces the panel on improving the health of society.



From left: Panelists are Sowmya Kumble, via video feed, Larry Benz, and Antony Duttine.

of Move Together and FFITT Health and co-founder of the Global PT Day of Service.

Cieza said that 2.4 billion people around the world have a health condition that could benefit from rehabilitation. That's one in three people, and the number has increased by 63% since 1990. The significance of the number, she said, is that in many countries fewer than half of those who could benefit from rehabilitation have access to it. "All people should receive the services they need without financial hardship. The issue is one of equity. Not only is rehabilitation a good thing to do, it is their right," she said.

Saying that she became inspired by APTA's vision, Cieza continued, "The improvement of the health of society would make physical therapy the 'must' thing to do. Investing in rehabilitation is investing in health." Addressing COVID-19, she said, "One of the things COVID-19 has taught us is that investment in health is a cost-saving investment [in the same way] physical therapy is an investment in health." She asked rhetorically what needed to be done to make rehabilitation sustainable. Her answer: "It's not only about strengthening the system. It's strengthening the components of the health care system. It's about good governance. It's about policymakers seeing that reinvesting in rehabilitation contributes to health. It's about strengthening the workforce and strengthening the health information system."

Benz cited a recent study he was involved with: "We have a very unhealthy population. We found that the substitute for physical therapy is either nothing or an opioid."

Kumble cited the challenge of high caseloads, commenting, "We have direct access to patients in the hospital. But we need to ask whether we're providing to patients who really need therapy. When we have so many patients on our caseload and can't reach everyone, how can we make sure we're reaching the patients who really need it?" She also echoed Benz's comment on messaging:

> "We've recognized ourselves as movement gurus, but I'm not sure the mental health world has. We have to personalize physical therapy more."
> – Larry Benz





Cruz Romero (left) facilitates the "passing the torch" panel, with Laura Gull, Kathryn Sutton, and, in far right photo, Kelvin Rivera.

"The lack of awareness [of the benefits of physical therapy] is huge. How do we create the awareness of the role of physical therapy? How can we involve interdisciplinary members?"

During the panel discussion that followed, Benz was asked what areas of health care could be improved. He listed three: musculoskeletal spending, behavioral health, and messaging. Benz attributed part of the problem to the comparatively small — 8%-10% — "spend" on musculoskeletal issues and the number of PTs who treat those issues. On behavioral health, Benz said, "We've recognized ourselves as movement gurus, but I'm not sure the mental health world has. We have to personalize physical therapy more. If you look at the success of Peloton and similar services, they've personalized it. But it will take us a lot of effort," he said, adding, "If we want to expand our role, we have to greatly increase the number of PTs." He also said that messaging has been "outside our wheelhouse."

Duttine added, "People are living longer. We see the impact. But that brings new challenges. We see a lot more attention to things — like mental health — that haven't been addressed as much. For years, mental health has been hidden away. But that brings new challenges, because health care can't be delivered the way it was 20-40 years ago because health has changed. It's a positive trend, but it also highlights where the gaps are. Duttine warned that if the situation seems challenging now, it will only become more so. "The need of 2.4 billion people is not going to hold there. It's going to grow. We need to take this opportunity now." He also urged bringing more groups to the table, including people of color and the LGBTQ community, "because that's where a lot of the need is."

Guobadia commented, "The less we look like society, the less society will look to us." Guobadia asked the panel what next steps are needed. Duttine answered, "Data and information is key, and it's about learning from the information we have, but it's also going into our communities and society — how we engage in that. There's no magic tool. We have to be upfront and engage with that society. Kumble urged, "We want to think about patients who are being discharged from the hospital: How can we improve their quality of life and help them return to society sooner? During the hospital stay itself, we can use our resources responsibly — as PTs providing the right

"Data and information is key, and it's about learning from the information we have, but it's also going into our communities and society — how we engage in that. There's no magic tool. We have to be upfront and engage with that society."
– Antony Duttine

interventions — so we can reduce the burden on society that immobility can impose." Benz said, "What we're good at for one patient, we can't do for everyone. We must be a force multiplier."

Passing the Torch

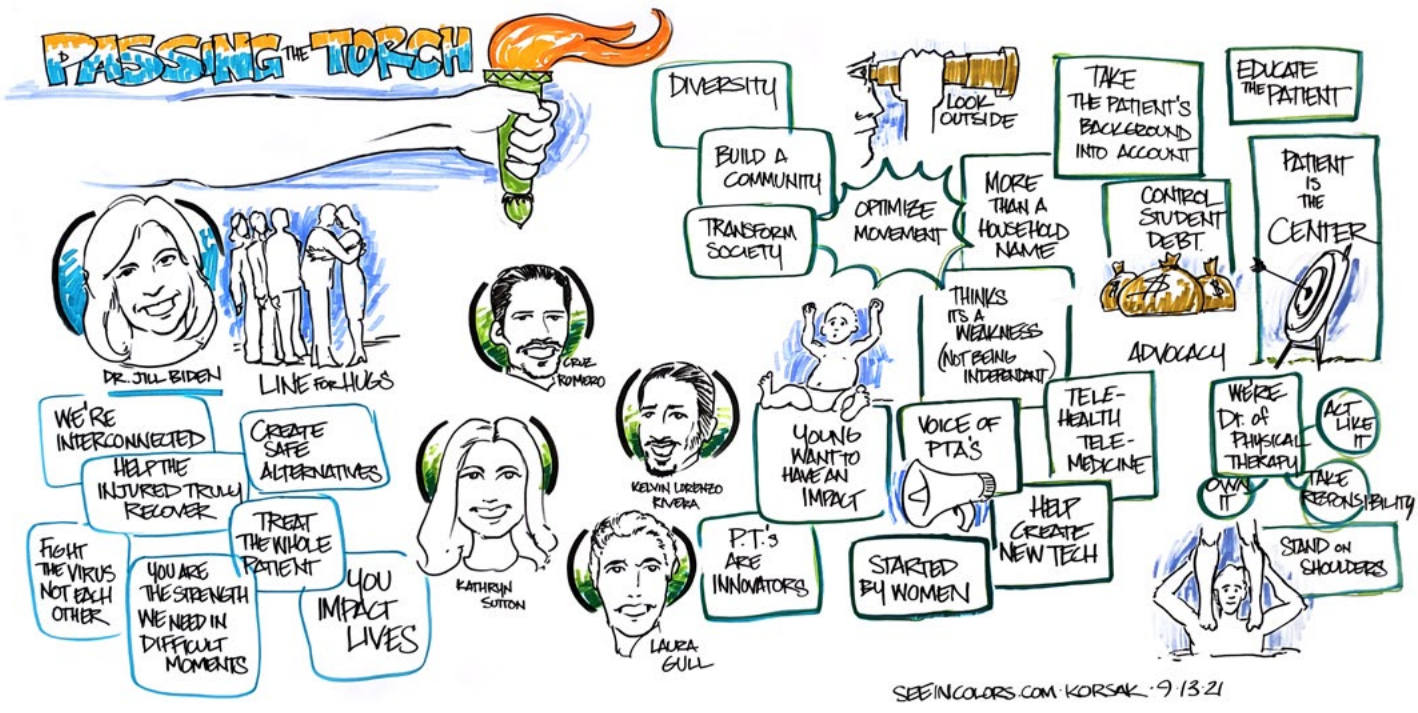
The last session of the day was all about the people who would be counted on to help make that future happen — the new and coming generations of PTs and PTAs.

The panel discussion was moderated by Cruz Romero, PT, DPT, manager of EXOS physical therapy in Phoenix, and a former member of APTA's Student Assembly Board of Directors. Romero was joined by Laura Gull, PT, DPT, clinic director of Professional Physical Therapy in Holden, Massachusetts; Kathryn Sutton, PTA, MA, academic coordinator of clinical education for the Kent State University PTA program; and Kelvin Rivera, PT, DPT, who recently served as president of the APTA Student Assembly Board of Directors and, earlier, as APTA student core ambassador for Puerto Rico.

While topics of the discussion shifted, two common themes emerged throughout: the level of engagement in and enthusiasm for the profession among the younger generation of PTs and PTAs, and the importance of channeling that energy into making the connections that will elevate the profession — with the public, other providers, and payers.

"It's like sending 15 bowling balls down the alley at once," is how Gull described the level of passion for the profession among the new generation of PTs and PTAs.

Sutton and Rivera agreed, with each panelist offering possibilities for how that passion could be channeled to accomplish the APTA mission. Sutton tended to look at the younger generation as agents for change, saying that they could help the profession stop looking at a subservient relationship with physicians and become the sought-after profession that makes the impact. "We need people to know we are innovators," she said. "We need people to ask 'Do we have a PT on that? Why don't we have a PT on that?'" Rivera's perspective was centered more on the possibilities for younger PTs and PTAs to make significant inroads in connecting with their communities, stressing that it's crucial to "remember where you're from" in order to build awareness and trust. "Sometimes the hardest part is going home and explaining to your family what you do," he said.



A third illustration covered the panel discussion on passing torch to future PTs and PTAs.



2015-2021 APTA President Sharon Dunn addresses the summit audience.

"Don't be afraid to experiment. Don't be afraid to fail."
– Sharon Dunn



An audience member asks a question.

Gull added that in addition to the aspirational goals described by Sutton and Rivera, the younger generations also have a responsibility to take up their predecessors' commitment to advocacy for appropriate pay and recognition of the role of the PT and PTA in a wider range of areas, including telehealth.

"Advocacy is important," Gull said. "It's what we must do now for the future."

"Try Something. Be the Change"

The summit was bookended with remarks from APTA President Sharon Dunn, PT, PhD, who emphasized the importance of believing in the profession and its potential, even when the news of the day makes that belief seem elusive.

In her view, it boils down to a matter of faith.

Dunn described faith "not in the strictly religious sense of the word," but as "the part of us that embraces more than what's in it for me, or what's the path of least resistance, or what's the safest course of action."

"Faith liberates us to look outside our own experience," Dunn said. "Faith makes us believe in what firsthand evidence might suggest is impossible."

Dunn's closing remarks stressed the importance of acting on that faith in the profession, even when there's risk involved.

We may feel unsure about how to make change happen, "but that doesn't mean give up," Dunn said. "That means try. Try something. Be the change. Don't be afraid to experiment. Don't be afraid to fail."

(Portions of this article originally appeared within "100 Years and Counting," published in the December 2021-January 2022 issue of APTA Magazine.)

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Something To Run Toward



BY MICHELE WOJCIECHOWSKI

New APTA President Roger Herr, PT, MPA, talks about moving from clinician to manager, how his parents were role models, and his plans for the future of the association.

When he was in college, APTA President Roger Herr didn't originally plan to be a physical therapist. But once he discovered the field, he knew exactly where he belonged.

Born in Niskayuna, New York, and raised in Lancaster, Pennsylvania, as the oldest of three children, Herr is the son of veterinarians. His parents, Donald M. Herr and Patricia Thomson Herr, not only built and owned their own practice, but also served as role models for him as he moved from being a practicing PT to a manager and leader.

Herr, who lives in New York with his partner of six years, Vincent Fiorenti, spoke with us about his life, his work, and how he plans to lead APTA. What follows is our interview, edited for length and clarity.

When did you first decide that you wanted to be involved in physical therapy?

I was in college becoming a teacher in special education, and when I was student teaching, there was a physical therapist helping with the students. The faculty and I were in awe.

This physical therapist could go anywhere because it was a small community: to the school, nursing home, private practice, wherever. This PT did everything in every part of the community, and that fascinated me — to work with people of all walks of life and age. I saw the career potential as well.

I decided then that I was going to become a PT. I transferred from Mansfield College [now Mansfield University of Pennsylvania] to Temple University.

"This PT did everything in every part of the community, and that fascinated me — to work with people of all walks of life and age."

How did you move from working as a PT to earning your MPA?

When I graduated from Temple, I sought other places to learn, and the move from Lancaster to Temple made me realize I liked cities. I went to New York and worked at NYU Medical Center — now NYU Langone — while also earning my master's in public administration degree there.

The reason I chose an MPA was that while working at NYU, which is a major medical center, I saw a lot of people advancing their careers in clinical practice and then getting a manager job that was using data — back then tables — and not knowing how to use Lotus Notes or Excel or any data systems. These clinicians weren't using the best of their skills because they had been promoted to managers. I thought, I want to become a manager who knows how to do management so these amazing clinicians can keep doing what they do very well and have a passion for.

While I loved working with my patients, I also liked helping to manage a department, so all these people could function and focus on the providing the best services to patients they could do well.

"I needed to take time to learn how to best integrate with my community versus competing with it."

I liked working at NYU, and it's where I learned I wanted to develop my managerial skills. But I decided to leave and follow one of my mentors, Kate Mangione, because she had left as well to work at a nursing home. I went to work with her to learn to manage a population. When I was finishing my last two years in graduate school, I began working half a day at the nursing home and the other half in home health. I loved being out in the community.

When and how did you get involved in leadership?

When I changed practice from facilities to home care, I realized that I needed a peer support system. While I'd been an APTA member since I was a student at Temple, I became more active in district and state advocacy in the New York Chapter, and I joined the APTA Home Health (then called the Home Health Section). From there, I got involved in leadership. I kept being asked to become more involved, and I did. I became an advocate. I found my voice in advocating for practice, but through the patients' needs. It was a natural fit for me.

When I graduated, I became the youngest manager, at the time, of the home health agency Visiting Nurse Service New York. After an interesting career working for other agencies, such as a



Newly elected APTA President Roger Herr addresses the 2021 House of Delegates.

surveyor, post-acute care benchmarking/analytics organization, and a health plan — where I traveled around the country and also spoke on health care data, what it tells us, and more — I was back at VNSNY as a vice president.

You mentioned Kate Mangione as a mentor. Have you had any others who helped you find your path?

My parents are role models for me. I learned a lot from them, both in their professional skills as veterinarians and in running a practice. I saw how to manage a career, from the clinical skills in addition to everything that goes into owning a practice. They were also really involved in their professional association.

And my parents were equal in their careers during a time when very few women were in veterinary medicine. My mom kept her maiden name in practice, and she became the first woman president of the Pennsylvania Veterinary Medical Association. All the men wore tuxes when she assumed office because they realized what a milestone it was to have a female president in an agricultural community. Back then, she had been told she couldn't treat farm animals because "women didn't do that."

As for mentors, a couple stand out in my career. Kate taught me about geriatrics and supporting people with the effects of aging. Another wonderful mentor is Felicita Clare. She and Alex Caiola are two home health PTs who serviced the Bronx



and Harlem. They had pearls of wisdom that I needed throughout my career such as, "Don't run away from something; find something to run toward." What I admired about them is they both always customized care. They always understood the individual and applied their professional judgment to each situation.

They've been able to serve their community in a no-nonsense, strong clinical fashion, and so they've been really good mentors and role models.

Tom Schmitz is another. He taught me that we each bring different skill sets to our profession. The diversity in our skills enables us to have a management team that supports different staff in specific ways.

What is the importance of having or being a mentor?

The personal relationships built on trust, and getting honest feedback and opinions are essential. Mentors can give you advice based on their experience and expertise. Sometimes I use the advice; sometimes I don't. But the point is they are a sounding board. Sometimes just talking to them helps you sort it out yourself because that helps you articulate it.

Why did you decide to run for the office of APTA president, and what do you bring to the table?

What I bring to the table is my journey and continued curiosity to make things better. I've been in practice, I've managed practice, I understand public reporting and models of payment, and I've been active in advocacy. But I also have been involved with different parts of the association as well as different parts of the profession. I became involved with World Physiotherapy, so I understand a little bit on an international level. On the state level I've been involved in many chapters, and my experience as a surveyor and in benchmarking and analytics has added breadth to my practice expertise. I believe I bring a nice composite, and I understand many different parts of our profession.

I really believe in APTA's mission, and I really believe we need to provide for those who need it in the traditional ways. But we also need to look at how



Herr credits his parents for being strong role models. In these family photos are (opposite page, from left) Roger, his sister Martha Brown, mother Trish Herr, father Don Herr, and sister Elizabeth Collier; and (above, from left) Roger; his partner Vincent Fiorenti, Elizabeth Collier, Don Herr, Martha Brown, and Trish Herr.

"I really believe we need to provide for those who need it in the traditional ways. But we also need to look at how we keep people in society healthy."

we keep people in society healthy, the direct and indirect ways we can do that. This is where my curiosity comes into play. I want to respect our historical strengths and enter new ways of serving society.

I want to help people age well; I want to help people live well, and I think that's what our profession offers.

That's why I ran, but I also see that we need to embrace some of the changes of the world, technology and the like, that in a hands-on profession is sometimes a challenge for us.

One of APTA's goals is to have physical therapists be the first stop in health care, at least in terms of musculoskeletal injuries and issues, balance issues, and vertigo — anything that a PT would treat. What are your plans to help make this happen?

My idea is two-fold. One, we need to partner with other professionals because they can refer those patients to us. We need to educate the consumer, but we also need to educate our peers in other health professions so that we can help them with patients with these kinds of problems.

We also need to continue to establish partnerships and coalitions with other organizations, such as APTA's partnership with the Arthritis Foundation. In such organizations' peer groups, for example, someone could ask if they've worked with PTs — because often people will really hear what's said in their peer groups as compared with trusting or trying to navigate the health system.

What's your vision for the future of APTA?

There's my vision for members and my vision for the profession. I hope members see the value of APTA, and that we embrace the diversity of APTA membership not just in practice, but also in our racial, ethnic, and cultural ideals.

PROFILE

Roger Herr

TITLES

President, American Physical Therapy Association

Vice President, Visiting Nurse Society in New York

EDUCATION

BS in physical therapy, Temple University
MPA, New York University

RECOGNITIONS

Lucy Blair Service Award, 2021
American Physical Therapy Association

Dr. Marilyn Moffat Distinguished Service Award, 2021
New York Chapter of the American Physical Therapy Association

Physical Therapist of the Year, 2006
Physical Therapy Association of Washington

OTHER ACTIVITIES & INTERESTS

Yoga (Vinyasa and Bikram), good old body-weight workouts, triathlons, (currently prefer the swimming and biking over the running, but my favorite shifts every few years), playing upright bass, orchestra, and traveling to see other ways of life and the world.

MEMBERSHIPS

American Physical Therapy Association

National, Member since 1985

- Board of Directors, President, elected 2021; Secretary, 2016-2019; Executive Committee, 2012-2014, 2016-2019; Member, 2010-2016
- Chief Delegate New York Chapter, 2019-2021
- APTA Representative North America Caribbean Region of World Physiotherapy, 2020-2021
- Public Policy & Advocacy Committee, 2010-2012
- Committee on Sections & Chapters, 2004-2006
- Government Affairs Committee (appointed), 2007-2010

APTA Geriatrics, Member

- New York State Liaison, 1996-2002

Health Policy & Administration Section, Member

APTA Home Health, Member

- President, 2001-2003, 2004-2006
- Delegate to the House of Delegates, 2002-2006
- Treasurer, 2000-2001
- Federal Legislative Liaison, 1999-2002
- Nominating Committee, 1997-1999

APTA Washington, Member

- Delegate, 2007, 2008, 2010, Chief Delegate, 2009
- Board of Directors, 2004-2008
- Administrative Special Interest Group, 2003-2011
- Legislative Committee, 2004-2010

APTA New York, Member

- Chief Delegate, 2019-2021
- District Legislative Co-Chair, 1999-2004
- Delegate Assembly, 1998-2003

Washington Hospice and Palliative Care Association
2008-2011

Northwest Orthopaedic Institute
Board of Directors Member and Secretary, 2008-2009



Herr speaks before the 2016 House of Delegates.

What I hope for the profession and our members is that we are more comfortable pursuing other payment models, because some of the current payment systems are futile. They're frustrating, they're extra work, they take a lot of administrative burden, and they have a lot of rules that aren't aligned to providing patient care. We need to start pursuing and embracing other payment methods, but that means we're going to have to start with smaller groups before we do that with our major payers, because the major payers may not be the first to change.

What are some of your short-term goals as president?

To serve our mission, my first job is leading the APTA Board of Directors. Partnering with the CEO is my second job. Given the motions just passed by the House of Delegates, we need to make sure those and the work of the strategic plan the Board has just created gets done. The next job is connecting with members. We need to know what each of the chapters and sections needs — whether they're in big or small states, with urban or rural areas. I want to understand the different needs of our membership and determine how we can help.

What about long-term goals?

What are we doing about payment, what are we doing about education, what are we doing to evolve practice? Those aren't overnight changes. We need to be sure that we have academic models that will evolve our education to be the most effective and efficient for the future of physical therapy, for the students but also for what practice will be in the future.



Participating in a 2019 Board of Directors service project, Herr works with colleagues to retrofit a child's ride-on car for Go Baby Go. The national program supports community "builds" in which volunteer groups convert battery-powered cars for children who can't operate foot pedals.

We also need to keep up life-long learning — not everything can be learned in school. We do continuous learning well in APTA's Combined Sections Meeting, but in-person education is not accessible for all PTs and PTAs or for all learning. We also need to progress in terms of technology — for those who have grown up using computers and those of us who learned the profession before computers and other technology came into it.

We also need to know who we need to partner with. It might be others in different health professions.

In terms of our members, we need to know what resources they need in practice, but also what resources they need to be vibrant in their careers. Do they have the skill set and the education they need, do they have the personal resilience skills, do they have the technology, are they connected to technology in ways that could enhance and grow their practices?

There are so many different ways to support members, and that's what I'm excited about.

What is the biggest challenge or challenges that you think PTs and PTAs face in today's current climate, and how can APTA help them through it?

Payment is a challenge. People are part of bigger systems now, and figuring out how to navigate them is a challenge.

An example is the Medicare payment differential for services provided by PTAs. It's being pennywise and pound foolish. On an individual treatment, you could say, yes, the PTAs are paid less money. But you're not looking at the whole patient care plan, the



Former Board Member Carolyn Oddo, PT, MS, Herr, and current Board Member Dan Mills, PT, MPT, await the 2019 groundbreaking ceremony for what is now APTA Centennial Center, the association's new headquarters building completed in 2021.

"We need to move away from the assumption that higher scores are the primary driver for getting into a PT school, discounting everything else about prospective students."

continuity of care, who's providing the oversight, who the PTA is collaborating with in between, and who's going to help manage change. There is a team involved in providing services, and that's what is being paid for during a visit. Cutting payment for those services based on the individual who is treating the patient for a given amount of time doesn't make sense in terms of being patient-focused.

How can APTA help with that?

That's where our advocacy team is seen as very reliable and dependable, and able to rally people around the cause. I think this will be an issue that rallies members because it impacts many practices across the country where PTAs work.

APTA provides a vehicle to figure out who you need to talk to and when about these things, when are the right times that things are being heard, what bill number you need to reference, and who you need to write to. APTA's advocacy team is really good about providing those resources, so you don't have to figure out how to navigate it.

In your candidate statement you wrote, "As a gay man, I'm aware of the impact when some members have felt marginalized in past strategies," and then you go on to say that one of your strengths has been "to understand individual perspectives and identify ways to engage with larger systems and initiatives and adjust to be inclusive." With APTA actively promoting diversity, equity, inclusion, can you expand on this?

I think it's helped my career in that I take all the lenses, all the hats I wear, whether I grew up in a conservative farming community, whether I live in an urban community, whether I am a gay male, and can view the world through them. At the same time, I'm also a white male in my 50s, so I look very stereotypically privileged.

First, we need to understand our own biases. We become aware of them only when we work with others. That's what I love about travel and where I work — both challenge my assumptions and ways of being.

But how do you create models for change for someone who has lived and worked in one community? How do you give them opportunities to explore their biases? There are tools out there, but we have to find safe ways of doing that on an individual level. What's helpful is meeting others; we become more aware of how different we all are from each other.

How can APTA and its members work together to recruit a more diverse population in the profession?

First, we need to recruit much earlier on — we need to recruit within the primary education system, not wait for secondary education. Students need to know that physical therapy is a career choice early on, before they make those decisions.

In primary education, if they have career days or other days, we can introduce them to physical therapists and what they do. We want people to love the profession and the opportunity it has. We want them to love what we do.

Second, we need to move away from the assumption that higher scores are the primary driver for getting into a PT school, discounting everything else about prospective students. We want to make sure students have the minimum scores so they do not struggle in the program. But what other dimensions can schools look for in applicants beyond the scores?

I also think we need to understand our communities. For example, there are health deserts. In my day job, there are areas we can't get a home health aide to visit because there's no public transportation, and they don't have a car. The whole point is you need to know your community and where the challenges are — whether it's transportation problems, cultural issues, benefits, and the like.

"Your practice only sees who comes in your door. If it's not reflective of your community, then maybe ask, should it be, and what are the barriers to it being that way?"

Some PTs are very active in their communities to keep a pulse on that. Others have a natural access because they're engaged, such as parents having awareness of what's happening in their school system.

There are so many ways you can get in touch with your communities that are an extension of your practice. Remember, your practice only sees who comes in your door. If it's not reflective of your community, then maybe ask, should it be, and what are the barriers to it being that way?

As a profession, we're overall more comfortable in diversity in practice; for example, I do geriatrics, pediatrics, orthopedics. We need to become more aware of how we are serving our diverse communities — in terms of socioeconomic factors, culture, race, sexual identity, orientation, etc. — and being comfortable with that diversity.

"In clinical practice my greatest reward was helping patients. Then, helping a team of clinicians who help hundreds or thousands of patients has been a reward, too."

The nice part is that in our profession, in addition to being safe, we tend to be very objective. But sometimes we miss things when we're objective, and we don't always see all the things that aren't visible through our clinical lenses.

So, for example, when I worked for the nursing home, it was faith-based, Catholic. I'm not. But the nuns were thinking I wanted to convert because I asked so many questions. I engaged in my community, and that helped me understand them so I could serve them better. I learned to never schedule treatment during Mass. That was my time for documentation. The point is, I needed to take time to learn how to best integrate with my community versus competing with it.

Over all your years in the profession, what are some of the most important lessons you've learned?

Find something to run to, never run away from anything — that's one of my life lessons. Because you need to find things that bring you joy, things that bring opportunities that you want in your life.

One wonderful opportunity I had was to work in a large medical center and to learn a lot about medicine that I would never trade — such as ICU, postop, and acute medicine experiences. I also understand more about the needs of patients and



Herr and APTA President Sharon Dunn, PT, PhD, share a moment of humor at the 2019 House of Delegates as she recognizes his service as House secretary from 2016 to 2019.

the capabilities of health care providers in these environments that I would've never known if I had stayed in traditional inpatient rehabilitation. So, I'm very thankful for understanding the continuum of care. I understand that health care services have changed a lot since I did that 30 years ago, but I do have an understanding.

What have been some of your greatest rewards?

Helping others. First, in clinical practice my greatest reward was helping patients. Then, helping a team of clinicians who help hundreds or thousands of patients has been a reward, too. The reward is helping others who help others, helping a larger community and expanding on that.

Another reward is realizing the value of advocacy. One of the winning formulas for me is whenever I do advocacy, I do it from what it brings to the patient, what it brings to the constituent, what it brings to the community, and how I can help realize that versus just focusing on getting paid more.

Is there anything else that you think is important for readers and fellow PTs, PTAs, and students to know?

We're all individuals. Some people may see me as part of the system because I'm the president of APTA, but I am an individual and a person. I've been elected to serve a role, but I'm still a person. I'm still a member like you.

All of us together are a force to be reckoned with. No one is more important than anyone else. I just have a different seat at the table now.

Michele Wojciechowski is a national award-winning writer and a frequent contributor to APTA Magazine.

Blood Flow Restriction Training Becoming Standard Practice

A novel treatment not long ago, blood flow restriction training is rapidly being used by more and more physical therapists.

The patient, recalls Corbin Hedt, PT, DPT, was a women's Division I basketball player who had the "gnarliest meniscus and ACL injury that I think I've ever seen as a clinician." She'd made a routine pivot in her team's first practice of the year, "and her knee went into this massive valgus, slamming her medial tibia into the floor."

Examination revealed significant bone bruising, and an MRI showed the player had torn her anterior cruciate ligament. Later, when the orthopedist went in for surgery, "he literally couldn't locate the meniscus anywhere," says Hedt, who is a board-certified clinical specialist in sports physical therapy and a certified strength and conditioning specialist.

Eventually, the surgeon did find the cartilage — it had been pushed back into the knee's posterior capsule — "so he took it out, cleaned it up, and put it back into place," Hedt says. "And then he finished up with the ACL reconstruction."

A sports physical therapist at Houston Methodist Orthopedics and Sports Medicine, Hedt had helped many elite athletes get back on their feet after significant injuries. In this case, though, he wasn't sure what to think, and it didn't help that the surgeon had his doubts as well. "We talked quite a bit before I saw her for the first time, and I remember him telling me, 'You know what, if this one gets back to sport, I'll sing your praises from the mountaintops.' He wasn't confident in her prospects at all, and this was one of the best knee surgeons in the country."

From Research to Results

What that surgeon may have failed to consider was that Hedt had what amounted to a secret weapon in his physical therapy toolbox. "We hit BFR from basically day one — the very first session that I saw her," he recalls. Blood flow restriction training, he explains, was something he'd used since he started



Marc Sherry works with a 37-year-old patient performing heel raises on the leg press machine with BFR to help repair her Achilles heel.



> "All of our participants who used BFR saw significant improvements in terms of building back their bone mass, while those in our control groups that didn't use it, they really struggled to even return to baseline."
> — Corbin Hedt

at Houston Methodist as a sports resident in 2014. He and a colleague had enrolled in the very first BFR course offered by a San Antonio-based company called Owens Recovery Science. Intrigued by what they learned, they'd gone on to establish many clinical trials investigating the benefits and potential of the technique.

As part of that research, Hedt says, one of the areas they'd focused on involved how BFR might benefit a patient post-ACL reconstruction. Blood flow restriction training entails applying a pneumatic tourniquet cuff to the proximal portion of an extremity and applying pressure to partially impede arterial blood flow to the limb. Pioneered in the 1960s in Japan and named "Kaatsu" by its inventor, the technique causes blood pooling in the capillary beds of muscles distal to the cuff, and has been shown in numerous studies to increase muscle strength and size when used during exercise.

In their ACL research, Hedt says, they looked at how BFR use in postoperative physical therapy affects muscle mass and functional outcomes, and they explored its impact on bone mineral density. They were familiar with previous studies that had demonstrated gains in musculature, so they weren't surprised when their own findings mirrored those results. What they learned about bone mineral density was another story, he says. "All of our participants who used BFR saw significant improvements in terms of building back their bone mass, while those in our control groups that didn't use it, they really struggled to even return to baseline."

In the case of the basketball player, Hedt's patient arrived at the clinic with substantial effusion in her knee. "We knew she'd have to be entirely non-weight bearing for six to eight weeks, which meant she was going to be extremely weak," he recalls. "My goal was to do absolutely everything in my power to keep that leg viable so that once she did start walking and bearing weight, she would have a good outcome."

Hedt talked to his patient about the benefits of BFR, and once he had her buy-in, they got to work. "It took her a solid 14 months of straight rehab," he says, "but she made it back for the following season and was a key contributor in helping her team to the national tournament."

From Innovative to Integrated

There was a time when Drew Contreras, PT, DPT, would have been skeptical that BFR training might provide a patient such big returns. Today, though, he's a BFR believer — and he knows from personal experience how effective it can be.

"Seven or eight years ago, I'd have been surprised," says Contreras, APTA vice president of clinical innovation and integration. "I'm not surprised anymore." From his perspective, he adds, BFR has moved "from innovative to integrated." Practices are using it, it has clinical research behind it, "and it can be safely implemented and used across the physical therapy profession."

The ever-increasing number of promising studies on the subject is one reason for the uptick in BFR adoption, Contreras notes, but its use by PTs working with high-profile patients is also helping its popularity. "You see someone like Alex Smith utilizing BFR and the dramatic success that came out of that — as a physical therapist, you can't ignore that." Smith, the ex-quarterback for the Washington Football Team, was able to return to the NFL after suffering a compound fracture to his right tibia and fibula in 2018. He underwent more than a dozen surgeries for the injury, and he eventually developed sepsis in the limb, but he made it back to play again following a rehab program that included BFR.

Contreras, who also runs a private physical therapy practice in the Washington, D.C., area, says he uses BFR regularly in his own work. "It lends itself very well to outpatient orthopedics, where you're trying to accelerate healing and strength gains, and I've also found that it's highly effective with geriatric and postoperative patients."

BFR can be appropriate for these populations in particular, because it allows a patient who may be weak or healing from surgery to build muscle using very light weights. "When you use blood flow restriction, you can get the same training and rehabilitative effect with a lower load," Contreras explains. "That's the key to BFR. I can work with somebody and get the same effect without having to use the same amount of resistance."

That concept of "less is more" is certainly familiar to Johnny Gray Owens, PT, MPT. Owens is the physical therapist who worked with Alex Smith, and he's CEO and director of clinical education at Owens Recovery Science.

The company, Owens notes, leads clinical research on BFR and provides continuing education on the technique to physical therapists and other health care professionals. In his practice, he serves as a

Getting Started With BFR

BFR is within the scope of practice for any physical therapist and within the scope of work for PTAs under PT supervision (check local regulations and your state practice act), but experts in the technique say it's important to undergo training before using it in the clinic.

"The big thing to understand is that blood flow restriction rehabilitation requires a medical-grade tourniquet or equivalent," says Drew Contreras, PT, DPT, APTA vice president of clinical innovation and integration. The cuffs that typically are used for BFR are specifically designed to restrict blood flow without occluding flow completely. Training in the technique typically covers equipment options, how to safely apply cuffs at the appropriate pressure, and applications for BFR in rehabilitation settings.

BFR training and education resources include:

- APTA: "Blood Flow Restriction Rehabilitation: State of the Science," Centennial Lecture Series presentation by Johnny Owens, PT, MPT, September 2021. Recording available for purchase in the APTA Learning Center. learningcenter.apta.org/
- In-person BFR training course: One-day on-site training courses by Owens Recovery Science at locations throughout the United States. owensrecoveryscience.com/get-certified
- Online BFR training course: Produced by Mike Reinold, PT, DPT, ATC, co-founder of Champion PT and Performance. www.mikereinold.com/blood-flow-restriction-training-online-course



"It lends itself very well to outpatient orthopedics, and I've also found that it's highly effective with geriatric and postoperative patients."
— Drew Contreras



BFR is applied to the upper body for performing an inverted rowing exercise. (Courtesy of MikeReinold.com.)

medical consultant for teams across the professional and collegiate sports landscape, and he led a presentation on BFR at APTA's 2021 Combined Sections Meeting.

Owens says he first encountered BFR more than a decade ago as chief of human performance optimization at the Center for the Intrepid at San Antonio Medical Center. There, he worked with military service members who'd experienced severe musculoskeletal trauma during combat. "One of the major problems was, their injuries were often so bad that they couldn't handle any loads to get strength back and rebuild muscle," he says. Using federal research grants, his team led several trials studying the efficacy of BFR with these patients. "They did fantastic, and that's what led me to start my own business — the idea that I could share what we learned in the military with clinicians working with other patient populations."

Mike Reinold, PT, DPT, ATC, co-founder of Champion PT and Performance, also provides education of the science and application of blood flow restriction training, through an online course he produced. The board-certified clinical specialist in sports physical therapy, certified strength and conditioning specialist, and champion performance specialist, agrees about the benefits of BFR when load is an issue. "If someone is coming back from an injury or surgery and they can't lift heavy weights during exercise, we can use BFR to get the response that we want, while having them move a much lighter load."



> "If someone can't lift heavy weights during exercise, we can use BFR to get the response that we want, while having them move a much lighter load."
>
> — Mike Reinold

Beyond Elite Athletes

Today, Owens says he's most excited about applications for BFR among older adults. "I can use this technique with a professional athlete and maybe help them move just a little bit faster, but if I do this successfully with grandma, maybe she can get up those stairs."

Owens recently worked with one older patient who had an incomplete spinal cord injury and could move only with a walker or wheelchair. "He had some muscle that he could use, but he was never going to be able to push enough weight to get to where he could walk unassisted again."

Owens put his patient on a BFR training regimen, "and that really changed the equation," he says. With pressure cuffs on the man's limbs, he used anaerobic metabolism and fast-twitch fibers to lift light weights and quickly rebuild strength. "He saw significant improvements almost right away, and within four or five weeks he was using a cane," Owens recalls. "The best part about it, for me, was that he reached his goal of being able to walk his daughter down the aisle when she got married."

Like Drew Contreras, Owens thinks that the word has gotten out about BFR. Still, he says, based on surveys that he's seen, adoption among physical therapists appears to be lagging. (One such survey showed that while 88% of PTs had heard of BFR, only 39% percent had tried it clinically.)

"There's still some resistance," Owens says, "and I think that will continue to be the case until we do more clinical trials," including research on potential complications with its use on patients with comorbidities, for example. He says he's personally comfortable using BFR "because I've done it with older patients, and with guys who've been blown up by IEDs, and with these athletes like Alex Smith postinjury or postsurgery." But he's also eager to learn more about the technique and to help facilitate new studies toward that end. "What does BFR do when you have elevated blood pressure? What does it do if you have cancer? We have some ideas, but for some of these populations, I can understand the need to pump the brakes."

Introducing BFR to Practice

One clinical practice that's taken a cautious approach to incorporating BFR into patient care is UW Health Sports Medicine in Madison, Wisconsin. The clinic's manager, Marc Sherry, PT, DPT, LAT, took a BFR-certification course last August



Mike Reinold applies measures for the right amount of pressure after applying BFR cuffs to a patient's legs.



> "I can use this technique with a professional athlete and maybe help them move just a little bit faster, but if I do this successfully with grandma, maybe she can get up those stairs."
>
> — Johnny Gray Owens

after "researching and talking" about blood flow restriction with his colleagues for the better part of a year, he says. By November 2021, the practice had two BFR tourniquet systems on hand, but it had only used them with a few patients. The team was holding meetings to review the science behind the technique, and to discuss how they might apply it to their patient population in a standardized way.

"We're basically doing a little fine-tuning before we fully roll it out," Sherry notes. If they're going to rely on BFR with their ACL patients, for example, "it shouldn't be that John's doing it differently than Melissa, who's doing it differently than Gary or me." In a large academic medical center such as UW Health, "we don't do anything unless it's evidence-based," he adds. Two years ago, he didn't think there was enough evidence around the use of blood flow restriction training in the types of patients they see. "But now I think that's changed. Today we know that it's not only safe; it's also beneficial."

Sherry, a certified strength and conditioning specialist, anticipates his team at UW Health will start by using BFR only for a limited number of cases. "If you read the BFR literature, it helps muscle strength and hypertrophy, it can decrease pain, it can increase muscle endurance, and it can promote bone healing. In our setting, because it's new to us, we're going to focus on the muscle-strength component before anything else."

Sherry adds that the patients they're most likely to treat with BFR fall into three categories: "Post-operative-protection" patients, including those with ACL or Achilles or other ligament or tendon repairs for which loading must be restricted during healing after surgery; "weight-bearing-precaution" patients who are still healing from fractures or procedures



BFR is applied to the lower body for performing lunges. (Courtesy of Owens Recovery Science.)



Johnny Owens works with a patient performing ham curls with BFR.



> "We don't do anything unless it's evidence-based. Today we know that it's not only safe; it's also beneficial."
> — Marc Sherry

and need time before they're able to handle exercises such as body-weight or loaded squats; and "overload-management" patients with conditions such as tendinopathy, whose pain or dysfunction resulted from excessive high-intensity loading.

The handful of patients with whom he's used blood flow restriction so far have "really liked it," Sherry says. In one case — a middle-aged woman with an Achilles repair — he'd started working with the patient before the clinic received its BFR tourniquet systems. They'd tried incorporating progressive-resistance exercises into her rehab, but she was limited by pain and discomfort at the tendon. "Once we got the BFR cuff, we were able to do those exercises, and she said it was the first time she'd felt soreness in her calf muscle — that prior to that, she'd only felt it in her tendon."

Another patient had suffered an Achilles rupture that was treated nonoperatively. Because the patient lived 40 minutes from the clinic, he'd only been coming to appointments once or twice a month and had struggled to get his strength back. "He came in one day," Sherry recalls, "and we decided to try BFR, and I told him that for it to be effective we'd probably need to do it a couple of times a week." The patient seemed skeptical initially, but the day after his first treatment, he was sold. "He said, 'You know what, that's the best my calf has felt from a workout in two months. The drive is worth it — I want to do more.'"

A Tool of Choice

If patients are saying they want more BFR, the same is true of many physical therapists. In his niche-area of practice working with professional athletes, Derrick Nillissen, PT, DPT, says, "I've been blown away with how much the use of BFR has increased over the last two years."



> "I've been blown away with how much the use of BFR has increased over the last two years."
> — Derrick Nillissen



Derrick Nillissen holds a personalized tourniquet system for BFR as he prepares to treat one of the Phoenix Mercury basketball players.

A PT and strength and conditioning coach for the WNBA's Phoenix Mercury who also works with the NBA's Phoenix Suns in the NBA during the Mercury's offseason, Nillissen was introduced to the technique as a colleague of Corbin Hedt's at Houston Methodist. "When I came into this team-sports environment, I thought I'd use BFR the same way I used it in the clinic." Instead, he says, he's using it all the time. "Pretty much for any extremity injury but also as a recovery modality, and as an additional tool for strength training when the players are on the road."

Nillissen, a board-certified clinical specialist in sports physical therapy and a certified strength and conditioning specialist, describes BFR as a "first line of defense" for preventing muscle atrophy following injury. In the case of an Achilles or patellar tendon, for example — "a lot of our athletes have symptomatic tendons," he notes — his typical protocol would involve estimating the injured player's expected one-rep max for either a calf raise or leg extension, and then setting the weight for their exercise at 30% of that figure. Then he'd put a cuff on their limb to provide 80% occlusion, and from there, he'd have them do one set of 30 repetitions followed by three sets of 15 repetitions. "Once they're able to complete all the reps for two sessions in a row, we'll increase the load by 5%-10%," he explains. "It ends up being really uncomfortable, but they don't mind because they see the benefits and they want to push as much as possible."

Nillissen says he also uses BFR with injured players to help them maintain endurance — having them ride a stationary bike, for instance, with cuffs affixed to both legs — and with players who are healthy, he'll use it for ischemic preconditioning. "For IPC, it's meant to be done passively; they literally lie on the table while we alternate 100% occlusion for five minutes with no occlusion for five minutes." There's evidence that using BFR this way can increase vascularity throughout the limb and improve cellular exchange, he explains, "so it's something we like to do to speed up recovery, especially the day after a game."

The players he's worked with tend to ask for BFR once they've been introduced to the technique, Nillissen says, and he predicts that other physical therapists will find their patients respond the same way. The good thing is, he knows blood flow restriction training isn't just popular, it's also a great tool for a large number of patients. In the practice settings where the technique has been studied and proven safe and effective, he says, "if it's not a staple, I think we're doing our patients a disservice."



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Health Care Headlines

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



2022 Hospital Outpatient and ASC Rule Ups the Ante on Price Transparency

Hospital outpatient and ambulatory surgical centers that violate transparency rules are facing tougher sanctions in 2022, including more severe civil and monetary penalties, under a final rule issued by the U.S. Centers for Medicare & Medicaid Services. The rule also includes a 2.0% increase to payment rates for hospitals and ASCs for 2022 and reiterates CMS' intention to require greater health equity quality reporting at some point in the future — but not in 2022.

The transparency penalties can add up quickly: The minimum penalty is $300 a day for hospitals with a bed count of 30 or fewer, and $10 a day, per bed, for hospitals above that limit, not to exceed $5,500 a day. A full calendar year of noncompliance could lead to a total penalty of $109,500 per hospital and a maximum total penalty of just over $2 million.

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

Researchers: Over 50% of COVID-19 Survivors in Study Experienced Symptoms After Six Months

A new systematic review of studies involving more than 250,000 COVID-19 survivors found that over half were still experiencing one or more long COVID symptoms six months after recovery or hospital discharge. Authors of the review, published in JAMA Network Open say that given the scale of the pandemic, their findings should serve as a warning that postacute sequelae of SARS-CoV-2 infection, or PASC, "could overwhelm health care capacity, particularly in low- and middle-income countries."

2022 Home Health Rule: No Big PDGM Changes, But a Surprise Payment Boost

With the coronavirus making it hard to tease out data that could affect the Patient-Driven Groupings Model, the U.S. Centers for Medicare & Medicaid Services made no significant changes to the model for 2022. However, CMS warns that if the PDGM doesn't stabilize in 2022, more drastic corrective action may be needed in 2023. The agency did make changes to payment amounts, upping 2022 payment by 2.6% over 2021 rates for home health agencies that have submitted required quality performance data. The increase was a change from the proposed rule, which set the increase at 1.8%.

Study: Pre- and Post-TKR Physical Therapy Lowers Odds of Long-Term Opioid Use

Researchers tracking health records of 67,332 patients who underwent total knee replacements found notable reductions in risk for use of opioids beyond the first 90 days after surgery for those who received physical therapy — including among patients classified as "opioid experienced" and more likely to continue use for longer periods of time.

In both the opioid-experienced and opioid-naive groups, pre-TKR interventions were associated with 25% lowered odds of long-term opioid use. Receiving post-TKR physical therapy was associated with 25% lower odds of long-term opioid use among the opioid-experienced group; the opioid-naive group's odds were also lower but not enough to reach statistical significance. The study was published in JAMA Network Open.



Overhaul for Federal Loan Forgiveness Program Aimed at Making It More Accessible

The Public Service Loan Forgiveness Program, considered by many to be overly complex and largely ineffective, is undergoing some big changes that could dramatically increase the reach of its assistance. The original intent of the program was to provide debt relief for a range of jobs considered public service, including some positions filled by PTs and PTAs, by allowing loan forgiveness on the remaining balance of federal direct loans after making 120 qualifying monthly payments.

Thanks in part to widespread denials and an overly strict interpretation of rules, the system largely failed to live up to its promise. The retool announced by the U.S. Department of Education is meant to breathe new life into the system. Among the changes to the program: temporary waivers on disqualifications and prior payments to the system that were rejected, inclusion of active-duty military service in relief qualifications, and a full review of all denied applications to the program.

Study: Early Physical Therapy for Spinal Stenosis Lowers Later Utilization

Researchers tracking Medicare data from 60,464 beneficiaries with lumbar spinal stenosis found that patients who received physical therapy within 30 days of diagnosis had lowered risks for hospitalization, opioid use, spinal surgery, and spinal imaging, compared with those who didn't receive physical therapy early on. The problem? Just 1.9% of the beneficiaries studied received early physical therapy.

The question of why use of physical therapy was so low — worse than the estimated 7% of beneficiaries referred to physical therapy for low back pain within 90 days of diagnosis — could be related to two possible factors, authors theorize. First, physical therapy may have occurred at some point but was not prioritized as an intervention early on. Second, the greater presence of comorbid conditions in the non-physical therapy group could indicate greater mobility limitations, steering practitioners away from early physical therapy. The study was published in the Journal of Geriatric Physical Therapy.

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

APTA Practice Advisories Keep Members Updated on Vaccine Mandates, Good Faith Estimates

Two APTA advisories provide members with information on federal vaccine mandates and new regulations on providing cost estimates to uninsured and self-pay patients.

Concerning vaccine mandates, at the time of this writing, court challenges to COVID-19 vaccination requirements announced by both the U.S. Centers for Medicare & Medicaid Services and the federal Occupational Health & Safety Administration are interrupting application of the new rules, at least in some states. APTA is urging members to keep a close eye on the evolving situation and be prepared to follow the rules if applicable. The CMS rule is explained in depth in an APTA Practice Advisory that will be updated should details of the mandate change.

As for cost estimates, another APTA Practice Advisory outlines new regulations that, as of Jan. 1, 2022, require providers to supply uninsured or self-pay patients with good faith estimates for the cost of services as part of the 2020 No Surprises Act, aimed at protecting consumers from surprise medical bills.

The advisory provides background on the requirements, and information on how the estimates must be provided and what they should include. Noncompliance could result in enforcement actions that include monetary penalties.

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 June 2021 post by Ramsey Bankert, SPT, who is a student at the University of Wisconsin-Madison.

Making a Positive Impact on Healthy Body Image and Diet

Growing up I participated in both cross country and gymnastics, two sports that emphasize a lean body image and associate that image with enhanced performance. When pursuing these sports, I and a handful of teammates believed this association to be true. At the time, I was unaware that pursuing a thin body image came with health risks. Now, as a DPT student, I am thankful to have gained this knowledge along with the opportunity to educate others.

My teammates and I would under-fuel our bodies in the hope that doing so would improve performance by cutting a few seconds off a 5K or allowing us to flip just a little higher. What we didn't realize were the negative health effects of low energy availability. We didn't recognize the risks of fatigue, loss of menses, stress fractures due to poor bone health, and eventually worsened performance. Instead, we focused on the idea of a lean body — the body we perceived would help us beat our competitors.

Thinking back to this time in my life, I try to analyze what factors led my teammates and me to believe that a slender figure was equivalent to enhanced performance. Although there's no single answer to this question, one thing I can say with certainty is that our popular culture did not do anything to counter this belief.

The media advertises faulty messages that a lean body image is equivalent to optimal athletic performance. Not to mention the many fitness and nutrition trends pushed by the media that fail to be supported by scientific evidence. These trends continually place an emphasis on unhealthy dietary habits and negative body image standards.

Those in our profession are aware of the female athlete triad and relative energy deficiency in sport — along with how these concepts negatively affect metabolism, menstrual function, bone health, immunity, cardiovascular health, and psychological health. But are we getting through to our patients and the public regarding these negative health consequences? Or are we being drowned out by the latest Instagram influencer?



I believe our profession both understands and values general wellness as an important component to healing and performance. I believe it is crucial that we as PTs and PTAs advocate concepts of general health and wellness, encourage open conversations about body image and dietary habits, and begin to reduce the emphasis of the thin body ideal that can counteract the development of true, long-lasting health habits.



Read the full story from June 29, 2021, at **apta.org/article/2021/06/29/making-a-positive-impact-on-healthy-body-image-and-diet**

APTA Member Value

As we gear up for the new year, gain some inspiration from members taking advantage of their APTA membership to build a community that advances the physical therapy profession.



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

Members Share Their Inspiration

Members have varying motivations for joining and continuing in the profession. These defining moments are captured in perspectives, podcasts, and articles.

For example, during Women's History Month last year, female PTs shared what led them to enter the profession. For Andréa Leiserowitz, PT, DPT, a chance meeting with a PT as a teen led to volunteering at a summer camp for children with disabilities. Inspired by the creativity used to help campers reach their functional goals, she started on her career path in physical therapy. To read more, visit the APTA website and search "Making History One Woman at a Time."

Looking for more inspiration? Read APTA Magazine's Defining Moment column in each issue. This month, Linda Pillow, PT, recounts her beginnings in the profession in "The Perfect Profession for Me" on Page 62. Better yet, spread inspiration by sharing your own defining moment with your colleagues; see the instructions for signing up on Page 63.

Members Serve

Closing out 2021, members participated in the APTA Centennial 100 Days of Service. Meant to spark member engagement in local communities, promote collaboration, and raise awareness about the profession, members made an impact through volunteerism. One example of this is Ricardo Fernandez, PT, PhD, board-certified clinical specialist in orthopaedic physical therapy, who has dedicated his time over the years to serving current and former members of the military and their families. Search "100 Days of Service Member Profile" on apta.org to read his story.

It's never too late to join in or create a service opportunity of your own:

- Visit centennial.apta.org/home/serve for more information and service ideas including toolkits from Special Olympics, Go Baby Go, and Move Together.
- Want to participate in a volunteer opportunity this year? Check out APTA Engage, the association's volunteer portal, at engage.apta.org.

Members Advocate

Last fall, more than 450 PTs, PTAs, students, and supporters held 300 meetings with members of Congress and staffers as part of APTA's Advocacy Day in Washington, D.C. Theresa Marko, PT, DPT, APTA New York federal affairs liaison, Sabrina Basile, SPT, and Zaryna Sanchez, SPT, shared their experiences in an APTA blog post. Search "We Went to D.C. to Advocate for our Profession" to read about it.

Can't make an in-person advocacy day? APTA makes it easy for you to make an impact remotely:

- Download the APTA Advocacy app and you'll be ready to take action in minutes by writing a letter or email using talking points or prewritten messages. Download the APTA Advocacy app from the Apple or Google app stores.
- Watch for the annual student-led Flash Action Strategy event, when all members are encouraged to contact their member of Congress on a designated issue of importance to the profession.

Members Get Recognized

Each year, APTA honors members for their outstanding achievements. At the Honors & Awards ceremony in 2021, more than 70 individuals were recognized in different categories for their achievements in areas such as service, education, practice, publications, and academic excellence. Among those there were 13 newly named Catherine Worthingham Fellows of the American Physical Therapy Association, and 21 Lucy Blair Service Award recipients.

Recognition comes year-round too. Your achievements make APTA and the profession stronger, whether it's a chapter or section recognizing their emerging leaders or a mention in APTA's "The Good Stuff," a periodic news article highlighting members featured in the media, such as Karena Wu, PT, DPT, MS, who outlined the pros and cons of exercising with weighted vests and ankle/wrist weights in a Washington Post article.



Bonus: Patients Inspire, Too

Patients share their stories on the ChoosePT.com website. Listen to how Morgan, who had complex regional pain syndrome, learned how to manage, not mask, her pain with physical therapy. Or how Elizabeth, a teenager with chronic pain and postural orthostatic tachycardia syndrome, had such severe symptoms she couldn't attend school or do the activities she loved, and was forced into bed. With physical therapy and patient education as part of a treatment program she got stronger, and her pain lessened.

Celebrate all that APTA and its members have done together and consider sharing your inspiration and passion for physical therapy as we enter 2022 and our next century.

APTA's Centennial Scholars Program built a cadre of future leaders at the component and national levels. The program supports APTA's quest for a diverse and prepared leadership pool and is an investment in the sustainability of the association as it begins its next 100 years.

The scholars, supported by their sponsoring stakeholders and guided by mentors, designed and completed capstone projects that address a need identified by their sponsor. APTA Magazine is spotlighting many of these capstone projects in each issue during 2022.



Rebekah Griffith PT, DPT, board-certified clinical specialist in neurologic physical therapy

Sponsor: APTA Colorado

Mentor: David Morris PT, PhD, FAPTA

Early Professional Scholar Program

Project description: The program chooses one early-career PT and PTA each year in Colorado. They receive one-on-one mentoring and a curated curriculum to enhance their leadership skills and professional development, and they complete a capstone project. We provide a stipend to support their APTA dues and travel to an APTA event.

Goal: To provide focused professional development and leadership training for early professionals within APTA Colorado, and to enhance the development of a leadership pipeline within the profession in Colorado.

Why did you choose this project? Early professionals are highly supported throughout their school years but often suddenly are on their own after graduating. We want to ensure that APTA Colorado includes the voice of this group and supports them in service and leadership. By providing learning such as understanding APTA value and structure, advocacy training, competence in DEI, and PT-PTA collaboration, we help these leaders to be assets to APTA Colorado, the profession, and their communities.

What will success look like in two to five years? I hope to have many scholar graduates and a large pool of annual applicants. Those not selected for the program will be invited to serve on our Early Professionals Council. We hope that the capstone projects will serve the members of APTA Colorado.

What's one thing you've learned from the experience? The desire for mentorship and professional development is large. I've also learned many things about APTA and the profession from my colleagues in the Centennial Scholar program.



Alexandra Hill, PT, DPT, board-certified clinical specialist in oncologic physical therapy and women's health physical therapy

Sponsor: APTA Oncology

Mentor: Pamela Levangie, PT, PhD, DSc, FAPTA

APTA Oncology Mentorship Program

Project description: The program provides mentorship for students and early-career PTs and PTAs in oncologic rehabilitation.

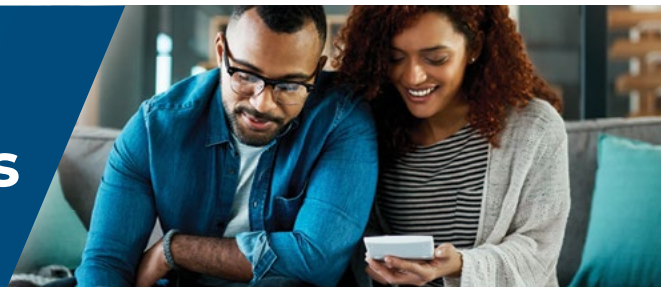
Goal: To advance oncologic physical therapy by facilitating learning experiences and mentoring relationships between mentees and oncology rehabilitation professionals.

Why did you choose this project? I was lucky enough over the years to have strong mentors who challenged me to reach higher and give back to the profession. As the number of cancer survivors continues to increase and survivors live longer, the need for more oncologic PTs and PTAs is evident. I hope that this mentorship inspires people to become engaged oncologic therapists.

What will success look like in two to five years? A successful program will include leadership development programming beyond one-on-one mentoring and will be robust in both programming and participants. Although participation in the mentorship program already started out strong, I want the number of participants to increase, indicating that we are reaching more people in the profession interested in oncologic rehab.

What's one thing you've learned from the experience? Have contingency plans! The small group I worked with helped me see things differently from how I originally imagined them, and they helped prepare for different scenarios with the program rollout. Even with four minds working on this project, some unexpected things happened. We were able to find solutions for those situations, and we outlined ways to avoid them in the future.

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APTA is committed to supporting the physical therapy community with tools to make strong financial management decisions and to manage student debt.

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APTA American Physical Therapy Association

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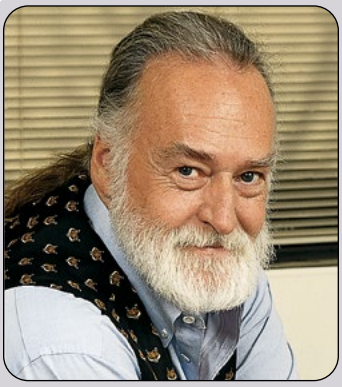
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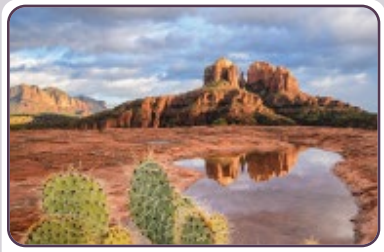
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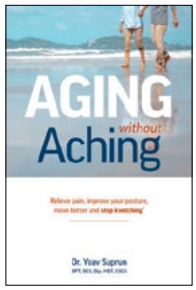
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/ By Linda Pillow, PT

A light came on not only in a dark hospital basement but in a future PT's head that this was her ideal career.

The Perfect Profession for Me

I was well into my career as a physical therapist when I began treating a 40-year-old woman who first came to our clinic being pushed by her husband in a wheelchair. Recently arrived in Kentucky from her native Honduras, she had been experiencing extreme dizziness for six years. Despite a merry-go-round of visits to various doctors, she had been unable to find help.

After being rushed to the emergency room by her husband one day with another bout of dizziness and nausea, she was diagnosed with benign paroxysmal positional vertigo. This condition occurs when calcium carbonate crystals become dislodged and drift into a canal of the inner ear. Because the crystals are not supposed to be there, the canal becomes sensitive to changes in head position and causes dizziness, nausea, and unsteadiness that can lead to falls.

Vestibular rehabilitation to treat BPPV involves a series of head and body movement maneuvers to reposition the crystals back where they belong in the utricle of the inner ear. The maneuvers sometime make the symptoms worse in the beginning. My patient was afraid to move her head at all, but she and her husband had confidence in the treatment. We began with small movements of her head and body to build her trust in me, the treatment, and herself. After two months of rehab, she was able to walk again and left her wheelchair behind. On her last day of physical therapy, all three of us were so happy we cried.

That was the day I decided to specialize in vestibular rehab. It was, however, not the defining moment of my career in physical therapy.

That moment occurred many years before, when, at the age of 16, I visited our local hospital as a member of a health careers club. I remember walking down the stairs to the basement thinking to myself, "What department could be down here in this dark dungeon?" Instead, I opened the door to a brightly lighted gym with patients in wheelchairs exercising, laughing, and having fun. That's when I knew physical therapy was the career for me.

As a physical therapist, I know that I make a huge positive difference in the lives of our patients. Over the years, I have seen many instances of dramatic improvements in people with BPPV and other vestibular problems. I have even treated several members of my own family. My mother experienced symptoms and took medicine for dizziness



Linda Pillow, PT, with H2 Health, is the director of Graves Gilbert Vestibular Rehab Clinic in Bowling Green, Kentucky. You can reach Linda at pillowl@ggclinic.com.



Linda Pillow performs the right posterior Canalith repositioning maneuver, also called the right Epley maneuver, for BPPV on a patient who is experiencing dizziness with her head movements.

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.

"Our patients come in sick, scared, and doubtful that physical therapy can help them. But with treatment, trust, and patience they can achieve life-changing results."

for years until I was able to convince her to try rehab, which proved to be effective. Unfortunately, her twin sister refused treatment because she was afraid of the temporary worsening of her symptoms. She fell in her home and suffered a fatal brain bleed.

BPPV eventually found its way into my own inner ear, and I have to maintain a regular regimen of the head and body movement exercises to keep my symptoms under control. I think having BPPV has made me a better physical therapist because I know how sick and frightened a patient can be.

While most people don't think of physical therapy as a way to treat dizziness, it is the most effective way to treat BPPV. We are seeing more cases and still getting excellent results at our vestibular rehab clinic in Bowling Green, Kentucky. Our patients come in sick, scared, and doubtful that physical therapy can help them. But with treatment, trust, and patience they can achieve life-changing results.

Yet even as I've given so much of my life and career to my profession and the people I treat, physical therapy has been equally generous in giving back to me. It has been the perfect profession for every stage of my career life over the past 50 years.

I started at the bottom, as a tech working in the summers during college. I even met my husband while cleaning the whirlpool in the physical therapy department at the hospital. I then transferred from Hanover College to the University of Kentucky physical therapist program under Richard (Mac) McDougal. He was one of the pioneers of our profession. Upon graduation from the UK PT program, I had the freedom to go wherever I wanted. I landed in Nashville, Tennessee, to work at Baptist Hospital.

A few years later, as a newlywed, I headed to the mountains of Eastern Kentucky, where my husband was working as a Kentucky state trooper. I was the director of Hazard Appalachian Regional Hospital Physical Therapy Clinic. This opened my eyes to what it was like to work among people truly in need. This is also where half of my house slid down the mountain one year, and I lived in the other half through the winter. Brrr.

As a new mother, I moved with my husband home to Bowling Green, where I began working through a contracting company (now called H2 Health) as a director of physical therapy at Graves Gilbert Clinic, an outpatient facility, three days a week. I felt like I had the best of both worlds: a perfect combination of practicing physical therapy and being a mother. I did not miss a milestone of any of my children. I continued this until recently when I became a grandmother, "Gee Gee." I now work two days a week. I have found throughout my lifetime that a physical therapist can get a job, full time, part time, anytime, anywhere.

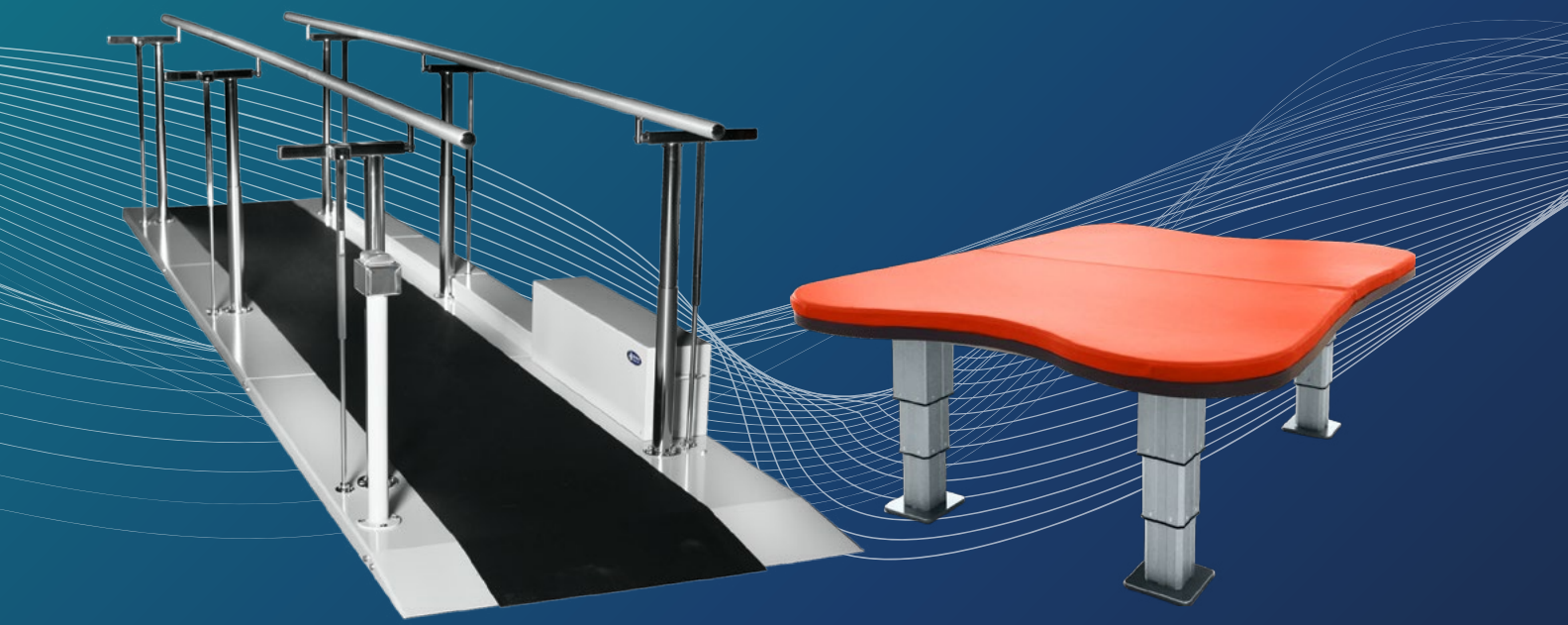
Physical therapy is a very giving profession. It gives people a way to lead their best lives. It has given me both professional satisfaction and a great family life. It gave me a grateful patient who has sent me a Christmas card every year for 40 years.

These are the outcomes of my decision to become a physical therapist — and the wonderful benefits of the defining moment and all the subsequent moments that have directed my life.

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