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¹Hesse 2013
²Pradon 2011



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— QUOTED —

‘ This new generation of PTs thinks differently. They get it. They understand that just fixing people after they’ve had a pathology isn’t enough—PTs need to be health promoters, as well. ’

MARYSUE INGMAN, PT, DSc,
in “Community Health Promotion:
Reaching Beyond the Clinic”
(page 16)



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PT in Motion welcomes your opinions. We will consider letters, email, and posts that relate to specific articles in the magazine and those of general interest to the physical therapy profession.

Online Comments

Ethics: The Perils of Self-Deception

Even though the scenario in “Ethics in Practice” in the February issue may be fictitious, I am certain it is far more prevalent than any of us would admit. In fact, I believe it is pervasive. The presented scenario violates all of the ethical standards listed in the column and represents and leads to nothing more than malpractice, insurance fraud, unethical behavior, and violation of state laws. What does this say about a profession where standing up for these pillars results in 1 thing—getting fired? The problem is created by a reimbursement rate that cannot support a sustainable business model.

Mark Macri

In California, it is illegal for employees to work off the clock. This problem can and should be reported to the Labor Department if you are brave enough to do so. The employee will be due payment for the hours worked off clock, and, possibly, the business will be fined.

Kristin Slaughter

Improving the Lives of People With Dementia

Thank you for highlighting the importance of creatively engaging individuals, and for pointing out that it is skilled care!

Christine Brussock

Career Transitioning Advice for Aging PTs

I entered practice later in life and knew from the beginning that I’d have to conserve my body if I wanted to have a full career. I chose vestibular therapy because it was a specialty that I could continue as long as I could stay on my feet. So far, so good!

Nancy Wubenhorst

Very well-written article, and pertinent to so many of us who are charting our life and career paths as we enter our golden years. I have been a PT for 28 years and am considering the next step in my life and career. My thanks to the PTs who have shared their life experiences.

Radhika Gandhi

Educational Costs

This is a very important topic to emphasize to individuals entering into DPT programs (whether they are in a 6-year direct-entry format or a 3-year grad school portion). The most important thing that I did not consider when budgeting for PT school was the increase in grad school cost by the time I got into that portion of the program. The percentage increase in tuition was incredible from the time I entered the direct-entry program as an incoming freshman to the time I was required to pay it as a graduate student. I feel there should be a cap on the percentage increase of graduate tuition per year so that students can estimate what they will be paying 3-4 years down the road and determine if that is feasible for them.

Erin Van Buskirk

Ethics: Acutely Insufficient

Years ago, as a CI, I was once in the situation described in the March issue of *PT in Motion*. My student clearly was not interested in working with pediatric patients and was resistant to learning about our clients. Nonetheless, she needed a successful pediatrics rotation to graduate. I felt it dishonest to give her the same grade as her classmates who had done so much better work. So, after consultation with her school director, I offered her the option to repeat her affiliation with us or to do another rotation at a different facility. She chose to remain with us and did acceptable work on the second try.

Linda Clymer

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Supervision Requirements for PTAs and Physical Therapy Students

A brief primer on what to ask and where to seek answers.



Sharita Jennings, JD, is a senior regulatory affairs specialist at APTA.

Supervision requirements for physical therapist assistants (PTAs) and physical therapy students (both physical therapist and PTA students) depend on such factors as the policies of individual payers and insurers, state practice act provisions, and the setting in which physical therapy is being provided. Let's simplify this situation by looking at some key issues.

Levels of Supervision

It is the responsibility of the physical therapist (PT) alone to evaluate and assess patients, develop a plan of care, and oversee provision of services. PTAs and physical therapy students play important roles in carrying out the plan of care, however. Supervision rules are meant to ensure that patients and clients always are receiving the safest and most effective care. Depending on the setting,

practitioner, and applicable state laws, 1 of 3 types of supervision will apply to PTs and the PTAs and students they supervise.

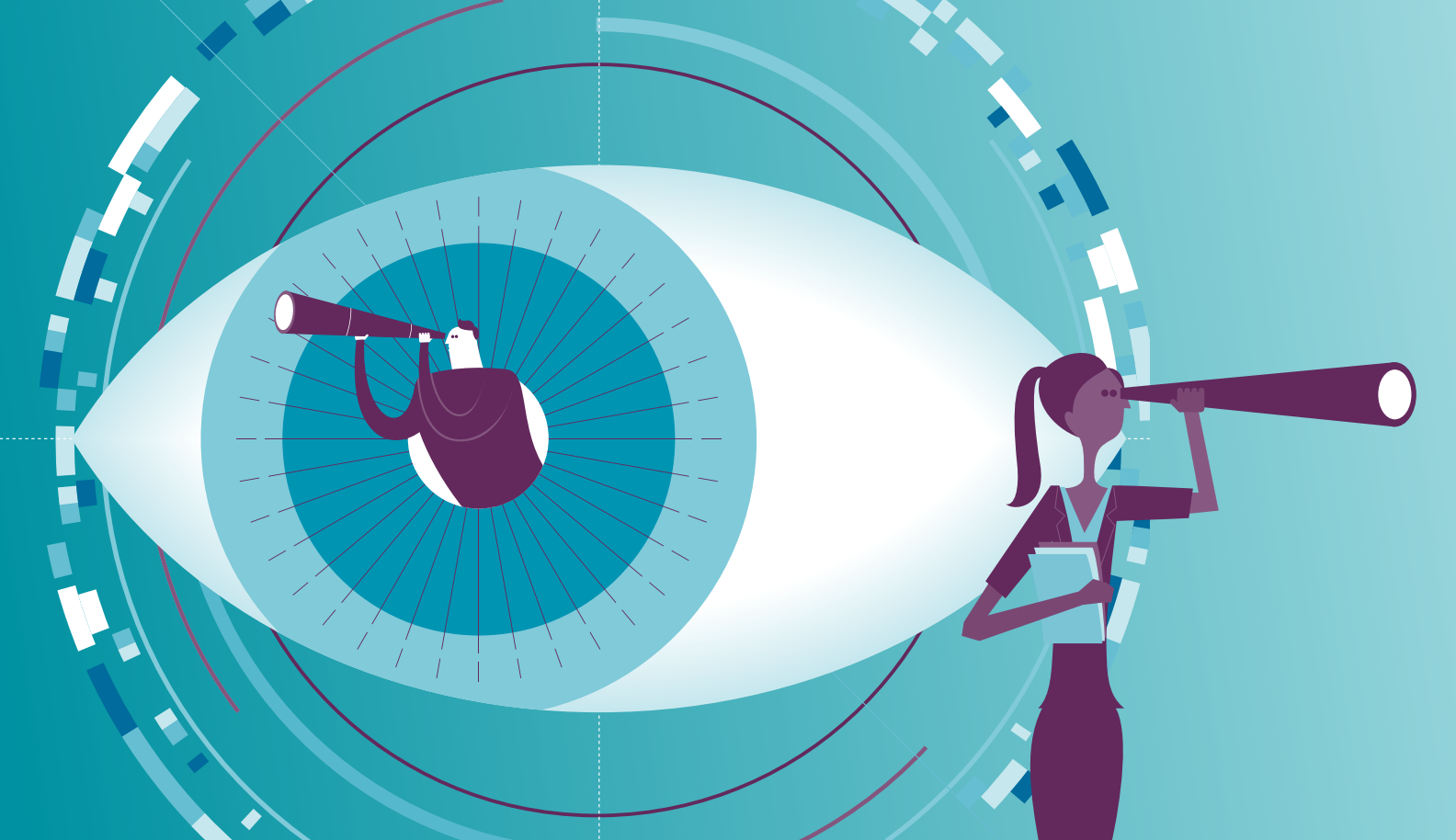
General. This is the least restrictive type of supervision. It requires only that the PT be available for direction and supervision by telephone or another form of telecommunication during the procedure in question; the PT need not be onsite.

Direct. This type of supervision requires the PT to be physically present at the facility and immediately available for in-room direction and supervision. The PT must have direct contact with the patient or client for the duration of each visit—defined as all encounters with that patient or client within a 24-hour period.

Direct personal. This is the highest level of supervision. The PT must be physically present in the room and immediately available to direct and supervise tasks related to patient and client management, and must provide continuous direction and supervision throughout the time these tasks are performed.

Factors to Consider

To determine the required level of supervision of PTAs and students, PTs should ask themselves these questions:



- What does the state practice act say about supervision of PTAs and students?
- When Medicare patients are involved, what are Medicare's regulations regarding PTAs and students?
- When a commercial insurer is involved, what are that payer's policies regarding PTAs and students?
- In what type of practice setting are the physical therapist services being provided?

State practice acts. State practice acts typically define the scope of practice of PTs and the scope of work of PTAs and physical therapy students. It's the PT's go-to document, therefore, for determining supervision requirements. Links to all state practice acts are available on APTA's website. (See "Resources" on page 10.)

Be advised, however, that not all state practice acts address supervision of either PTAs or physical therapy students, while some acts address PTAs but not students. Here's what do in these situations:

- If the state practice act is silent on supervision of students but *does* contain policies on PTA supervision, apply the rules of PTA supervision to physical therapy students.
- If the state practice act addresses *neither* supervision of PTAs *nor* supervision of physical therapy students, look to the supervision requirements of the payer policy. For example, if the individual who is receiving services has health insurance from Blue Cross, consult that company's policies regarding supervision of PTAs and students. If the person is a Medicare or Medicaid patient, check that agency's billing policy.

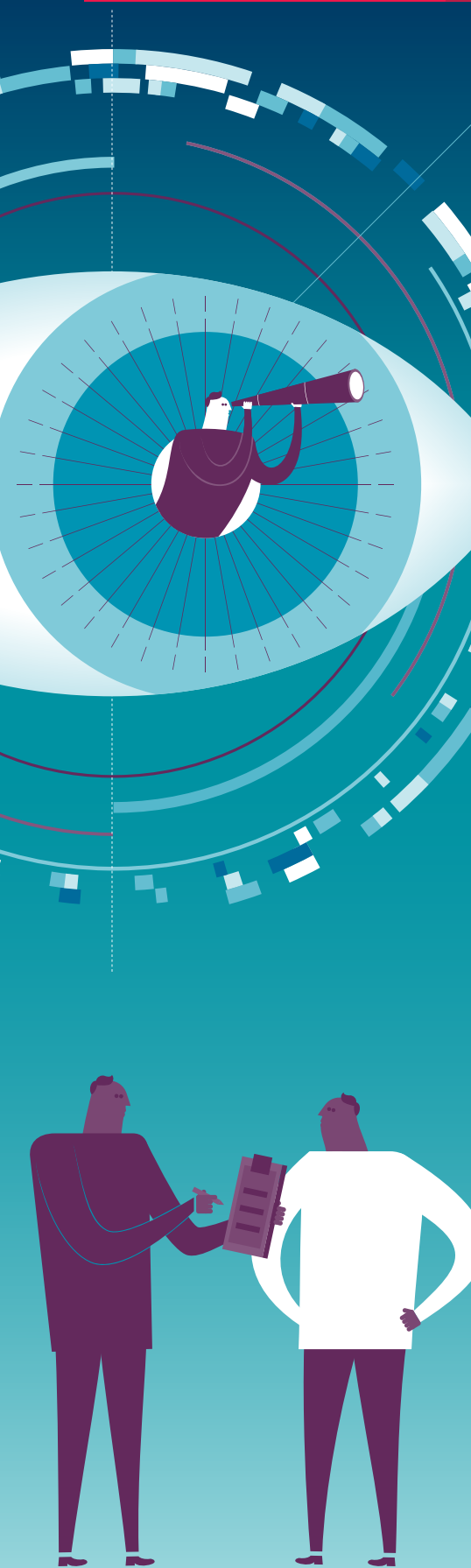
Medicare provisions. Again, if the state practice act is *silent* on supervision requirements, turn to Medicare's billing guidelines to determine the needed level of supervision for PTAs and students in providing services to Medicare beneficiaries. Medicare dictates general supervision of PTAs in all settings other than private practice, in which direct supervision is required. In some settings, however, Medicare stipulates additional requirements even under general supervision.



For instance, when a PTA provides services to a patient in a standalone clinic (defined by Medicare as "a facility that is not part of a hospital but is organized and operated to provide medical care to outpatients"), rehabilitation agency, or public health agency, the supervising PT must make an onsite visit at least once every 30 days.

Medicare states that PTs may not bill for services provided by physical therapy students, because they are not licensed practitioners. Students may help PTs provide billed services, however, and PTs may physically guide students through the provision of a billed service. PTs, therefore, need to exercise their best judgment in such situations. Medicare offers these scenarios as guidance for appropriately billing Part B services:

- The PT is present and in the room for the entire session. The student



resources

Levels of Supervision (APTA House of Delegates Position)

- www.apta.org/uploadedFiles/APTAorg/About_Us/Policies/HOD/Terminology/Supervision.pdf

State Practice Acts

- www.apta.org/Licensure/StatePracticeActs

Report to Congress: Standards for Supervision of Physical Therapist Assistants (Under Medicare)

- www.cms.gov/medicare/billing/therapyservices/downloads/61004ptartc.pdf

participates in the delivery of services only when the PT is directing the service, exercising skilled judgment, and is the party responsible for assessment and treatment of the patient or client.

- The PT is present in the room, guiding the student in service delivery whenever the student is participating in its provision. The PT is at no time engaged in treating other patients or performing any other tasks.

The PT is the responsible party and, as such, signs all documentation. (A physical therapy student also may sign, but the student's signature is unnecessary.)

PTAs and physical therapy students cannot bill for their services under Medicare or any other payer. The supervising PT, rather, must bill for all services under his or her National Provider Identifier issued by the Centers for Medicare and Medicaid Services.

(A note on payment for services provided by PTAs: Medicare and commercial insurers currently reimburse for services rendered by PTAs at the same rate as they do those furnished by PTs. Beginning in 2022, however, services provided by PTAs will be reimbursed at 85% of the Medicare physician fee

schedule rate that applies to those rendered by PTs. At this writing, this upcoming change has no bearing on supervision rules for PTAs.)

Commercial insurers. PTs treating patients or clients whose health care is covered by a commercial insurance plan must closely read the contract with the insurer to ensure that they meet supervision policies covering PTAs and students. Commercial insurers typically defer to Medicare guidelines, but it's important to check with the insurer to be certain.

Who Signs?

The answer to this question is simple. Because the PT is responsible for drafting the plan of care and supervising all procedures carried out under it, the PT must review and sign all care notes and the plan of care itself.

PTAs and students may draft notes on the care they've provided under the appropriate level of supervision. The supervising PT then must authorize and sign that documentation.

As with all supervision rules, the PT should check the state practice act and agreements with participating insurers to determine if more-stringent rules on signatures apply to any given situation. ■

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ITEM NUMBER: SPT18 | AVAILABLE: DEC 2017

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Untenable Intervention

What is a PT to do when the solution is a problem?



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. She also practices in northern New Jersey.

Expanding patient access to effective and affordable health care is an admirable goal, but successfully doing that requires 3 elements—that access be expanded, and that the health care be both effective and affordable. Consider the following scenario, in which affordability is provided under federal law, but the effectiveness of care is very much in question.

Negative Reinforcement

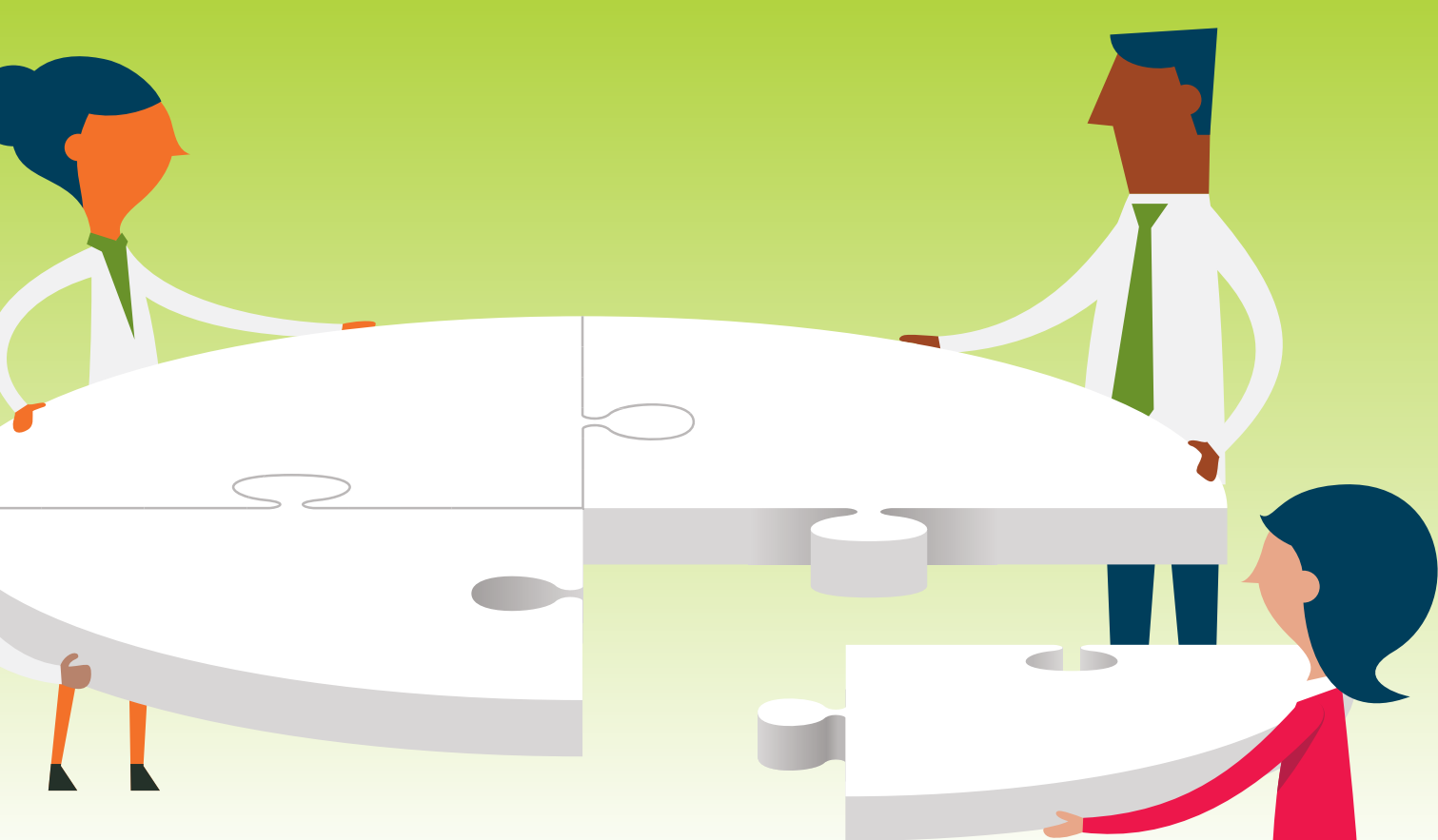
Gwen provides early intervention (EI) physical therapist services at Bright Start, a small multidisciplinary agency. Although she'd more or less stumbled into the job early in her career, she's now been a physical therapist (PT) at Bright Start for more than 20 years and can't imagine anything more rewarding than helping children younger than 3 years old who are

experiencing or are at risk for developmental delays. She feels privileged to have played a role in improving the lives of many children—enhancing their immediate quality of life and working with families, caregivers, and her Bright Start colleagues to better ensure their long-term prospects.

While Gwen's love for her patients and her work haven't changed over the years, much in the EI field *has* changed. Children with

severe disorders who likely would not have survived when Gwen started at Bright Start now often far exceed initial expectations. Gwen long has marveled at the dedication and resilience of these children and their families, but she also has watched with concern as economic necessity increasingly has forced both parents to work, making caregiving more splintered and complex. This has resulted in Gwen using technology to ensure that all parties participating in the children's care—including parents, other relatives, and daycare staff—are “on the same page,” because seamless carryover is critical to achieving optimal patient outcomes.

Another big change from the early years is increased



demand for Gwen's services. When she first came to Bright Start, her caseload was manageable. That has not been the case for some time, however. For the past few years, her schedule has been full. She's had to turn down many requests to take on additional children. She initially is thrilled, therefore, when Bright Start's physical therapy coordinator, Ruth, announces during a monthly staff meeting that the facility is "evaluating its options" to meet the ever-growing need. Ruth's wording is curiously vague, but Gwen hopes this means that Bright Start soon will hire at least 1 additional PT who has EI experience. This would allow Bright Start to meet the physical therapy needs of more children. In addition, Gwen would enjoy sharing treatment ideas with a peer.

To Gwen's surprise, however, at the following month's staff

meeting, Stacy, a developmental interventionist (DI), is introduced. "We're excited to welcome Stacy on board to help us serve more children who need our services," Ruth says.

Gwen has worked with DIs occasionally over the years—exclusively with higher-functioning children who are nearing their third birthday and thus are soon to move out of EI. In her experience, DIs have helped create learning activities that enhance children's learning strengths. Gwen has had good experiences with DIs, but their scope, she knows, is limited.

After the staff meeting, Gwen conducts a web search to learn more about DIs' qualifications. To provide EI services, they must have an undergraduate degree in a related health, human service, or education field. DIs also

need a certificate in early childhood education or at least 6 credits in infant or early-childhood development and/or special education coursework. The DI's role is described as promoting skills acquisition in a variety of developmental



resources

At www.apta.org/EthicsProfessionalism/

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

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

- "Ethical Decision Making: Terminology and Context"

Considerations and Ethical Decision-Making

Even when Gwen tries to give Bright Start the benefit of the doubt, it's hard for her to view Stacy's hiring as a good-faith effort to give more children and families opportunities to avail themselves of the agency's physical therapist services. It doesn't escape Gwen's notice that DIs not only lack the education and specialized knowledge and skills of PTs, but they are paid less—and thus are more affordable to employers.

Might some children who would not otherwise be served by Bright Start benefit from services that Stacy can provide? Undoubtedly. Is that sufficient justification, however, for simply abetting Stacy's insertion in a role that would be better filled a PT? Gwen cannot make that leap.

Realm. The ethical realm here is both *institutional*—between Gwen and Bright Start—and *individual*—between Gwen and the children and their family members.

Individual process. *Moral sensitivity* is required of Gwen in this situation. Should she refuse to delegate the children's care to Stacy, she will be displaying *moral potency*.

Ethical situation. This is a *moral distress*. To Gwen, the right and wrong courses of action are clear, but she faces the institutional barrier of Ruth's directive.

Ethical principles. The following principles of the Code of Ethics for the Physical Therapist offer Gwen guidance:

- **Principle 3A.** Physical therapists shall demonstrate independent and objective professional judgment in the patient's/client's best interest in all practice settings.
- **Principle 5A.** Physical therapists shall comply with applicable local, state, and federal laws and regulations.
- **Principle 5E.** Physical therapists who have knowledge that a colleague is unable to perform their professional responsibilities with reasonable skill and safety shall report this information to the appropriate authority.
- **Principle 7A.** Physical therapists shall promote practice environments that support autonomous and accountable professional judgments.

areas, ranging from cognition and language-communication to social behavior and environmental modifications.

All of which is great, Gwen thinks to herself, but how, exactly, does hiring a DI square with the need for an additional physical therapy at Bright Start?

The answer to that question awaits in Gwen's inbox when she checks her Bright Start email that evening. Ruth has sent Gwen a list of children who are to be moved from Gwen's caseload to Stacy's, and another list of children who Gwen is to evaluate, then transfer to Stacy.

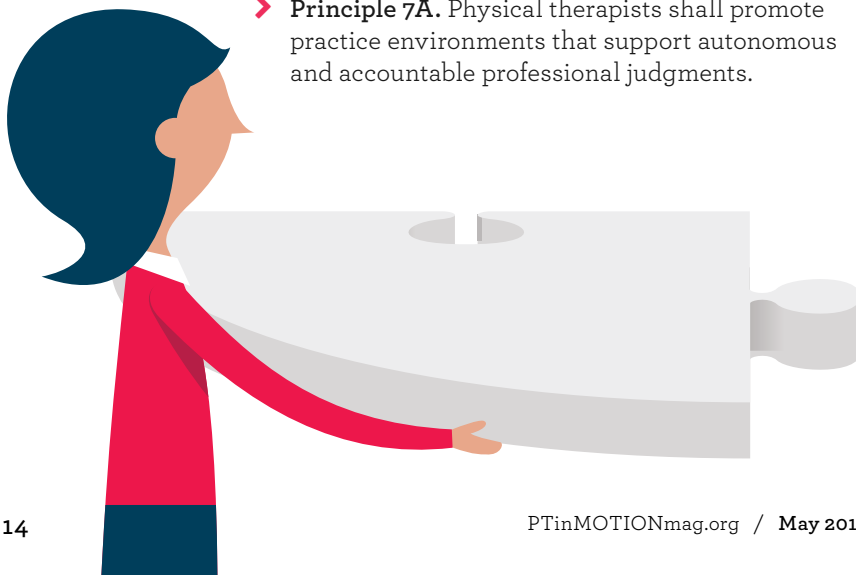
"What the heck is going on?" Gwen exclaims aloud. What if these are kids who need the skilled services of a PT? DIs can play valuable roles in EI, but they are *not* PTs!

Gwen wonders if what Ruth is mandating is even legal. If the need for physical therapist services is documented in a child's individualized family service plan under Part C of the Individuals with Disabilities Education Act (IDEA)—the section that governs services for children younger than 3 years old—those services must be provided by a licensed PT. Right?

"Am I missing something?" Gwen asks herself. Yes, she wanted some easing of her workload. And yes, she wanted more children to be able to receive EI services from Bright Start. But this hardly seems to be an appropriate or acceptable way to meet those ends. How can she responsibly agree to turn children's care over to a lesser-trained individual? What is Gwen to tell parents who trust Bright Start to provide their children with the physical therapist services they need?

For Reflection

Gwen recognizes the value of DIs for some children who receive EI services. But DIs do not and cannot—by training and by law—provide the physical therapist services that



children are deemed to need and are authorized to receive under Part C of IDEA. As Gwen sees it, complying with Ruth's instruction would not be in the best interests of the affected children, would impugn the integrity of the physical therapy profession, and would go against her own professional values.

What guidance might she gain from the Code of Ethics for the Physical Therapist?

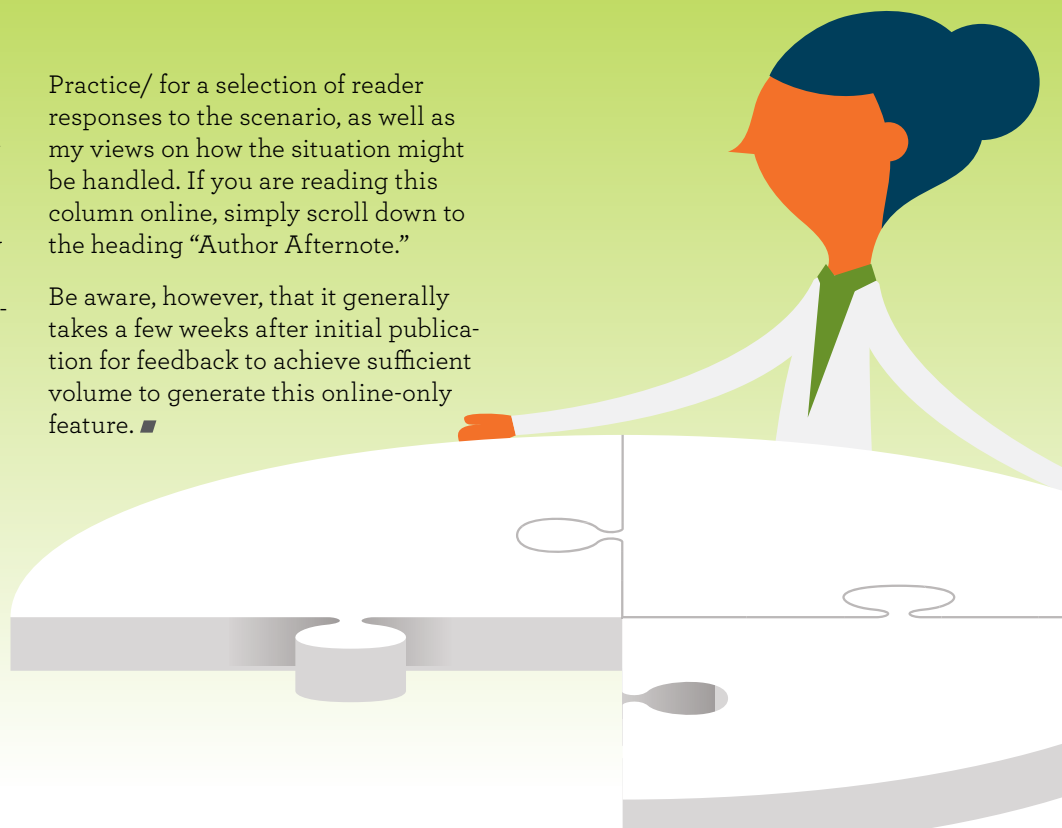
For Followup

I encourage you to share your thoughts about the issues raised in this scenario by emailing me at kirschna@shp.rutgers.edu.

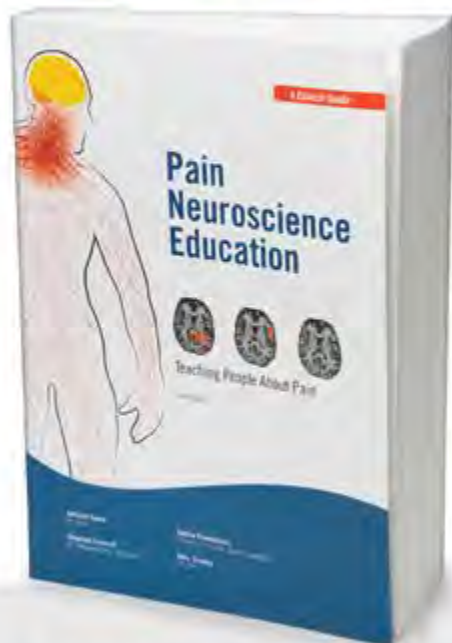
If you are reading the print version of this column, go online to www.apta.org/PTinMotion/2018/5/Ethicsin

Practice/ for a selection of reader responses to the scenario, as well as my views on how the situation might be handled. If you are reading this column online, simply scroll down to the heading "Author Afternote."

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



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Pain Neuroscience Education

Written by physical therapists Adriaan Louw, Emilio Puentedura, Steve Schmidt, and Kory Zimney, this revised second edition of *Pain Neuroscience Education* contains significant updates that serve as both a valuable guide for clinicians and textbook for students. Discover an evidence-based perspective on how the body and brain work together to create pain, as well as how to teach patients about pain and integrate neuroscience education into your practice. 536 pages.



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COMMUNITY HEALTH PROMOTION:

Reaching Beyond The Clinic

There's a growing role for PTs and PTAs in
addressing preventable illness.

BY ERIC RIES



WHEN it came to choosing a dissertation subject for her doctorate in health promotion and wellness, Rupal Patel, PT, PhD, targeted a field about which she's passionate—diabetes prevention—and an understudied population—Asian Indians in the United States.

Type 2 diabetes is the fifth-leading cause of death among Asian Americans, and Asian Indians have the highest prevalence of it within that population. According to the American Community Survey, from 2000 to 2010 the Asian Indian population in the United States grew by 67.6% (3.2 million people). Asian Indians who immigrate to Western countries are at risk of developing type 2 diabetes for reasons linked to the metabolic impact of a westernized diet and tissue resistance to insulin.¹⁻⁴ So, Patel, herself of Asian Indian descent, set out to effect change in her own backyard—reaching out to 1 of the largest Hindu temples in the Houston, Texas, area.

She developed a 12-week group-based lifestyle-modification program to reduce diabetes risk factors. It included sessions on physical activity and diet behaviors, while also seeking to debunk cultural myths with which she was all too familiar—such as the belief among many Asian Indians that “physical activity that makes you breathe hard is harmful to your heart.” As participants gained knowledge and confidence, they began walking fast or jogging—and feeling energized rather than scared.

“I plan to submit a grant later this year to sustain the program by training students from our physical therapy, occupational therapy, nursing, and nutrition programs to deliver it,” says Patel, an associate professor of physical therapy at Texas Woman's University (TWU). “Ideally, we would recruit students who also are of Indian descent, because that makes a real

difference in the comfort level of the people targeted by the program. There's a built-in trust factor there.”

Patel also is passionate about teaching students about community health. For several years, TWU students have been meeting the needs of people with early-stage dementia at a day facility in Houston named *Amazing Place*. It's part of Patel's effort to provide doctor of physical therapy students with experiential opportunities as part of a course on community health promotion. Among other activities, students have helped redesign group exercise classes to better meet participants' needs, trained nurses to perform balance screens, and even encouraged attendees to drink more water by working with the facility's chef to infuse it with fruit and herbal flavors.

“To me, community health promotion is about focusing your lens on a population with a specific risk factor or condition rather than on a single patient with that condition, and determining how you, as a physical therapist [PT] or physical therapist assistant [PTA], can positively impact that population's health,” Patel says. “I had never worked on hydration issues before, and my students hadn't, either. But we did our due diligence by identifying this need in our targeted population. We looked at the literature and developed a solution that could be implemented and sustained.”

Janet Bezner, PT, DPT, PhD, FAPTA, is a longtime proponent of community health promotion by PTs and PTAs. Accordingly, she was among a small group—a mix of veteran and early-career PTs—who shepherded the APTA Council on Prevention, Health Promotion, and Wellness to creation this January. (More on that later.) Bezner describes community health promotion as an inexact term that can mean different things to different people.

“It includes what I would call ‘population health’ approaches—where you



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— BETH BLACK

create a program for a population with a common condition, such as people with diabetes or those with osteoporosis,” says Bezner, an associate professor of physical therapy at Texas State University in San Marcos. “But it also includes efforts to enhance the overall health of an entire community or community group,” she says, “such as getting involved in efforts to increase the number and availability of sidewalks in neighborhoods. It’s a bucket term for activities that can address a range of social and environmental factors. The goal is to give people more control over their health and greater ability to improve it.”

Bezner has secured more than \$30,000 in grants from the Osteoarthritis Action Alliance in the past few years to create walking programs for people with that disease. With the money, she’s trained students to lead activities at 4 different locations. “Participants love it,” she reports. “It makes them feel better and gives them energy. They can’t believe that such a simple thing as walking can really improve their quality of life.”

In Michigan, meanwhile, Beth Black, PT, DSc, co-teaches a 6-week National Multiple Sclerosis Society program called Gateway to Wellness for people who have the condition.

“We talk with these folks about how they can safely incorporate physical activity in their lives,” says Black, an associate professor of physical therapy at Oakland University in Rochester. “We discuss ways to cope with fatigue, adapt their home and work environments, and tap community support

groups. We talk about the importance of adopting healthy behaviors such as eating properly and managing stress.”

Black’s co-instructor has MS, which Black believes is important to the success of the program. “When she says, ‘This is what I do’ or ‘This is how I handle that,’ it’s coming from someone who understands their challenges, because she has experienced many of them.”

Black also has brought PT students into the homes of individuals with MS to design exercise programs specific to their lifestyles, preferences, and challenges. They helped 1 person, for example, achieve her goal of walking down the aisle at her daughter’s wedding with only her husband’s arm as support, rather than a walker. They addressed another individual’s boredom with exercise by creating a program that alternates treadmill sessions with yoga.

At the Alabama Institute for the Deaf and Blind (AIDB) in Talladega, PT students from the University of Alabama at Birmingham (UAB) work alongside peers from the occupational therapy and kinesiology programs to help individuals with disabilities engage in regular physical activity and healthful

eating through a federal program called I Can Do It, You Can Do It. Tara Pearce, the school’s associate director of clinical education in physical therapy, explained in *UAB Magazine* that maintaining a healthy lifestyle “can be a bigger challenge with students with disabilities because they sometimes need 1-on-1 support to participate” in physical activities.⁵ PT students from UAB “work with people [at AIDB] in small groups to get individualized attention to participate at a greater level,” she noted in the article.

UAB’s participation at AIDB—and also at United Abilities of Birmingham, The ARC of Jefferson County, and the Horizons School in Birmingham—is a manifestation of UAB’s desire to expand its students’ reach beyond traditional clinical experiences, says David Morris, PT, PhD, FAPTA, who chairs the school’s Department of Physical Therapy. “We want our future physical therapists to get out there and have hands-on skills related to health promotion in the community.”

Community health promotion has played a big role in the early career of Jessica Berglund, PT, DPT, who completed school and was licensed as a PT in 2013. Already, she’s taught community education classes in falls prevention, strength training, balance and walking to older adults; has been active in the formation and development of the Council on Prevention, Health Promotion, and Wellness; and was installed as the council’s chair at APTA’s Combined Sections Meeting in February. Berglund also chairs the Minnesota Physical Therapy



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— JANET BEZNER

Association's Health & Wellness Committee—a panel that helps the state's PTs and PTAs better meet people's overall health needs, both 1-on-1 in the clinic and in the community.

Last fall, Berglund signed on with Lifesprk, a home health company serving older adults that promotes what it calls “7 elements of well-being”—including aspects of health and wellness. Berglund says she is looking forward to helping Lifesprk develop a robust community health promotion and injury-prevention program. Her enthusiasm is palpable.

“I have a big vision and big plans,” she says. “I believe the physical therapy profession has an obligation to address not only the physical therapy needs of individual patients and clients, but also to engage more broadly in community health. And we must do everything that we can toward—as APTA's vision statement says—“transforming society by optimizing movement to improve the human experience.”

An Ideal Match

“We've got to turn things upside-down, and not get stuck in what we've traditionally done as PTs and PTAs,” Black says. “We must continually evolve in response to the health needs of our communities. We must consider new delivery models. We need to step up and become leaders in health promotion.”

It's a role that's been a long time coming, Bezner says, and its time is now.

“The impetus is epidemiology showing that most of the disease that causes morbidity and mortality is preventable. With conditions such as cancer, heart disease, and diabetes, risks are greatly lessened by behaviors such as engaging in physical activity, eating healthfully, getting sufficient sleep, and managing stress,” Bezner notes. “We've known this for a couple of decades, but it's just in the past 10 years

A RELEVANT MODEL

Among the factors that may hold PTs back from engaging in community health promotion efforts are unease when it comes to asking people about their unhealthy habits and uncertainty about how best to do it. Researchers at the University of Alabama at Birmingham (UAB) have developed a clinical model that they think can help.



DAVID MORRIS

The Health-Focused Physical Therapy Model (HFPTM), described in the December 2017 issue of *Physical Therapy*,¹ offers a series of steps to integrate a health promotion and wellness focus into physical therapist practice. Although it pertains solely to 1-on-1 care and specifically addresses only PTs encouraging smoking cessation and regular physical activity, the model has implications for broader health-promotion efforts, according to 1 of its authors.

“If PTs become more comfortable addressing modifiable risk factors and unhealthy behaviors with patients on an individual basis—and I believe our model is useful in that regard—they'll be better-equipped and more motivated to address these issues in the community,” says David Morris, PT, PhD, FAPTA, who chairs UAB's physical therapy department.

“The patient-client management model in the *Guide to Physical Therapist Practice* is a sequential process, but it's not linear—there's movement back and forth between different stages,” Morris notes. “Recognizing its benefits, we thought, why not try to come up with a health promotion model that could be embedded into the patient-client management model?”

In the resulting HFPTM, PTs screen patients and clients for health promotion needs, then develop a management plan. It might include “health-focused interventions” by the PT, referral to other providers, or both. The model also features an outcomes-analysis element—creating a feedback loop to further refine PTs' understanding of health promotion needs in the clinic and potentially at the community level.

To gather additional insight and further refine the model, the UAB researchers convened a summit consisting of 21 researchers, educators, and practitioners from other health care fields. UAB researchers set up a “world café” format in which various questions were addressed in a series of roundtable discussions. The goal was for the summit participants to provide feedback on PTs' appropriate role in health promotion and on the draft HFPTM.

“We sought out a broad group of people who understood lifestyle medicine but didn't necessarily know that much about what physical therapists do,” Morris says. He and his PT colleagues described the patient-client model and the enhancements proposed in the HFPTM. The response from the summit attendees was gratifying.

“Overall, the group was quite positive about our role in providing health education and promotion services,” Morris reports. “Once they understood how much time we spend with our patients and the extent of our education, training, and preparation, there was a feeling among them of, ‘You guys are well-suited to this.’”

REFERENCE

1. Lein DH, Clark D, Graham C, et al. A model to integrate health promotion and wellness in physical therapist practice: development and validation. *Phys Ther.* 2017;97(12):1169-1181.

RESOURCES

APTA Council on Prevention, Health Promotion, and Wellness Webpage

www.apta.org/PHPW/

Describes objectives, offers signup opportunities via the APTA Hub community, and lists related information and materials available from the association.

- Twitter: @PHPWCouncil
- Facebook public: www.facebook.com/APTAPreventionHealthPromotionWellnessCouncil/
- Facebook group: www.facebook.com/groups/199939420551282

APTA Prevention, Wellness, and Disease Management Webpage

www.apta.org/PreventionWellness/

Links to APTA positions on the roles of the association and of PTs in prevention, wellness, fitness, health promotion, and management of disease and disability; language in state practice acts; information on annual checkup by a PT; balance and falls resources; information on nutrition and physical therapy and physical fitness for special populations; and *PT in Motion's* “Well To Do” wellness column.

APTA Racial and Ethnic Health Disparities Homepage

www.apta.org/HealthCareDisparities/

Links to research and resources on an important factor affecting community health provision.

PT in Motion Articles and Columns

www.apta.org/PTinMotion/

- “Opportunity of a Lifetime” (November 2014). Looks at specific community health efforts and programs serving individuals across the lifespan—ranging from a family-fitness program in underserved areas of Los Angeles to a PT-owned multidisciplinary, cash-pay health promotion and wellness practice in the Washington, DC, suburbs.
- “PTs and Population Health” (March 2018). Examines why the association envisions a greatly expanded role for PTs and PTAs in direct-to-employer health services, and the implications of that for addressing societal health needs.
- “Getting Around: Community Mobility” (November 2017). Describes how PTs are helping to transform society by reducing literal and figurative barriers to movement in cities and towns.
- “A Different Kind of Group Therapy” (February 2016). A PT recounts why she created a business that offers PT-designed and -supervised group-exercise classes to older adults and people with conditions such as cerebral palsy and Parkinson disease.
- “Free To Lead” (March 2010). A look at student-run pro bono clinics—how they operate and the community goals they address.

or so that the need to promote these behaviors has become imperative. So, we need not only to address these issues in the clinic during the course of physical therapy but also to figure out ways to do that with groups in our communities.

“We can’t ignore the fact that these issues are harming society and fueling skyrocketing health care costs,” Bezner continues. “If we don’t address them, we’re complicit—frankly, we’re contributing to the problem.”

Many roads lead to the change that Bezner and others want to see—volunteer efforts, grant-funded initiatives, and cash-pay businesses such as those described in past *PT in Motion* articles—including the multidisciplinary Body Mechanics clinic in Falls Church, Virginia, and the PT-designed exercise offerings of GroupHab in Simpsonville, South Carolina. Community health promotion extends, too, to citywide mobility programs, direct-to-employer health services, and pro bono health clinics. (To read more about these efforts, see “Resources” at left.)

But while there’s no single way to do it, there *is* a specific health care provider who’s uniquely qualified to provide it: the PT, say those interviewed for this article.

“Our background is ideal, because we’re trained in physiology and pathology,” Berglund says. “We know what goes on in the body and why things happen—which means that we also know how to *prevent* many of those things from happening.”

PTs spend more time with patients than do most other health care providers, she adds, which fosters trust. That trust facilitates discussion of behavior change—so, Berglund notes, many



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— DONALD LEIN

PTs already are comfortable asking health questions, discussing options, and referring out when individuals need help with exercise and physical activities. PTs also are well-positioned to discuss with patients such lifestyle matters as healthful eating, getting sufficient sleep, managing stress, and smoking cessation—although, Berglund says, too few PTs tend to feel comfortable discussing those issues.

PTAs, too, are well-suited to roles in community health promotion, Bezner adds.

“If PTs are really smart, they’ll set up community programs and deploy PTAs to help implement them,” she states. “All of these services realistically can be delivered by PTAs. They certainly have the needed abilities—although they may in some instances need some additional instruction in areas such as motivational interviewing and health coaching.”

Donald Lein, PT, PhD, agrees.

“Community health potentially opens up the playing field for PTAs,” he ventures, “because it’s a less-restrictive environment in terms of payment.” Lein, director of clinical education in the physical therapy department at UAB, is among a group of faculty members there who have developed a physical therapy model that has implications for community health promotion efforts. (See “A Relevant Model” on page 19.)

Addressing Barriers

Ask PTs why they *don’t* engage in community health promotion efforts, and they’ll most likely cite 3 factors, say the PTs contacted for this article: time, money, and comfort level. Berglund

suggests a possible strategy to address the first 2.

“If you’re passionate about addressing health behaviors, prevention, health promotion, and population health, but your job doesn’t allow you to do that, 1 option is to reconsider where you’re working,” Berglund says flatly, noting that some businesses and practices—like her employer—provide such opportunities. “Or,” she advises, “if your employer doesn’t offer or encourage injury prevention and health promotion activities, consider being the person to spark that change by starting a new program or class.”

Patel is sympathetic to the reluctance of PTs and PTAs to commit to obligations after work hours, recognizing that nearly everyone feels stretched thin by life’s varied demands. Still, she says, it’s important that PTs and PTAs seek opportunities to get involved in their local communities—whether or not they’re getting paid for it.

“Reimbursement isn’t always going to be there right now for community health programs led by PTs,” she concedes, “but we need to get beyond that—and, in the process, build the case for why we *should* be paid for the community health services we provide. We don’t necessarily have to look very far, or venture into unfamiliar settings,” she adds. “Where do you live? Where do you work? Where do you pray? To which clubs or activity groups do you belong? Think about the ways in which you can have an impact in those places and settings by helping people change their behaviors to improve their health.”

APTA deems altruism to be essential to professionalism in PTs and to value-based behavior in PTAs,⁶ Patel

notes. “Being altruistic in these situations should be foremost,” she says, “because community health is a huge issue with broad societal implications. As more of us speak up and take actions that show that we can make a dent in lifestyle behaviors, policy changes related to reimbursement will come.”

Berglund concedes that there aren’t yet nearly as many paying models in community health as she’d like to see. She adds, however, “No one is going to create innovative models for us. We need to step outside our traditional box, as PTs rooted to our clinical space, and say, ‘We are members of a doctoring profession who have a great deal to offer our communities. Are you willing to invest in some of the valuable services we can provide?’”

That’s 1 reason APTA’s Council on Prevention, Health Promotion, and Wellness (see “Resources” on the facing page for the link) came into being in January—to serve as an actionable networking and information-gathering venue to share ideas about, and experience with, innovative practice models.

The council’s mission statement, Berglund notes, is “to facilitate the profession’s role in transforming

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— JESSICA BERGLUND





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— MARYSUE INGMAN

society and physical therapist practice by connecting people and knowledge to develop and disseminate best practices in prevention, health promotion, and wellness for all individuals and populations.” What that means in practical terms, Berglund says, is sharing ideas, experiences, information, and evidence on everything from creating consistent language to pooling evidence, developing best-practice guidelines, offering practical resources and tools, and devising advocacy strategies. The council also aims ultimately to bring PTs and PTAs together with members of other health professions for collaboration.

The idea is to address prevention, health promotion, and wellness “from the individual level up,” as Berglund puts it—from conversations with physical therapy patients in the clinic about their health behaviors to efforts directed at social determinants of health (the physical environment, socioeconomic status, social supports, and other factors) in the community.

As for the third reason PTs and PTAs may avoid community health opportunities—insufficient comfort level—the council aims to help there, too.

“As we work together to develop best practices in prevention, health promotion, and wellness for PTs and PTAs in individuals and populations, more and more of us are going to feel comfortable, knowledgeable, and proficient offering these services,” Berglund says.

Black acknowledges that many PTs question the propriety of asking people about their health habits—and fear blowback if they do. She counters those concerns with study results that she helped garner.

A few years ago, she and 2 other PTs surveyed 230 physical therapy patients at outpatient clinics in the Minneapolis and Detroit areas. “The results of this study,” the research report concluded, “suggest that the majority of patients believe it is appropriate for physical therapists to incorporate health promotion into their clinical practice through discussions of patients’ personal health behaviors in the areas of physical activity, healthy weight management, and abstaining from smoking.”

The survey results confirmed that “our patients have a lot of faith in us and trust us. They know we’re looking out for their best interests in terms of health in the broadest sense. We have a lot of credibility with them. They will listen to us,” Black says.

Thinking Differently

MarySue Ingman, PT, DSc, says it’s no coincidence that Berglund, a recent graduate and her former student, is among APTA’s movers and shakers in encouraging greater PT and PTA involvement in health promotion within the clinic and beyond.

“This new generation of graduates thinks differently,” says Ingman, an

associate professor of physical therapy and assistant director of clinical education at St Catherine University in Minneapolis. “They get it. They understand that just fixing people after they’ve had a pathology is not enough—PTs need to be health promoters, as well.” (Ingman was 1 of Black’s coauthors on the patient survey.)

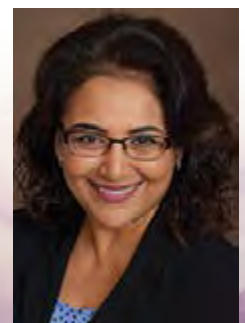
At St Catherine—as in many PT education programs across the country, Ingman notes—students are taught motivational interviewing techniques and health coaching principles. “They know we need to ask people about a variety of health behaviors that impact well-being—sleep, stress, diet, smoking—and help to facilitate improvement in those areas.”

“Students are coming out of school with these skills,” Berglund says. “My peers among early-career PTs tend to feel very strongly that we can’t operate in a reactionary mode anymore, because too many people succumb to preventable conditions and diseases. Our health care system will continue to fail if we are not actively and aggressively engaged in health promotion on both the individual and community level.”

At Oakland University, Black says, “our students not only are learning the theory behind health promotion in their coursework, but they’re also going out into the community and modeling it. They’re running balance and falls clinics. They’re educating dancers in injury prevention. We’ve incorporated health promotion service projects for our students so that when they graduate,

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— RUPAL PATEL



they've already had experience with various community populations and can take things from there when they embark on their careers."

That has been Patel's experience.

"We've been teaching community health promotion at TWU for almost 10 years. Many of our alumni are involved in health promotion activities in their communities—most of it pro bono," she reports. "It's so gratifying to have my former students working alongside my current students and me on projects the former students started. Engaging in community health promotion is an important way in which we can help transform society."

Because recent graduates aren't caught up in a traditional way of practice, they're likelier to "see opportunities

that those of us who've been in practice for years don't see," Black says. "They're likelier to question our way of doing things and come up with new ideas."

That excites Bezner, who urges veteran PTs who own practices and lead departments to jumpstart the process.

"Today's students are prepared for these roles at graduation," she says, "So, hire them. Put them to work. Take advantage of their skills, mindset, and enthusiasm to expand our profession's footprint and improve community health." ■

Eric Ries is the associate editor of *PT in Motion*.

REFERENCES

1. Thomas A, Ashcraft A. Type 2 diabetes risk among Asian Indians in the US: a pilot study. *Nursing Research and Practice*. 2013; article ID 492893. doi: 10.1155/2013/492893.

2. Centers for Disease Control and Prevention. National diabetes fact sheet: general information and national estimates on diabetes in the United States, 2010. http://www.cdc.gov/diabetes/pubs/pdf/ndfs_2011.pdf. Accessed February 27, 2018.
3. US Census Bureau. The Asian population, 2010. <http://www.census.gov/prod/cen2010/briefs/c2010br-11.pdf>. Accessed February 27, 2018.
4. Lee JWR, Brancati FL, Yeh HC. Trends in the prevalence of type 2 diabetes in Asians versus whites: results from the United States National Health Interview Survey 1997-2008. *Diabetes Care*. 2011;34(2):353-357.
5. Short GA. Exercising their abilities. *UAB Magazine*. Fall 2017. <https://www.uab.edu/uabmagazine/features/exercising-their-abilities>. Accessed February 8, 2018.
6. American Physical Therapy Association. Professionalism webpage. <http://www.apta.org/Professionalism/>. Accessed February 8, 2018.
7. Black B, Ingman M, Janes J. Physical therapists' role in health promotion as perceived by the patient: descriptive survey. *Phys Ther*. 2016;96(10):1588-1596.

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Taking the Road **Less Traveled**

By Danielle Bullen Love

These PTs have widened their possibilities by narrowing their patient and client base.

Many roads are open to physical therapists (PTs) looking to start their own practices. While generalist clinics certainly are beneficial, some PTs have chosen to specialize in sports medicine, neurology, or a multitude of other practice areas. Even fewer physical therapists drill down to more narrow, often untapped patient niches that focus on specific populations or conditions. Here are a few examples.

People With Ehlers-Danlos Syndrome

For some PTs, choosing their niche is highly personal. Susan Chalela, PT, MPT, owns FYZICAL Charleston, a private practice in Daniel Island, South Carolina, that focuses heavily on people with Ehlers-Danlos Syndrome (EDS). “I have EDS myself,” she notes.

“I first went into physical therapy because of the mechanical challenges I had with my body growing up,” Chalela explains. Her joints would lock up or dislocate. She first heard of EDS during her PT education and thought the symptoms matched her experiences. It wasn’t until she’d had a stroke and become pregnant with her first child that she was diagnosed with classical and/or hypermobile EDS. (Classical EDS—or cEDS—is characterized by skin hyperextensibility and atrophic scarring, and generalized joint hypermobility.¹)

As described by the Ehlers-Danlos Society, “The Ehlers-Danlos syndromes are a group of connective tissue

disorders that can be inherited and are varied both in how they affect the body and in their genetic causes. They are generally characterized by joint hypermobility (joints that stretch further than normal), skin hyperextensibility (skin that can be stretched further than normal), and tissue fragility.”²

“EDS is so misunderstood by the medical community and the general public,” Chalela observes. Her practice, which she opened in 2017, is fighting to change that. “When I see patients with hypermobility,” she says, “I know how to treat them.”

Sunil J. Patel, MD, a professor of neurosurgery at the Medical University of

South Carolina (MUSC), has a professional interest in EDS and has hosted conferences on the subject. “Dr Patel ran across EDS patients in his practice and wanted me to connect with them as a physical therapist,” Chalela says. He encouraged her to start an EDS-focused private practice.


She continues, “I’m still in the building phase of the practice, but I have a full schedule.” She receives referrals from neurosurgeons and neurologists at MUSC. Individuals with EDS also find her through Facebook support groups. Some travel long distances and come only once a month. “I try to do a lot of education in management of their symptoms and help with stabilizing or bracing as needed,” Chalela says. EDS is a chronic condition, so treatment focuses on ongoing disease management, and patient and practitioner education.

Health care professionals’ unfamiliarity with the signs and treatments of EDS frustrates people who have the disorder. Living with the syndrome herself gives Chalela knowledge that other PTs may lack. She has presented to her fellow PTs on the condition. “Understanding



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the science behind EDS is the only way to understand the patient,” she says. “And, as always, PTs must listen to what patients say about complications they are experiencing.”

PTs working with this population must think creatively, Chalela says. For example, a person with EDS may not be able to lie down during treatments. The reason? Some individuals with EDS have a CSF leak (in which cerebrospinal fluid leaks through a defect in the dura, or skull, and out through the nose or ear) or a Chiari malformation (a congenital defect in the base of the skull and cerebellum). Creative workarounds are needed.

Surgery is an option for pain relief.³ Chalela, however, recommends providing patients with coping mechanisms to facilitate delay of their first EDS-related operation. Once patients with EDS have 1 segment of the spine stabilized or fused, the already weak collagen above and below the stabilized segment deteriorates more rapidly, causing a cascading effect, she explains. That 1 surgery then turns into many.

Chalela says her time as a patient has given her a great deal of empathy and has made her a better PT to this overlooked population.

Female Teenage Athletes

Allison Stringer, PT, MS, also drew inspiration from personal experiences to find her niche in physical therapy. She grew up figure skating and now has spent more than 25 years working with competitive figure skaters.

“I became a physical therapist because it was movement-based—which matched my interest and skills as a figure skater,” she says. As she progressed in her career, she met another PT who worked at a skating club and asked herself, “Why am I not doing that?”

Stringer and a colleague started a program at the Skating Club of Boston. She moved on to the Colonial Figure Skating Club in Boxborough, Massachusetts, where she provided physical therapy part-time for 14 years. Stringer worked with skaters on injury prevention and strength and conditioning, and provided rink-side physical therapy for acute injuries. Her services at Colonial were cash-based, bypassing insurance companies.

Stringer wanted to move to a full-time position and in 2012 found an opportunity at ProEx, an affiliate of Professional Physical Therapy, in nearby Woburn. Her years at the skating club had built her reputation, and a large network of skating instructors were sending patients to her. Indeed, she reports, word-of-mouth established her as an expert in skating-related injuries. Today, Stringer is ProEx’s regional clinical director.

Eventually, her patient base expanded to include ice hockey players and

ice dancers. The core of her patients, however, were preteen and adolescent female figure skaters. Last September, she moved into the legal and compliance department at Professional Physical Therapy. However, she still shares her expertise with colleagues who treat figure skating injuries.

“Figure skaters wanted me to work with them because I spoke their language,” Stringer says. She watched videos to assess issues with skaters’ form—particularly during jumps—that could cause misalignment, pain, and, eventually, injury. In the clinic, she worked with the skaters on proper form and technique, sharing feedback with their skating coaches. She’d note, for example, that a skate’s blade alignment was off—forcing the hip to either drop the knee medially or pronate the foot, and causing a chain reaction of problems up the leg and spine.

“The biggest thing I’ve seen in my career are lumbar stress fractures,” she says. Clients as young as 8 years old presented with them, but Stringer saw those fractures most often in 12- to 16-year-olds during growth spurts. Such injuries were more likely to occur over the summer; Stringer theorizes that once school let out, skaters may have increased their training regimen and



“Figure skaters wanted me to work with them because I spoke their language.”

— ALLISON STRINGER

overworked their bodies. After jumps, they would land on 1 leg and drop their opposite hip. The figure skaters had the ability to learn the jumps but did not have the necessary matching core strength to manage them without putting excess stress on their bodies. The shock of landing should have been absorbed by the core. Instead, their hips and back were taking the punishment.

Stringer created a weekly physical therapy plan for skaters that included strength-training programs to be implemented by their coaches. The goal: add new elements during each session to get the skaters back on the ice slowly and safely. Stringer says she was fortunate to work with clients who were motivated to seek out additional physical therapy. “People who are invested in their sport are a good niche,” she says.

PTs at Girl Fit Physical Therapy in Newtown, Massachusetts also know the value of young, motivated clients who are invested in their chosen sport. The practice serves adolescent female athletes. Founder Kate Hamilton, PT, DPT, initially wanted to go into pediatrics. “In 1 of my orthopedic rotations, I had a great mentor,” she recalls. “He challenged me. I ended up going into orthopedics, and I loved it.” Hamilton is a board-certified clinical specialist in orthopaedic physical therapy.

After working at her mentor’s private practice, she moved to Boston when her husband accepted a job there. She struggled to find the right fit for work, personally and professionally, before striking out on her own. “There are so many adolescent female athletes who need physical therapy and could use



“There are so many adolescent female athletes who need physical therapy and could use injury prevention. I’m happy to fill that space.”

— KATE HAMILTON

injury prevention. I’m happy to fill that space,” Hamilton says.

“A lot of people told me I was crazy for cutting out huge chunks of the population,” she allows. But, she adds, having a laser focus means PTs gain deeper exposure to their niche and quickly garner valuable experience. She markets her practice, with its focus on young female athletes, to sport medicine physicians and orthopedists who also work with her target population. Girl Fit’s specificity makes girls want to come there, Hamilton says, and makes their parents, who are paying, want to send them.

“We see girls in all different sports,” Hamilton notes. “As physical therapists, we know biomechanics and can treat any sport’s injuries. We treat the whole athlete and send her back better than she was before she got hurt.”

Hamilton and her colleagues also tap into their own backgrounds to relate to their patients. Christina Beachy, PT, DPT, calls on her experience as a volleyball player when treating upper extremity injuries. Jen Wardyga, PT, DPT, was a soccer player, and treats both that population and other athletes

who have lower extremity issues. Hamilton travels with the US figure skating team and treats performance athletes such as skaters, dancers, and gymnasts.

Hamilton says that across different sports, noncontact injuries of the anterior cruciate ligament—often stemming from improper running, jumping, and pivoting mechanics—are common. Patellofemoral pain also occurs frequently in adolescent female athletes, as do foot and ankle injuries. Hamilton and her coworkers encounter a lot of overuse injuries, as well. Girl Fit’s unique selling proposition is its holistic approach to the needs of young female athletes. “Girls don’t get as much training as boys do on how to work out and walk into a gym confidently,” Hamilton notes. In addition to injury prevention techniques and injury rehabilitation, the clinic offers fitness classes that are tailored to this age group.

“We assign home exercises, because strength and flexibility training at the clinic is never enough,” Hamilton says. The PTs at Girl Fit educate clients on why they should work certain muscle groups. Some girls faithfully follow at-home programs. Others, however,

Top Marketing Tips

The PTs interviewed for this article use various means to find and maintain a steady stream of patients and clients. Marketing to narrow populations is essential to professional and financial success. Different populations responds differently to outreach efforts, so marketing can be a trial-and-error process. Here are some ideas for PTs looking to boost their niche practices.

Target decision makers. Multiple people can function in the role of decision maker. In marketing for workers' compensation cases, Aideen Turner, PT, MPT, advises targeting middle management, as they sometimes can be more receptive to new ideas than are higher-level executives. For her practice, her decision maker is anyone with a say in risk or safety for workers' compensation.

Writing blogs, and presenting at and sponsoring conferences, can be effective ways to get your services in front of decision makers, some PTs advise.

Physicians also play a role, funneling referrals to physical therapists. So, nurture relationships with physicians who treat your population, such as the relationship that Susan Chalela, PT, MPT, has with Sunil Patel, MD, who refers his patients with Ehlers-Danlos Syndrome to Chalela. Chalela advises teaching potential referral sources how physical therapy can help their patients.

Word of mouth. "You have to establish relationships with the community," says Allison Stringer, PT, MS. Reach out to the target population, ask questions, and build your comfort level, she advises. Meet your patient

population where they are. Sponsor a 5-kilometer race, or partner with sports teams to offer injury-prevention workshops. Market your services to generalist PTs, fitness professionals, massage therapists, and other wellness providers.

Learn everything you can about your target niche, so potential patients and clients will trust you as an expert. Building such a reputation will encourage current patients and clients to speak highly of your services, as well as use them. Your knowledge will help you gain additional clients, Stringer says, adding, "The more people who can talk about you, the better."

Social media. "In today's world, it's all social media," Turner says.

Kate Hamilton, PT, DPT, agrees. It's no surprise that Instagram is a favorite among Girl Fit patients. "They pay attention [to what we post] and feel included and involved," she says. Her clinic's social media marketing was started by a student who reached out and offered to be a marketing intern—proving that strong ideas can come from anywhere.

Yet social media marketing is not just a young person's game. Chalela's involvement in social media groups funnels new patients to her clinic. Turner's company also has a robust presence across multiple social sites. No matter the marketing channel, PTs need to put in extra hours for outreach. "Always say yes if you can," advises Hamilton. "You never know where that next satisfied patient is waiting."

aren't as motivated. So, Hamilton chose exercises that were common to many female athletes, such as those aimed at balance and at core and glute strength, and set them to music. The class maintains gains from physical therapy and builds strength and flexibility. It even includes participants who were never in physical therapy but are seeking to prevent injury.

Telehealth for Musculoskeletal Pain

A willing patient population is at the heart of any niche physical therapy practice. Aileen Turner, PT, MPT, chief executive officer of Virtual Physical Therapists, knows that firsthand.

Turner—who holds licenses in both Pennsylvania and Florida—previously had a brick-and-mortar clinic in Pennsylvania, but she occasionally would provide phone consultations when she was staying at her Florida vacation home. Once, while she was at a park in Florida, a patient sent an online request. She responded to him with some basic advice. “He was so grateful. That made me think—we should be doing this to help patients,” she recalls.

“Health care is changing, so we need to be more creative” in how we provide the right care to the right person at the right time, Turner says. That first call inspired her to launch a virtual practice focusing primarily on musculoskeletal injuries.

The company's services now include a secure proprietary mobile app and online interface. The app asks the patient for a quick medical history, functional assessment, and pain feedback. Patients log onto the app or

the website for real-time video sessions with Virtual Physical Therapists' network of licensed clinicians.

Regulatory and reimbursement issues can be “sticky,” as Turner describes it, but solutions slowly are emerging. For example, Medicare doesn't reimburse for online physical therapy services. Private insurers do not always recognize PTs as telehealth providers, but individual practitioners can reach agreements with their own insurance companies. Alan Chong W. Lee, PT, DPT, PhD, chair of the telehealth group of APTA's Frontiers in Research, Science, and Technology (FiRST) Council, says, “Physical therapists need to address future practice opportunities by advocating that state and federal regulations and laws include PTs and physical therapist assistants as telehealth providers.” And, of course, any software and the security involved in its use must be HIPAA-compliant.

Currently, regardless of where the PT is located, he or she must have a license to practice in the patient's state. But applying for and renewing licenses in multiple states can get expensive. The Federation of State Boards of Physical Therapy's Interstate Licensure Compact is changing that.

As of January, 14 states had signed onto the compact. PTs licensed in those states may purchase a compact to practice in 1 or more of the 13 other member states without needing to go through the lengthy licensing process. “That will open some doors for physical therapists working in telehealth. The future is treating across state lines,” Turner believes. (For more

information on the compact, go to <http://ptcompact.org/>)

Beyond the regulatory issues, telehealth faces a reputation hurdle. Turner admits that addressing the perception that physical therapy always must be hands-on was a challenge in building her practice. However, she insists, “Patients who have gone through virtual [physical therapy] love it.” She gives this example: Early on, before fully transitioning away from her physical clinic space, she was treating a patient for neck pain. But at a point in the treatment, the patient couldn't find time for an in-clinic appointment. Instead, he tried virtual therapy and was won over.

Convenience plays a large part in acceptance of online physical therapy, Turner says. One target audience for Virtual Physical Therapists is workers' compensation patients, as that population can have difficulty getting to clinics. Turner's background includes practicing in onsite workers' compensation physical therapy, so she understands some of the related challenges. “Physical therapists working onsite in workers' comp need to be creative in [developing] exercises without all their equipment,” she notes. Such creativity carries over into virtual rehabilitation for work-related musculoskeletal injuries,” Turner says.

Aquatic Physical Therapy

Sometimes finding a niche is serendipitous. Sean Hayes, PT, is clinic director of First Colony Aquatic and Rehabilitation Center in Sugar Land, Texas. He and his partners purchased



“There is always the option of leasing pool space at a local hotel or gym to see if there is a need. In the last few years it has become easier, because all public pools have been required to ensure their accessibility.”

— SEAN HAYES

a building already equipped with a therapy pool. This avoided the set-up costs of building a pool, which can be a hurdle to new practices. “There is always the option of leasing pool space at a local hotel or gym to see if there is a need,” he advises PTs interested in starting an aquatics practice, adding, “in the last few years it has become easier, because all public pools have been required to ensure their accessibility.”

Since January 2013, the Americans with Disabilities Act (ADA) has required that newly constructed or altered swimming pools, wading pools, and spas have an accessible way for people with disabilities to enter and exit. The ADA has technical specifications for when a means of entry is accessible—such as, for pool lifts, the location, size of seat, lifting capacity, and amount of clear floor space needed. For pools built before January 2013, standards from 2010 are the guide for accessibility.⁴

When Hayes’ clinic opened, it was the only combination aquatic and land-based physical therapy facility in the area, giving it a foothold on marketing. The clinic has a dedicated salesperson who promotes the practice to physicians. Charlotte Norton, PT, DPT, MS, ATC, president of the APTA Aquatic Section, advises, “It is critical to inform those receiving marketing that a physical therapist is always assessing the care plan and applying skilled interventions to optimize movement, function, and wellness.” First Colony is an in-network provider for many insurance companies, which provides a steady stream of patients.

“The rewards of aquatic physical therapy are the amazing benefits that patients experience,” Norton says, noting that aquatic therapy often helps patients “jumpstart” the rehabilitation process. “An athlete with an ankle sprain can usually tolerate sport-specific drills such as cutting and jumping in the water long before he or she can tolerate similar activities on land,” she points out.

Many of First Colony’s patients come to physical therapy after total shoulder replacements. “We also see many patients with spinal pain who cannot handle weight-bearing exercises,” Hayes says. People who have had ankle surgery and can’t yet bear their full weight are another common population for aquatic physical therapy. In the pool, with the support that the water provides, patients lose their fear of falling. That allows PTs to address balance impairments more effectively. Beyond the orthopedic applications, aquatic practices also can treat patients after stroke or other neurologic impairments.

For Hayes and his colleagues, the biggest challenge is operational—namely, long holiday weekends, when the clinic is closed. Without water continuing to refill to pool, it evaporates below the skimmers and the pool’s heater no longer is effective. It takes an hour to reheat the pool by 2 degrees. “Imagine having to cancel 10-20 clients because the water is 10 degrees below where they expect it to be,” he says.

Norton concurs. “Pools are expensive, and it isn’t as though you can turn out the lights and stop paying for electricity,” she says. “A pool must run 24/7, so there needs to be some creativity with programming.”



“The rewards of aquatic physical therapy are the amazing benefits that patients experience. An athlete with an ankle sprain can usually tolerate sport-specific drills in the water long before he or she can tolerate similar activities on land.”

— CHARLOTTE NORTON

Like Hamilton, Hayes cites the importance of mentors in identifying physical therapy niches.

“We offer a supportive environment for professional growth. All our therapists begin in a mentoring program,” he says. Hayes credits the Aquatics Section with being a strong resource for continuing education, with its course “How to Develop an Aquatic PT Program” and a certificate in Aquatic Physical Therapy Clinical Competency. For its part, First Colony

pays for continuing education courses and encourages PTs to pair up when attending sessions. “If there is no one to share questions and ideas with, knowledge that’s gained may quickly be lost,” Hayes remarks. ■

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REFERENCES

1. Ehlers-Danlos Society. EDS Types. Classical EDS. <https://www.ehlers-danlos.com/eds-types/#cEDS>. Accessed February 26, 2018.

2. Ehlers-Danlos Society. What are the Ehlers-Danlos Syndromes? webpage. <https://www.ehlers-danlos.com/what-is-eds/> Accessed January 16, 2018.
3. Ericson Jr. WB, Wolman R. 2017. Orthopaedic management of the Ehlers-Danlos syndromes. *Am J Med Genet C Semin Med Genet.* 175C:188-194.
4. Questions and Answers: Accessibility Requirements for Existing Swimming Pools at Hotels and Other Public Accommodations. US Department of Justice, Civil Rights Division. https://www.ada.gov/qa_existingpools_titleIII.htm. Accessed February 19, 2018.

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COMBINED SECTIONS MEETING:

Better Together and BIGGER THAN EVER



Stories are abridged from PT in Motion News @ CSM, published by APTA and produced by CustomNews Inc. Contributing editors and writers are Donald E. Tepper, APTA; Lois Douthitt, APTA; Tim Mercer, CustomNews Inc; and Deb Nerud Vernon, BS, MA, EMT-P, CustomNews Inc. Photographer is Jonathan Bachman.



The Combined Sections Meeting brought more than 17,000 people to New Orleans—yet another record-breaking attendance for the annual conference of the association’s 18 specialty sections.

Using Causal Models to Develop Knowledge-Based Practice

A scientist claiming “Your practice isn’t evidence based” and a clinician countering “Your evidence isn’t practical” likely resonates with PTs on both sides of the argument. In his delivery of the Cardiovascular and Pulmonary Section’s Linda Crane Lecture, Sean Collins, PT, ScD, asked the audience to consider just how wide the gap is between them: To what extent can practice be evidence based, and to what extent can research be practical?

Setting up his discussion for the lecture, titled “Synthesis: Causal Models, Causal Knowledge,” Collins contrasted ontology—the ways things are—with epistemology—the way things are known. The concept of critical realism, in which the human mind is part of the process of knowledge, is premised on the claim that ontology determines epistemology. In other words, what is real is still real even if every aspect of the reality hasn’t empirically been verified.

The challenge to finding evidence for every aspect is that clinicians are faced with all sources of variation at the same time, while dealing constantly with the full burden of the complex system. To illustrate, Collins asked attendees to suppose that a clinician is considering 2 interventions, each with 2 possible states—do or don’t do the intervention. There are 4 possible alternatives. With



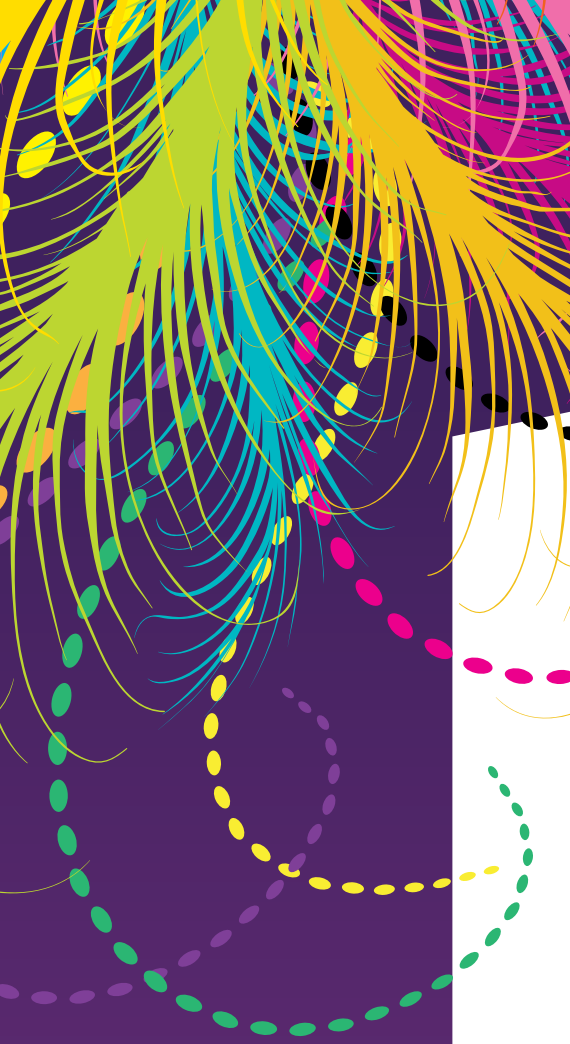
Sean Collins

4 interventions, there are 16 alternatives, and so on. “But why encode the interventions as only yes or no?” he asked. “Why not high, low, or no,” with 2,187 possible alternatives? Or even “high, medium, low, or no” with 16,384 alternatives, and so on? Taking a purely empirical approach to verify all of the alternatives isn’t practical, Collins argued.

Instead, causal models (abstract models that attempt to describe the cause-and-effect relationships among a group of variables) provide a bridge

for knowledge development in the profession—as opposed to evidence that identifies empirical connections, then is translated to the clinician.

“Causal models represent a synthesis of knowledge-based practice,” Collins said, in which the models fit with reality “even when we cannot empirically verify each and every component of such models; but where knowledge assumptions that are encoded in the models are clear, combine knowledge with reasoning, and are subject to empirical verification when possible.”



Frost, left, is congratulated by APTA President Sharon Dunn, PT, PhD.

End the Coddwompling, Cerasoli Lecturer Urges

Physical therapy education must stop “coddwompling”—slang for traveling in a purposeful manner toward a vague destination—and instead should begin traveling in a purposeful manner toward an intentional destination. That was the message Jodi Frost, PT, DPT, PhD, delivered in her presentation of the Academy of Physical Therapy Education Section’s Pauline Cerasoli Lecture.

She asked the audience to reflect on the changes that have occurred in physical therapy during the past 20 years: “What have we learned? With Vision 2020, we understood it was the profession’s intention to transition to the DPT degree. Did we imagine that in 20 years the number of high-quality applicants to PT programs would nearly double, or that program development would accelerate? Did we anticipate a decline in PTA enrollment? Did we imagine that the average number of clinical sites affiliated with a PT program would more than double, or that DPT programs would decrease in length? How well did we plan for an aging professoriate and leadership as baby boomers reach retirement age? Did our past 20 years embody coddwomple?”

Frost then suggested factors that can influence the future of physical

therapy education. Among those already affecting the profession—and certain to have an even greater impact in the years to come—are disruptive innovation and new technology, big data analytics, and relationship transformation. She described the “flipped classrooms” at the University of Vermont’s College of Medicine, with lectures delivered by videos outside the classroom and small groups of students meeting for active learning during class time. Another example: The HoloLens, a wearable holographic computer that presents 3D images, is the result of a partnership among Case Western University Medical School, Cleveland Clinic, and Microsoft.

Frost then asked, “How can we embrace disruptive innovation and contribute to the development of new technologies?” and offered suggestions. One is collaborative and shared leadership: “We must consider models of leadership that enable innovation, flexibility, and bold decision making to navigate a more complex, dynamic, and unpredictable environment,” Frost said. She also proposed greater use of design thinking, which begins with empathy and combines creative and analytical approaches.

Initiatives for Chronic Pain Management Go Beyond the Opioid Epidemic

Speakers for the Orthopaedic Section session “The Chronic Pain Epidemic: National Research, Education, and Practice Initiatives” addressed what they called not just the “opioid epidemic” but also the “chronic pain epidemic”—noting that the issue of pain management is larger than just finding alternatives to opioids, more broadly encompassing the need for better approaches to acute and chronic pain.

The presenters were Kathleen Sluka, PT, PhD, FAPTA; Linda Porter, PT, PhD; and Kara Gainer, JD.

Sluka said the chronic pain management problem starts in professional education. Most schools—not just for physical therapy but for other health care disciplines as well—do not include curricula for pain management, she said. Research also is lacking: “Funding doesn’t match the problem,” she said.

“The expenditures to address the problem vs the societal cost of the problem is unbalanced.”

Porter described several federal initiatives to address chronic pain management, including the National Pain Strategy, National Pain Research Strategy, National Institutes of Health Pain Consortium, and Interagency Pain Research Coordinating Committee.

One challenge is the need for more data. One hundred million American adults may experience pain, Porter said, “but we don’t know if they have access to pain care, or what type of access.” She compared PT education on pain management unfavorably with that of veterinary education, saying it is “exponentially less than it is in veterinarian schools—your pets can get better pain care than you can.”

Gainer described APTA’s efforts toward promoting physical therapy as a nonpharmacological option for pain management. At the forefront is the #ChoosePT campaign to increase public awareness of the benefits of physical therapy. But much more is going on behind the scenes as the association advocates for expanded coverage of services, smaller patient copays, and more recognition of the role of physical therapy in prevention strategies.

“We talk to the Centers for Medicare and Medicaid Services all the time,” Gainer said, in addition to commenting on proposed rules—even those not directly related to physical therapy; for example, Medicare Part D proposals—to bring up physical therapy as an alternative to drugs.

Physical therapist assistants made their mark in the APTA Pavilion.

Managing Wrist Injuries for Better Function

Kristin Valdes, OT, OTD, began the Academy of Hand and Upper Extremity Physical Therapy session “Wrist Injuries: Evaluation and Treatment” by sharing 2 clinical pearls: assess composite motion of the hand and wrist to determine the presence of extrinsic tightness, and assess intrinsic tightness.

To assess for extrinsic tightness, Valdes said, have the patient make a fist with the wrist in neutral and then in full flexion. “If the motion is greater with the wrist in neutral, extrinsic extensor tightness is present.” To assess for extrinsic flexor tightness, Valdes advised having the patient straighten digits with the wrist in neutral and then with wrist fully extended. “If finger extension is greater with the wrist in neutral, then extrinsic flexor tightness is present.”

Valdes mentioned many available tests and techniques for assessing various modalities after a distal radial fracture,

including the Figure 8 technique, the Ten Test, and the Patient-Rated Wrist Evaluation (PRWE).

She suggested that clinicians, when seeing patients in the first week after fracture, should concentrate on techniques to reduce edema. “Start early edema reduction and passive range of motion to stiff noninvolved joints. Caution patients not to wiggle their fingers, but rather to stretch to full extension.” During week 2, concentration should be on scar management and edema reduction, Valdes said.





You're never too old or too young to learn something from another generation's perspective.

Managing Employer Health Care Costs Requires Managing Employees' Health

Two PTs from the Private Practice Section described their experiences in setting up and running health programs designed for employers and their employees. Russell Certo, PT, founded the MOG Group—MOG standing for “medically oriented gym.” The MOG Group is a co-op of MOG sites owned by independent PTs and provides a central place for these sites to share policies, procedures, and business practices. The other panelist, Tracy Ervin, PT, is the founder of the Center for Physical Rehabilitation.

Certo said, “Companies in the vanguard of containing health costs do it by managing health.” He criticized large health care systems and “big insurance,” saying “the health of communities continues to deteriorate despite the pseudo-attempts at prevention programs by ‘big insurance’ and health care systems. There is little incentive for change,” Certo said. “Less-than-optimum health drives higher premiums and the need for more services.”

The solution, he suggested, includes employers negotiating health programs

by identifying what actually provides value. “True prevention and wellness programs require expenditure initially,” he said, “and must have individual incentive-based outcome measures.”

Ervin described her development of a worker health care model. One critical element was coordinating services with the company’s human resources and safety departments, in addition to gaining support at the executive level.

Also critical is making a dollars-and-cents case to the company’s executives. Ervin cited such figures as the Centers for Disease Control and Prevention’s calculation that the medical costs of people who are obese are \$1,429 greater—about 42%—than are those of other workers, and that yearly medical costs and lost wages in the United States due to diabetes total \$245 billion.

Advanced Home Health Competency Program Goes Live at CSM

Preparation for assessment, examination, and developing a plan of care in the home health environment can be a daunting task for the PT. A preconference course, “Advanced Competency in Home Health Live Training,” was designed to help attendees enhance their skills. As part of the Advanced Competency in Home Health certificate program for PTs, the course fulfilled the face-to-face portion. The program is a partnership between APTA and the Home Health Section.

Presenters were Melissa Bednarek, PT, DPT, PhD; Christine Childers, PT, MS; Nick Panaro, PT, DPT; Donald Shaw, PT, PhD, DMin; and William Walsh, PT.

Panaro emphasized musculoskeletal assessments. “We need to know what we are assessing, why we are assessing, and how we are assessing,” said Panaro, a board-certified clinical specialist in geriatric physical therapy. He stressed strength, range of motion, endurance, and mobility as starting points, suggesting tests and measures for each area.

“Ask yourself what the most appropriate screening tool might be. Don’t do something just because it is quick and easy,” Panaro said. “The reason for using a test is twofold—confirming what we think or fear and planning for short- and long-term goals.”

Attendees used frequent lab opportunities to practice assessment techniques under the direction of instructors.

If the Shoe Fits, Does It Reduce Injury More Than Gait Training Does?

The popularity of running has never been greater. Concerns over concussions in high school contact sports, for example, have increased participation in cross country running. The Sports Physical Therapy Section session “Science Meets Practice—Form Before Injury Management” featured a debate on shoe selection versus gait training to manage running injuries.

Leading into the debate, Jeff Taylor-Haas, PT, DPT, a board-certified clinical specialist in orthopaedic physical therapy, presented the case study of a teenage female with right anterior knee pain aggravated by running, climbing stairs, prolonged sitting, and squatting. Her running shoe scored a

36% on the minimalist shoe scale, with 100% being a shoe closest to barefoot running. Gait analysis showed that strike factor was the cause of her pain.

Blaise Dubois, PT, SPD, opened the debate on “pro-shoe” side explaining that he looked at the science behind the current topic. “Technique is a small part of the puzzle,” Dubois said. “We need to do what we can to make sure the body can absorb the shock of running.” More technology just increases the bulk of the shoe, he said, and cushioning has no effect.

Rich Willy, PT, PhD, argued that gait retraining is more efficient than is shoe type for injury management. “Why

the fascination with running shoes?” he asked. “A study showed that shoe type had no bearing on injury rate.” Willy, a board-certified clinical specialist in orthopaedic physical therapy, pointed to another study, of 577 runners on the effect of zero heel-to-toe drop (“drop” being the differential in height between the toe and the heel of a shoe), that showed no difference in injury rate over 6 months between a 10-centimeter, 6-centimeter, and zero-drop shoe. He continued, “Certain shoes do reduce knee loads, but this increases Achilles tendinopathy. On the other hand,” Willy said, “we know that gait retraining reduces joint loads with lower Achilles tendon force.”

Spinning Out of Control: Approaching Dizziness in Acute Care

As part of the Academy of Acute Care Physical Therapy’s preconference course “My Patient’s Dizzy, Now What? An Acute Care Approach to Vestibular Dysfunction,” Kerry J. Lammers, PT, DPT, and Gabrielle S. Steinhorn, PT, DPT, led PTs in employing evidence-based practice for patients who present with dizziness to assess, evaluate, and determine the course of treatment or referral in the acute care setting.

Vertigo or dizziness may have many causes, but the interplay between the vestibular, oculomotor, and somatosensory systems combines to maintain postural and gaze stability. One cause, benign paroxysmal positional vertigo (BPPV), is triggered

by certain changes in head position, such as tipping the head up or down. Steinhorn, a board-certified clinical specialist in neurologic physical therapy, stated that BPPV may account for up to 50% of falls in older adults, but she added that more than 90% of cases can be treated in 1 to 3 sessions. She cautioned that contraindications for treatment may include neck surgery, severe rheumatoid arthritis, and issues with vertebrae C1 or C2.

Patients can be screened for balance in the hospital with an oculomotor exam, positional testing, or vestibulo-ocular reflex (VOR) test. “Observe that the patient’s eyes maintain fixation, [and observe] for skew deviation—1 eye higher than the other when performing vision tests,” Steinhorn said. She recommended the Vestibular Evidence Database to Guide Effectiveness (VEDGE) as a “great resource from neuropt.org.”

Video clips and demonstrations by Lammers and Steinhorn, as well as hands-on practice time, gave attendees practical knowledge during the course.



Steinhorn (left) and Lammers demonstrate assessment and treatment options for vestibular dysfunction as BPPV.



One feature of CSM's largest attendance ever—plenty of opportunities for personal connections and reconnections.

CPGs: From Idea to Final Product

A team from the Academy of Neurologic Physical Therapy shared the work that went into developing a clinical practice guideline (CPG) on locomotor function that is expected to be published in the near future. The panel for the session “Clinical Practice Guidelines, Strategies That Maximize Locomotor Function” included T. George Hornby, PT, PhD; Darcy Reisman, PT, PhD; Irene Ward, PT, DPT; Allison Miller, PT; and Patty Sheets, PT, DPT. Miller and Sheets are board-certified clinical specialists in neurologic physical therapy.

The group conducted a systematic review of the literature from 1995 through 2016 on the use of specific interventions to improve locomotor function—specifically walking—following stroke (cerebrovascular accident, or CVA), traumatic brain injury (TBI), or incomplete spinal cord injury (SCI). “The primary goal most patients had following an acute-onset of neurological injury was to restore walking ability,” Hornby noted. “Walking speed predicts survival, and that’s pretty powerful.”

He said they studied randomized clinical trials and looked at actual

interventions in both experimental and control groups. They also examined dosage, frequency, intensity, time, and type of therapy.

As a result of the literature review, the CPG’s recommendations include these:

- Clinicians may consider the use of strength-training strategies with multiple sets and repetitions to improve walking.
- Clinicians should not include sitting or sitting with dynamic standing to improve locomotor function. Clinicians may consider use of balance training with virtual reality.
- Clinicians may consider circuit training at high intensities with over 70% heart rate reserve to improve locomotion.
- Clinicians should include moderate- to high-intensity walking interventions for improving locomotor function in patients with chronic central nervous system injury.
- Clinicians should not perform body weight-supported training in lieu of over-ground walking, but they may use it as an adjunctive intervention for improving locomotor function.

Is Technology Moving PTs From a Hands-On to Hands-Off Profession?

Emerging Trends in Telehealth

Telehealth and mobile health applications are evolving rapidly, said the presenters of a Section on Research session. While they can't be a substitute for all aspects of physical therapy, they can be more effective and less costly in the right situations than are traditional face-to-face interventions.

Helen Hoenig, MD, MPH, addressed technology barriers to eHealth, as well as work-arounds and longer-term solutions. One challenge is low bandwidth—the inability to transmit enough data to show a patient at a remote location with sufficient detail and movement. “The resolution or the frame rate is reduced,” Hoenig said, “resulting in image ‘freezing,’ or the image is blurred.”

Other challenges include the need for an assistant to hold the recording device, the large amount of storage space required for video, and security concerns.

Rana Hinman, PT, PhD, described the Australian experience with telehealth, particularly as it relates to osteoarthritis (OA). There are obviously implications when there is no physical or hands-on contact with patients, she said, suggesting questions to ask when deciding which cases are suitable for telehealth. Regarding assessment, can diagnostic tests be performed remotely? Moving on to treatment, are manual techniques needed? Regarding the safety of patients, are screenings required?

Hinman said that setting expectations is relevant for both PTs and patients. For example, a widely held belief among patients is that all physical therapy requires hands-on treatment.

Kristin Archer, PT, PhD, cited studies showing that interventions via telehealth can be as effective as, and less costly than, in-person interventions. She conceded, however, that it takes some work to adjust communication styles when working remotely with patients.

In moderating the 2018 Eugene Michels Forum, James Gordon, PT, EdD, FAPTA, set up a discussion between Fay Horak, PT, PhD, and Dorian Rose, PT, PhD, with a question: Should we embrace the current wave of patient-oriented technologies, or exercise caution and wait for definitive evidence? Such was the topic of debate for the Section on Research session titled “The Current Wave of Technology: Should We Ride It or Should We Start Paddling?”

Although neither Horak nor Rose in reality endorsed either position, each had volunteered to take a side for the debate.

Horak's arguments for embracing technology now included these:

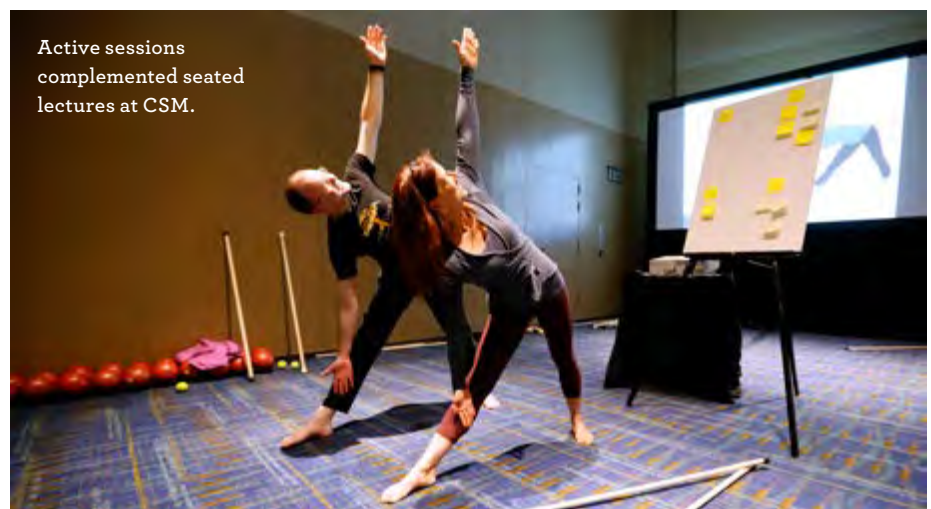
- Technologies give PTs more time and data, enabling them to give greater attention to their clinical decision making, as opposed to performing tasks. New equipment and devices “allow measures to be more accurate and sensitive to change than are clinical measures that use a rating scale,” she said.
- Technologies give patients more time and better feedback to practice the quality of the movements their PT has prescribed to them. “In the clinic,” Horak explained, “you can ask the patient only a limited number of times to ‘turn right,’” and the results may not represent how the patient moves in daily life. Wearing

a body-mounted video camera, the patient can record every right turn made in a day for the PT to analyze.

- Costs for equipment and devices are offset by the time the PT gains—that time being the largest part of a clinic's expenses.

Rose said PTs should consider these questions before jumping on the technology bandwagon:

- Does technology pose a risk to the therapeutic alliance between the PT and patient? Patients want to sense that the PT is listening, engaged, honest, and committed.
- Is evidence-based practice (EBP) a comfortable fit with technology? One of the 3 pillars of EBP, patient values, shouldn't be discounted. One study Rose cited indicated that patients preferred working with a human to a robot.
- How will new technologies be taught? There isn't a standard for teaching across programs, and technologies change so fast that they could be obsolete by the time a student graduates.
- Does equipment start to drive decisions? PTs might be tempted to think “I just spent thousands of dollars on this equipment, so I'd better use it” even if it isn't best for the patient, Rose said.



Active sessions complemented seated lectures at CSM.



A dozen “session on demand” areas accommodated overflow when sessions reached room capacity.

Treating Patients With HIV Focuses on Independence, Pain Management, Quality of Life

Although we may not hear about HIV and AIDS as much as we did 25 years ago, the virus remains prevalent. Sara Pullen, PT, DPT, MPH; Roberto Sandoval, PT, PhD; David Kietrys, PT, PhD; and Mary Lou Galantino, PT, PhD, MS, MSCE, presented the Oncology Section session “HIV in 2018: It’s Not Over Yet—What Every Physical Therapist Needs to Know.”

Pullen said the goals for working with a patient with HIV should be the same as working with any patient—increasing

functional independence, decreasing or eliminating pain, independent self-management of impairments, and improving quality of life. “Although there are many potential side effects, you must advise your patients not to stop taking their drugs,” said Pullen. “Stopping antiretroviral therapy [ART] allows HIV to multiply and become resistant, and resistant HIV can be passed to others.”

Kietrys said that 39%-55% of people living with HIV have chronic pain. Among those, 87% are more likely not

to adhere to ART. PTs can help manage chronic pain with exercise, transcutaneous electrical nerve stimulation, and manual therapy.

As people with HIV are living longer, they are at an increased risk for certain comorbidities, Galantino said, such as cardiovascular disease and stroke, osteoporosis and fracture, metabolic syndromes and diabetes, renal disease, neuropathy, malignancies, and geriatric syndromes.

Helping Prevent Toxic Stress in Infants

The trauma experienced by neonatal infants—those within 28 days of birth—can have lifelong effects, according to Mary Coughlin, RNC-E, NNP, MS. She presented the Academy of Pediatric Physical Therapy session “Trauma-Informed Care: A New Paradigm for the NICU.”

Pointing out that “you don’t have to be abused to experience trauma,” Coughlin said that individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening. Such an event has lasting adverse effects on the individual’s functioning and mental, physical, social, emotional, or spiritual well-being.

Although she acknowledged that not all stress is bad, Coughlin noted that even toxic stress may result without health care professionals or parents being aware of the situation. For example, an infant’s stress may arise from maternal deprivation or separation, unmanaged or undermanaged pain, social isolation, or sleep fragmentation or deprivation. Coughlin cited evidence that 50%-70% of infants born preterm develop behavior problems.

Coughlin said, “The secret sauce is maternal care. Parents are integral to the comprehensive care of their hospitalized infants.” Another important component, she added, is the knowledge and behavior of PTs who can contribute to the prevention of pain and stress in the hospitalized infant.

Medicare A to Z: APMs, CPT, MIPS, PFS, QPP, VBC, SZ, and More

Medicare and commercial payers have moved toward value-based care (VBC) models to determine payment—shifting from payment based solely on the volume of care to payment more closely related to outcomes. While changes in some federal approaches have slowed the pace of specific efforts, the overall trajectory still moves toward making providers accountable for the outcomes of patient care.

Three Section on Health Policy and Administration sessions ran through the alphabet of Medicare updates. “Emerging Issues in Medicare” (2 sessions) and “Strategies for Implementing Performance Measures in Value-Based Payment Models” featured speakers Stephen Hunter, PT, DPT; Bridget Morehouse, PT, MPT, MBA; Charles Thigpen, PT, PhD, ATC; Alice Bell, PT; Kara Gainer, JD; and Heather Smith, PT, MPH.

APTA staffers Bell, Gainer, and Smith offered descriptions, as well as specific instructions and suggestions, for

complying with several new Medicare rules. Among the issues covered:

- 2018 Medicare physician fee schedule (PFS), including changes to CPT code values, and new or revised codes
- Permanent fix to the therapy cap, and the future differential in payment for PTA services
- Prospective payment system updates for home health, skilled nursing facilities, inpatient rehabilitation facilities, and long-term care hospitals
- Postacute care payment reform efforts toward a unified payment system
- Change from the SZ modifier to 96 and 97 modifiers for habilitation and rehabilitation services
- Medicare Quality Payment Program (QPP), including the Merit-based Incentive Payment System (MIPS)

and Advanced Alternative Payment Models (APMs)

Hunter, Morehouse, and Thigpen shared takeaways from their implementation of VBC programs that incorporated performance measurement. Simply knowing a patient’s likelihood of achieving clinical improvement can influence the PT’s clinical decision-making, Thigpen said in opening the presentation.

From a private payer perspective, Morehouse said, companies could save “a ton of money if they look beyond number of physical therapy visits” and realize the savings from fewer MRIs, surgeries, and opioid prescriptions (with the potential costs for treating abuse).

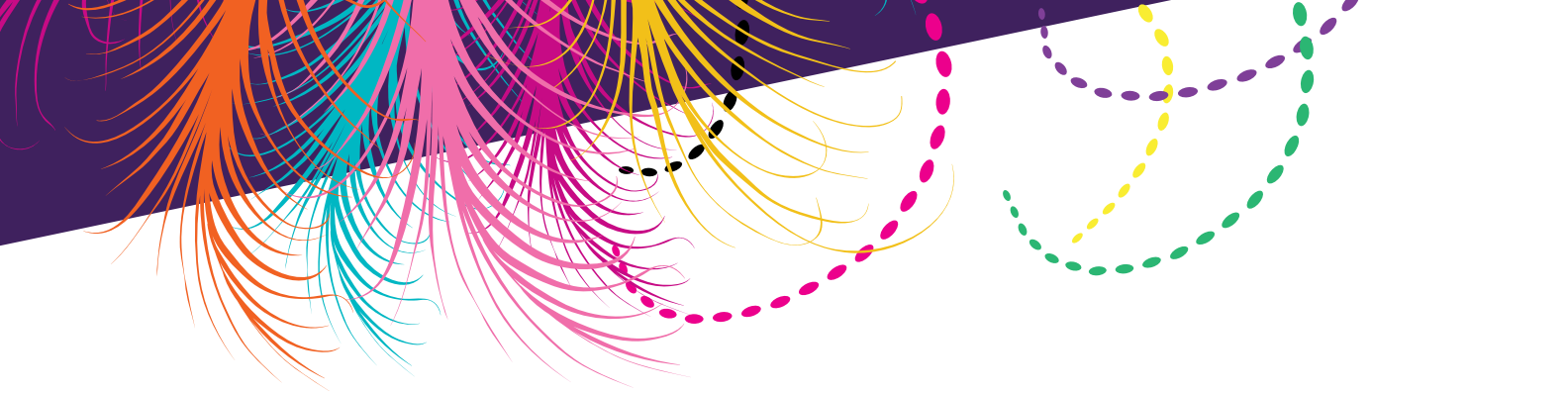
Hunter noted the challenge of getting accurate data on who’s providing the care. “You’ll know who signed the note,” he said, but any other PT or PTA who provided treatment needs to be identified, too.



Although walking through it contributed millions of steps toward the Shoes4Kids step challenge, the exhibit hall provided plenty of other activities.



Attendance wasn’t the only record smashed at CSM. 1,475 poster presentations reflected an increase of more than 300 from 2017.



Getting Around: Skills Training for Wheelchair Use

When they are independent in their mobility, people who use wheelchairs report better long-term well-being, health, and participation. Yet many people have trouble negotiating common obstacles. In their presentation of the Federal Physical Therapy Section session “Roll With It! Wheelchair Skills Training From Basics to Extremes,” speakers Kendra Betz, PT, MSPT, and Lynn Worobey, PT, DPT, PhD, shared their expertise as PTs and certified assistive technology professionals.

Fit is essential to ensuring successful wheelchair skills. “Treat the wheelchair as if it’s an orthosis,” Betz suggested. “You want a wheelchair to fit the patient in the same way, with the same

precision.” Rear-wheel position is particularly important. The wheel should be adjusted as far forward as possible without compromising the user’s stability. Betz cited research that shows this position decreases roll resistance and increases hand-to-push rim contact—allowing users to propel themselves with less muscle effort, smoother joint patterns, and lower stroke frequency.

In describing different propulsion patterns, Betz said the most common approach is “single loop,” but that a “semicircular” approach provides the best mechanics—with smooth, long strides that limit high impact on the push rim, and that lower the force and frequency of strokes. However, she

added, the best approach can depend on the task, and on surface conditions.

Despite its benefits, wheelchair training is hampered by barriers such as limited time for individualized training, fatigue and stress, lack of insurance coverage, and clinicians’ limited knowledge. Worobey offered that group training can overcome at least some of these obstacles. A group dynamic encourages user collaboration—they can mimic, mentor, cheer each other on, and engage in healthy competition. In addition, users can share their tips, supplier and repair referrals, and frustrations with routine activities such as traveling and parenting.



Theresa Spitznagle

Attendees Urged to Take ‘Exquisite Risks’ to Enhance Profession’s Social Responsibility

American Board of Physical Therapy Specialties (ABPTS) keynote speaker Theresa Spitznagle, PT, DPT, MHS, declared, “We should consider a shift in our clinical values. We can do a lot for our patients with very few resources.” Spitznagle, immediate past chair of ABPTS, is a board-certified clinical specialist in women’s health physical therapy.

The theme of her remarks, “Exquisite Risk: Reflections on Professional Values,” focused on the dual meaning of the word “exquisite”—suggesting both beauty and intensity. Speaking to physical therapists (PTs) who had earned ABPTS certification, she said, “I wondered: Why did you take this exquisite risk? Was there a benefit for you? For your patients? For our society? For societies beyond our own?”

Spitznagle addressed physical therapy’s core values of accountability, altruism,

compassion, excellence, integrity, professional duty, and social responsibility. She noted that a 2016 study of PTs found that social responsibility was embraced by only 5%.

If social engagement were to be better developed as a core value, Spitznagle asserted, more in the profession would engage in pro bono care. “To improve social engagement, we need to move from an individualistic perspective of our profession to a larger lens that includes interdisciplinary activities and strategies for improving society level practice,” she said.

She asked her audience to consider what their next exquisite risk will be. “Reflecting on our clinical experiences allows us to better serve our patients and, at the same time, put our professional values into action,” she said.



Attendees await the start of a session.

Adding Women's Health Content To an Already Full Curriculum

How can a DPT curriculum add women's health content while retaining other needed and desirable courses? Two PTs described their solution: Make a single course do double duty.

Skye Donovan, PT, PhD, and Carrie Pagliano, PT, DPT, explained their strategy in the Academy of Women's Health Physical Therapy session "Women's Health in a DPT Curriculum: Integration Without Adding to Academic Bloat."

Professional education programs already are constantly challenged with meeting the demands of advancing evidence, innovative practice, and entry-level practice standards. Curricula may be suffering from "academic bloat," as clinicians and students demand exposure to emerging areas of practice, while emphasis still is needed on an already long list of content areas.

Donovan and Pagliano said they realized they could take many modules in the current curriculum and replace them with modules that address those same areas, but from a women's health perspective. For example, CAPTE guidelines include topics—such as genital, reproductive, lymphatic, and systems interactions—that could encompass women's health. Further, the National Physical Therapy Exam, while containing few questions relating specifically to women's health, includes questions that potentially could be addressed in women's health courses.

Pagliano explained, "In geriatrics, we found a relationship between falls and urinary incontinence, because the patient may get up 5-6 times a night. Rather than focusing on falls, the module can focus on why they're getting up." Similarly, in acute care, Pagliano described the link between incontinence (and resulting dampness) and pressure ulcers. "If there's moisture, there will be skin breakdown," she noted. "Let's address the underlying cause of the moisture." ■

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Health Care Employment Rose 18,500 in February

Health care added 18,500 jobs in February, following an increase of 20,600 in January, according to the US Bureau of Labor Statistics (BLS), for a total of 15,909,200 people nationwide employed in that field.

Ambulatory services added 8,500 jobs. That includes an increase of 4,600 in physician offices and 4,000 in home health services. Hospitals added 9,300 employees, while nursing care facilities added 1,100. For the year, health care added 289,500.

Total nonfarm payroll employment increased by 313,000 in February. Rising sectors, in addition to health care, included construction, retail, manufacturing, and financial activities.

Meanwhile, according to payroll services company ADP's monthly National Employment Report, private sector employment increased by 235,000 in February. ADP, which uses a different methodology from that of BLS, calculated that employment in health care and social assistance increased by 38,000.

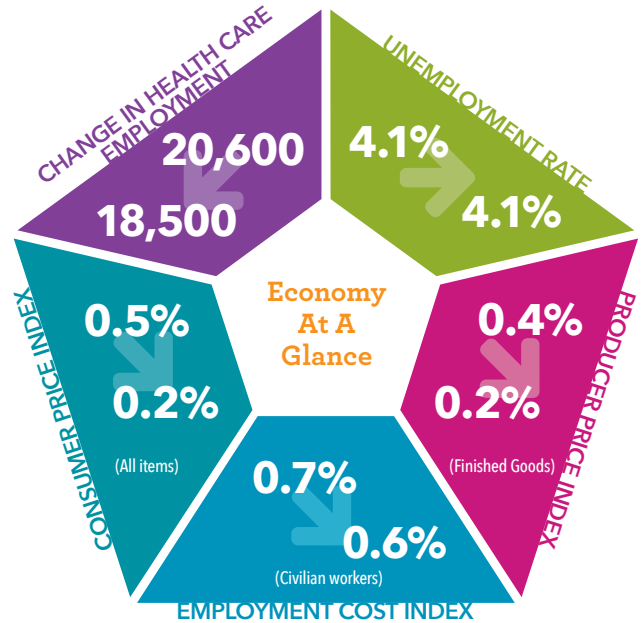
Other large gainers included leisure/hospitality (50,000), administrative/support services (22,000), and trade/transportation/utilities (44,000).

Companies of all sizes reported solid gains. Small businesses (1-49 employees) added 68,000 jobs, medium businesses (50-499 employees) added 97,000 jobs, and large businesses (500+ employees) added 68,000 jobs.

According to Ahu Yildirmaz, vice president and co-head of the ADP Research Institute, "The labor market continues to experience uninterrupted growth. We see persistent gains across most industries, with leisure and hospitality and retail leading the way as consumer spending kicked up. At this pace of job growth, employers will soon become hard-pressed to find qualified workers."

www.bls.gov/news.release/pdf/empisit.pdf

www.adpemploymentreport.com/2018/February/NER/NER-February-2018.aspx



All figures are January-February 2018 except Employment Cost Index, which reflects third-to-fourth-quarter change.
Source: Bureau of Labor Statistics, Department of Labor
<http://www.bls.gov/eag/eag.us.htm>

Operating Metrics of Selected Health Care Companies

	Income/Employee	Revenue/Employee	Asset Turnover	Receivables Turnover	Current Ratio
EHC	6,771	103,380	0.81x	8.82x	1.38
THC	-5,595	152,430	0.80x	6.20x	1.29
USPH	5,304	104,130	1.01x	8.16x	2.13
KND	-3,392	70,830	1.04x	5.00x	1.57
AVERAGE	772	104,883	0.92x	7.05x	1.59

Note: In 2017 HealthSouth changed its name to Encompass Health Corporation and its stock symbol from HLS to EHC.

EHC: Encompass Health Corporation | THC: Tenet Healthcare
USPH: US Physical Therapy Inc | KND: Kindred Healthcare

All data are TTM (trailing twelve months). Information updated: 3/18/18
* Last 4 quarters + Rounded to nearest dollar

Source: Fidelity Investments: www.Fidelity.com

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Health Care Spending Projected to Rise 5.5% Annually Through 2026

Health care spending is projected to rise by 5.3% in 2018 and continue at about that growth rate through 2026, according to estimates from the US Centers for Medicare and Medicaid Services (CMS). At the projected rates, spending on health care will represent nearly 20% of the US gross domestic product (GDP) by 2026, up from 17.9% today.

According to the report from the CMS Office of the Actuary, the estimated increases are driven by 2 major factors: an aging US population that will increase Medicare spending, and an inflation rate on medical goods and services provided directly to patients that will outpace the overall economy's rate of inflation—2.2%, compared with 1.1% annually.

The average 5.5% annual growth in spending is higher than both the post-Great Recession rate of 3.8% from 2008 to 2013 and the 5% uptick related to the startup of the Affordable Care Act from 2014 to 2016. It's still lower than the 7.3% annual increases experienced from 1990 to 2007, however, according to the report.

Among other findings:

- Medicare spending will be the fastest-growing of all health insurance categories, projected to increase

by 8% between 2019 and 2020 and by 7.7% annually between 2021 and 2026. In contrast, private insurance is projected to grow at slower rates of 4.1% and 4.7%, respectively.

- Part of the expected slower growth of private insurance can be attributed to an increased prevalence of high-deductible plans and the implementation in 2022 of a tax on high-cost insurance plans, which CMS actuaries believe will spark employers to offer employee health insurance with reduced benefits and higher cost-sharing.
- Prescription drugs will lead the way in increases to goods and services provided to patients, with a projected annual increase of 6.3% from 2017 to 2026.
- The share of the population with health insurance will likely decline, from 91.1% in 2016 to 89.3% in 2026, due to elimination of the individual mandate for health insurance.
- By 2026, government-sponsored efforts will represent 47% of all health care expenditures, up from today's 45% share. The portion of expenditures shouldered by private insurance is predicted to drop from 55% to 53%.

www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsProjected.html

CDC Issues 'Call to Action' to Address Treatment Gaps for Children Experiencing TBI

The US Centers for Disease Control and Prevention (CDC) says it considers traumatic brain injury (TBI) in children a public health problem with a ripple effect. Not only are children receiving inconsistent care at the time of injury, but variation in rehabilitation and recovery approaches can lead to disability that lasts through adulthood.

The CDC estimates that in 2013 there were roughly 640,000 TBI-related emergency department visits, 18,000 TBI-related hospitalizations, and 1,500 TBI-related deaths among children 14 and younger.

The CDC laid out its case in a recent report to Congress that identified what it believes are the most serious gaps in current treatment for pediatric TBI. "The management of TBI in children is complex and depends upon multiple service delivery systems that frequently do not provide systematic or coordinated care to ensure optimal recovery," the report stated. "Due to the lack of robust scientific evidence identifying optimal pathways to recovery, current management is too often based on clinical practice experience rather than research."

The agency said it hopes to address this issue through a "first-ever evidence-based clinical guideline on the diagnosis and management of mild TBI among children and adolescents," now in development. The CDC said those guidelines could help address gaps in the management of TBI in children, but it adds that guidelines alone won't be enough to fix problems in the current state of treatment.

The report, which the CDC describes as a "call to action," identifies 8 major areas in need of improvement:

Access to comprehensive care at the time of injury.

"There is substantial variation in care among the sites where children are seen for acute injury care," the report stated. "Not only are there inconsistencies in TBI assessment but also in the comprehensiveness of discharge recommendations for all severity levels of TBI."

Long-term management. The report asserted that "there are no formal systems to monitor the health of children with TBI over time" and that "frequently children who need pediatric rehabilitation services do not receive them."

Family support and training. According to the CDC, parents of children who experience TBI often find themselves thrust into a situation in which they have to take

on multiple roles, including being an advocate for their child in health care and school systems. "Few parents understand the potential for a TBI of any severity level to become a chronic condition," the report said.

Return to school. "Many students who sustain a TBI will need post-injury support at school... However, children and their families often experience difficulties accessing these services," according to the report.

Return to activity. The CDC acknowledged that return-to-play guidelines have been developed for sports, but it found a lack of similar guidelines for physical activities outside of organized sports and not much in the way of guidelines for return to activities after moderate and severe TBI.

Transition to adulthood for children with TBI. In what the CDC described as "a particular area of concern," the report maintained that the use of health care services tends to decline as adolescents with TBI transition to adult care, with a resultant worsening of outcomes. Making matters worse, according to the report, is the tendency for public school systems to limit post-high school transition planning to only those students covered by the Individuals with Disabilities Education Act (IDEA), and the lack of any requirements for specialized education and transition services in private schools.

Professional training. "Many medical, educational, and other professionals who provide care and support for children after TBI received limited training specific to TBI recognition or management," the report stated. "Lack of adequately trained health care providers leads to inconsistent and variable clinical assessments, inconsistent diagnoses, variable guidance about expected recovery course, and variability in management decisions early and later after injury."

Research. According to the CDC, "we currently know very little about long-term outcomes for children with TBI." The agency called for high-quality studies to establish parameters for duration of rest and return to physical and cognitive activity, medication use, and the management of prolonged symptoms. "A wide range of medical, behavioral, physical, and other therapies are used in the management of [mild] TBI, but definitive, high-level evidence-based guidelines do not currently exist," the CDC wrote.

www.cdc.gov/traumaticbraininjury/pdf/reportstocongress/managementoftbiinchildren/TBI-ReporttoCongress-508.pdf

FDA 2018 Priorities Include Opioid Crisis, Diet, and Nutrition

The US Food and Drug Administration (FDA) has released its 2018 Strategic Policy Roadmap, titled "Healthy Innovations, Safer Families." The document identifies 4 agency priority areas in 2018:

- Reduce the burden of addiction crises that are threatening American families.
- Leverage innovation and competition to improve health care, broaden access, and advance public health goals.
- Empower consumers to make better and more informed decisions about their diets and health, and expand the opportunities to use nutrition to reduce morbidity and mortality from disease.
- Strengthen FDA's scientific workforce and its tools for efficient risk management.

Among specific goals are the following:

Reducing Misuse and Abuse of Opioid Drugs. "We will assist in the conversion of the market toward wider use of opioid drugs with improved formulations that are harder to manipulate and abuse; advance the development of drugs and devices that can treat pain and are less likely to lead to addiction; and create new paths for the development and approval of better treatments for addiction..."

"Additionally, FDA will strengthen its enforcement activities that target those who unlawfully market or distribute controlled substances and other unapproved drugs. We will step up our efforts aimed at the interdiction of opioids being illegally shipped into the United States."

One specific action planned by FDA is modification of its Risk Evaluation and

Mitigation Strategies (REMS) programs to require training on nonopioid pain alternatives and broader training that covers more health care providers who help manage patients with pain.

Leveraging Diet and Nutrition to Reduce Preventable Death and Disease. "FDA will take new steps in 2018 to implement a comprehensive plan...to leverage dietary information to reduce the burden of disease through nutrition and encourage the development of more healthful food options."

Advancing Digital Health Technologies. "FDA will take new steps in 2018 across its regulatory portfolio to adapt its traditional approaches to regulation to better fit the challenges presented by new areas of technology. Digital health tools represent one such paradigm, and FDA's Pre-Certification Pilot Program is one such effort."

www.fda.gov/downloads/AboutFDA/ReportsManualsForms/Reports/UCM592001.pdf

Pediatricians Group Releases 'Choosing Wisely' List Of Orthopedic Treatments to Question

The "Choosing Wisely" collection of treatments that providers and patients should question continues to expand—this time into pediatric orthopedics. The American Academy of Pediatrics (AAP) has called for dialing back the use of imaging, ultrasound, and orthotics.

Launched by the American Board of Internal Medicine Foundation in 2012, "Choosing Wisely" lists ineffective and overused treatments and tests. It has grown to include 540 recommendations from more than 80 specialty society partners. The AAP list, developed in partnership between the AAP Section on Orthopaedics and the Pediatric Orthopaedic Society of North America, makes the following 5 recommendations:

- Do not order a screening hip ultrasound to rule out developmental hip dysplasia or developmental hip dislocation if the baby has no risk factors and has a clinically stable hip examination.
- Do not order radiographs or advise bracing or surgery for a child less than 8 years of age with simple in-toeing gait.
- Do not order custom orthotics or shoe inserts for a child with minimally symptomatic or asymptomatic flat feet.
- Do not order advanced imaging studies (MRI or CT) for most musculoskeletal conditions in a child until all appropriate clinical, laboratory, and plain radiographic examinations have been completed.
- Do not order follow-up X-rays for buckle (or torus) fractures if they are no longer painful or tender.

In 2014, APTA became the first nonphysician organization to contribute to Choosing Wisely when it released its list of "5 Things Physical Therapists and Patients Should Question."

www.choosingwisely.org/societies/american-academy-of-pediatrics-section-on-orthopaedics-and-the-pediatric-orthopaedic-society-of-north-america/

www.choosingwisely.org/

www.choosingwisely.org/societies/american-physical-therapy-association/

<http://integrity.apta.org/ChoosingWisely/>

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Study: Optimal Exercise Dose for Knee Disorders Still Unclear

While much research has shown positive effects of therapeutic exercise for common knee disorders, “optimal dosing is still unclear,” largely because of the way authors report their results. Identifying the best dosage is important, the authors of a recent research study wrote, because overdosing can have adverse effects and underdosing can mean no improvement for the patient.

In a systematic review published in the *Journal of Orthopaedic and Sports Physical Therapy*, researchers examined 45 “fair-quality” studies on the use of therapeutic exercise to treat knee osteoarthritis (OA), patellar tendinopathy, or patellofemoral pain (PFP). They analyzed duration of a single session, frequency of sessions, total number of sessions, duration of treatment, and effect size. They found:

- Effect sizes in the included studies varied widely because so many different outcome measures were used, even for the same conditions.
- For all 3 conditions, some studies did not report or were unclear about the length of each therapy session, frequency of sessions, and whether the exercise was supervised.

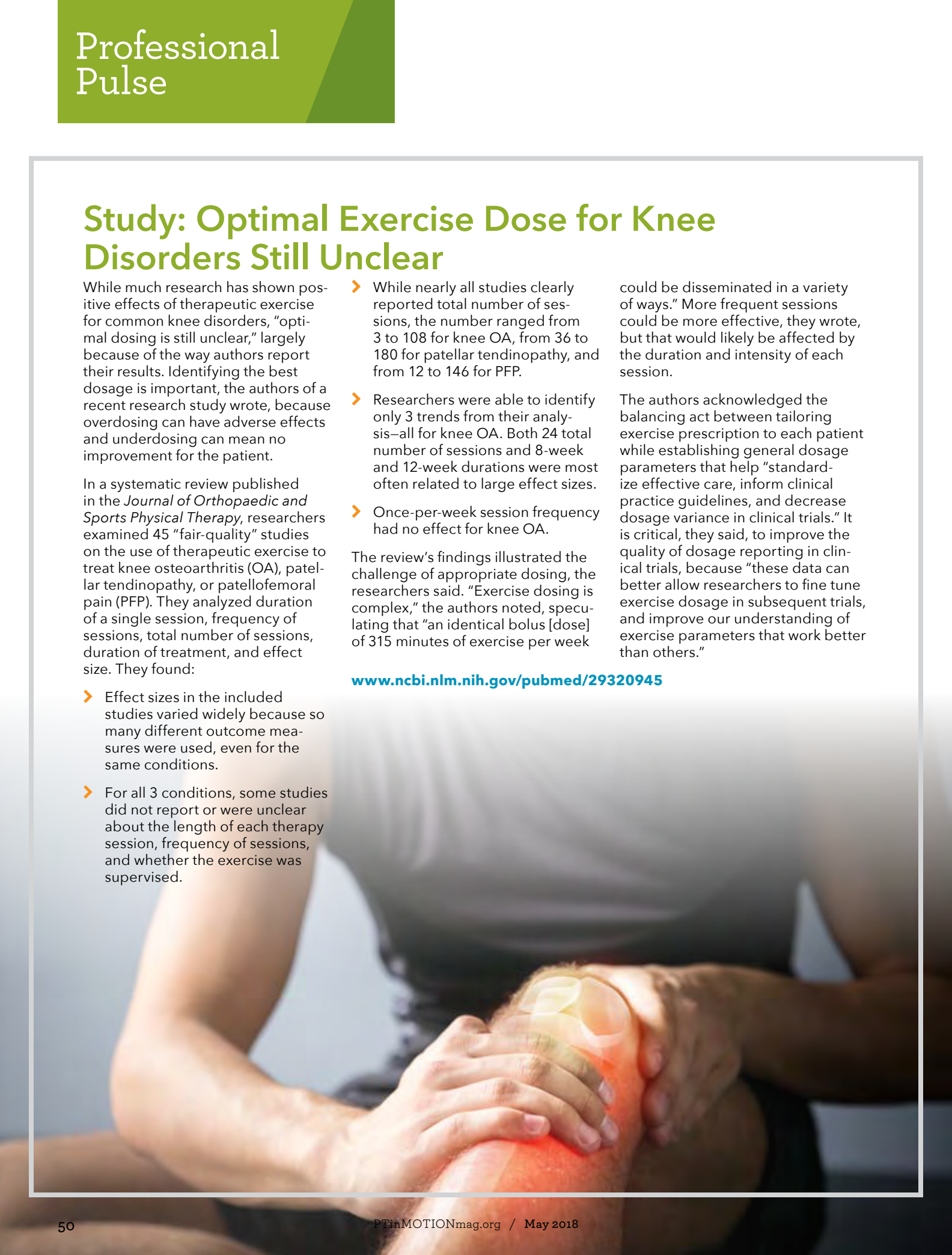
- While nearly all studies clearly reported total number of sessions, the number ranged from 3 to 108 for knee OA, from 36 to 180 for patellar tendinopathy, and from 12 to 146 for PFP.
- Researchers were able to identify only 3 trends from their analysis—all for knee OA. Both 24 total number of sessions and 8-week and 12-week durations were most often related to large effect sizes.
- Once-per-week session frequency had no effect for knee OA.

The review’s findings illustrated the challenge of appropriate dosing, the researchers said. “Exercise dosing is complex,” the authors noted, speculating that “an identical bolus [dose] of 315 minutes of exercise per week

could be disseminated in a variety of ways.” More frequent sessions could be more effective, they wrote, but that would likely be affected by the duration and intensity of each session.

The authors acknowledged the balancing act between tailoring exercise prescription to each patient while establishing general dosage parameters that help “standardize effective care, inform clinical practice guidelines, and decrease dosage variance in clinical trials.” It is critical, they said, to improve the quality of dosage reporting in clinical trials, because “these data can better allow researchers to fine tune exercise dosage in subsequent trials, and improve our understanding of exercise parameters that work better than others.”

www.ncbi.nlm.nih.gov/pubmed/29320945



Study: Falls Among US Adults 65 and Older Cost \$50 Billion in 2015

The US health care system spent an estimated \$50 billion on falls in 2015—an amount representing 6% of all Medicare payments and 8% of all Medicaid payments, according to a new study. The authors concluded that unless the United States steps up its game when it comes to falls risk assessment and prevention, costs are certain to steadily climb higher as the baby boomer generation continues to age.

The researchers based their estimates on data from the Medicare Current Beneficiaries Survey (MCBS), then applied these data to data from the National Health Expenditures Accounts (NHEA) to estimate nonfatal falls expense. For fatal falls, they used the Web-based Injury Statistics Query and Reporting System (WISQARS) to assess expense. The final MCBS sample included 3,460 community-dwelling individuals 65 and older. Excluded were respondents who were employed, died during the survey period, or lived in Puerto Rico.

Results of the study were published in the *Journal of the American Geriatrics Society*. Among the findings:

- Researchers estimated total 2015 health care expenditures for nonfatal falls in the US at approximately \$49.5 billion—\$28.9 billion for Medicare, \$8.7 billion for Medicaid, and \$12 billion for other payment sources including private insurance and out-of-pocket expense.
- Nearly 1 in 4 adults in the survey reported a fall in the past year.

Of those, 52.1% fell once, 21.3% fell twice, and 24.1% fell 3 or more times.

- Individuals who reported falls had significantly lower self-rated health and more chronic conditions, and were more likely to be female, white, and from lower income levels.
- Estimated costs were not distributed equally among service types, with an “other” category—spending in areas such as home health services, long-term care facilities, and durable medical equipment—leading the way at \$29.2 billion. That amount was more than double hospital-related spending, which was second at \$12.9 billion, followed by physician/other provider spending (\$10.8 billion), prescription drugs (\$2.1 billion), and dental (\$400 million).
- Unintentional fall deaths were recorded at a rate of 59.64 per 100,000 population in 2015, with associated medical costs of \$754 million—about 1% of the total estimated expenditures.
- Overall, spending on falls in 2015 increased by nearly 32% from 2013, when total spending was estimated at \$38 billion.

“The economic burden from falls is likely to increase substantially in the coming years,” the authors wrote. “Monitoring cost trends is important because 75% of the cost of older adult falls is financed through public health insurance programs that are already financially stressed.”

The good news is that “Preventive strategies that reduce falls in older adults could lead to a substantial reduction in health care spending.”

The researchers stressed that “evidence-based strategies including medication management and strength and balance exercises... have been associated with reductions in older adult falls,” and pointed to guidelines such as those included in the US Centers for Disease Control and Prevention’s Stopping Elderly Accidents, Deaths, and Injuries (STEADI) initiative as a good place to start.

For more on falls prevention, check out falls-related resources at PTNow—including a unilateral vestibular hypofunction clinical summary; a summary on falls risk in community-dwelling elders; an osteoporosis clinical summary; and tests and measures such as a fracture risk assessment, a clinical test of sensory interaction and balance, and a self-paced walk test. APTA also offers resources on its Balance and Falls webpage.

<http://onlinelibrary.wiley.com/doi/10.1111/jgs.15304/full>

www.cdc.gov/steady/index.html

www.ptnow.org

www.apta.org/BalanceFalls/

A Third of Patients Told to Lose Weight Have Functional Limitations That Could Make Exercise Difficult or Unsafe

Physicians increasingly may be prescribing exercise for patients who need to lose weight, but nearly a third of those patients have functional limitations that could interfere with their ability to safely follow those recommendations, according to new study. Researchers see PTs as providers who are uniquely positioned to help address that disconnect.

The study's findings, published in *Physiotherapy Theory and Practice*, are based on data from 5,480 participants in 2 rounds of National Health and Nutrition Examination Surveys (NHANES) who answered yes to 1 or more of 3 questions about whether a doctor or health professional had recommended physical activity or weight loss in the past 12 months.

The researchers looked at how this group answered other questions about functional limitations—involving activities such as walking for a quarter mile, walking up 10 steps without resting, preparing meals, dressing, standing up from an armless chair, and pushing or pulling large objects—as well as questions about past attempts at weight loss. Here's what they found:

- Among respondents (56.5% female, 43.5% male, ranging in age from 40 to 65) who were told to lose weight, nearly 1 in 3 (31%) reported 1 or more functional limitations.
- More than 20% reported difficulties with instrumental and basic activities of daily living (IADL and BADL) and with lifting, pushing, or pulling objects.
- More than 90% of respondents who reported difficulties with IADL and BADL also had a history of obesity, prediabetes, diabetes, hypertension, heart failure, angina, or a myocardial infarction, either alone or in combination.

- Among those in the functional limitation group, 57.6% reported intentionally attempting weight loss, with 40.7% using exercise as a weight-loss method.
- Only 9.9% of respondents who were told to lose weight reported seeking professional advice for weight loss: 48% of that group sought advice from a nutritionist or dietitian, 26% sought out a personal trainer, 23.5% met with a "doctor," and 2% reported "other." Physical therapists were not listed as a separate option.

Authors of the study acknowledged that while the relationship between functional limitations and lower levels of physical activity (PA) may be a 2-way street, with low levels of PA leading to functional limitations and vice-versa, this relationship only underscores the need for carefully planned and monitored prescriptions for exercise in this population. That's where they believe PTs can play an important role.

"Physical therapists are well-suited to manage the PA and exercise programs of individuals with functional limitations given [their] education, expertise, and documented self-efficacy in primary, secondary, and tertiary prevention with exercise testing, prescription, and implementation," the authors wrote. "This perspective is strengthened by the documented low self-efficacy of physicians with PA counseling."

The authors also suggested, "Individuals with these limitations should be identified at the time of health professional recommendation to increase exercise or lose weight and referred to an appropriate health professional for exercise testing, prescription, and program implementation. Physical therapists have an opportunity to assist with these efforts."



APTA offers resources on encouraging healthy lifestyles at its webpages on Prevention, Wellness, and Disease Management; and Arthritis. The association has also launched a knowledge-sharing opportunity: The Council on Prevention, Health Promotion, and Wellness in Physical Therapy.

www.ncbi.nlm.nih.gov/pubmed/29498558

www.apta.org/PreventionWellness/

www.apta.org/Arthritis/

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Referral to Physical Therapy for LBP Reduces Odds of Later Opioid Prescription

There's solid evidence that physical therapy as a first-line approach for low back pain (LBP) improves outcomes, but few studies have focused on the factors associated with referral to physical therapy in the first place, regardless of later participation in treatment. Now researchers believe they've found associations indicating that the very act of referral for physical therapy may point to the ways a primary care provider's approach to LBP can affect patient perceptions and reduce odds of later opioid use—even when the patient doesn't follow through with the referral.

The study, published in the *Journal of the American Board of Family Medicine*, looked at data from 454 Medicaid enrollees who initially were treated by a primary care provider for LBP. Of those, 215 received a referral for physical therapy. While researchers were interested in differences between the referral and nonreferral groups, the target of their study was something they believed is missing in current research: an examination of the entire referral population, regardless of whether those patients followed up with actual physical therapy.

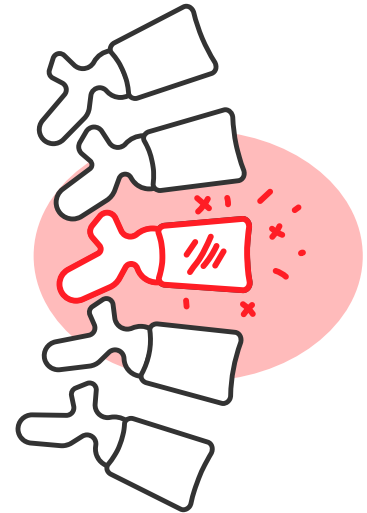
"Identifying only patients who have participated in [physical therapy] fails to account for the impact of the referral itself," the authors wrote. "The referral potentially represents a provider-patient interaction about the nature of the LBP and prognosis. Improved outcomes among [physical therapy] cohorts may represent a combination of patient compliance with the [physical therapy] recommendation and a provider's beliefs about the nature and severity of the LBP."

To explore this issue, researchers divided patients who received a physical therapy referral into 2 groups—those who, after a physical therapy

consultation, went on to participate in physical therapy, and those who didn't. Researchers compared those groups with each other, as well as with the group that didn't receive any referral to physical therapy.

Among the findings:

- Patients receiving a physical therapy consult tended to be younger, and had received a radiograph and/or prescription for nonsteroidal anti-inflammatory drugs (NSAIDs) or muscle relaxers. Patients less likely to receive a consult were associated with tobacco use, chronic pain, depression, 2 or more comorbidities, and having received a referral for specialty care or advanced imaging.
- The odds of a patient receiving a physical therapy consult increased 1.8 times if the patient also received an NSAID prescription.
- In terms of actual participation in physical therapy, patients who received multiple orders from the primary care provider (specialty referrals, advanced imaging, etc) in addition to a physical therapy referral were less likely to go to physical therapy, as were older patients and those with 2 or more comorbidities.
- Opioid prescriptions were the most commonly used interventions during the year after the initial LBP visit. While the strongest predictor of a later opioid prescription was associated with whether an opioid prescription occurred at baseline, patients who received a physical therapy consult were 35% less likely to receive an opioid prescription,



regardless of whether they participated in physical therapy after the consult.

The authors wrote, "These results highlight the impact of the initial provider visit and provide a foundation for future work understanding patient and provider beliefs surrounding the initial primary care visit for LBP," adding that "providing a physical therapy consult in place of an opioid prescription is a reasonable alternate strategy for pain management and improved function, particularly in this population of Medicaid enrollees."

The researchers added, "Patients with a consult to [physical therapy] represent a unique and important subset, as the consult may represent a reflection of a provider's values and subsequent communication with the patient. Recommending [physical therapy] provides reassurance to patients that their LBP is best managed with physical activity and is in line with advice to stay active. This in itself has potential to change cost and health care use."

Authors of the study included APTA members Anne Thackeray, PT, PhD, and Julie Fritz, PT, PhD, FAPTA.

www.ncbi.nlm.nih.gov/pubmed/29180553

JAMA Study: Opioids No Better Than Nonopioids in Improving Pain-Related Function or Intensity

APTA's #ChoosePT opioid awareness campaign makes the case that opioids simply "mask" pain, but a new study in *JAMA* has concluded that the drugs probably don't even do that much—at least not any more effectively than do nonopioid medications. The research, which focused on individuals with chronic back pain or hip or knee osteoarthritis (OA) pain, led the authors to an unequivocal conclusion: There's no support for opioid therapy for moderate-to-severe cases of those types of pain.

The published findings are based on a study of 240 randomized patients in the Minneapolis, Minnesota, Veterans Affairs (VA) health care system who reported chronic back pain or knee or hip OA pain—defined as daily moderate-to-severe pain for 6 months or more with no relief provided by analgesic use. Participants were divided into 2 groups: 1 received an opioid regimen, the second nonopioid drugs.

To more closely resemble real-world treatment, researchers used a "treat-to-target" approach that stepped up the drugs as needed for participants to reach identified goals. The opioid regimen began with immediate-release morphine, hydrocodone/acetaminophen, and oxycodone, but it could advance to sustained-action morphine and oxycodone, and on to transdermal fentanyl.

The nonopioid approach began with acetaminophen and nonsteroidal anti-inflammatory drugs (NSAIDs), but it could move on to topical analgesics and finally to drugs requiring prior authorization (such as pregabalin and duloxetine), including tramadol. All participants also were permitted to pursue nondrug treatment during the study, but researchers did not evaluate data related to those treatments.

Participants were monitored throughout the study and evaluated at 12

months using a range of tests, with the primary focus on how pain interfered with function, assessed through the Brief Pain Inventory (BPI); and pain intensity, measured using the BPI severity scale. Both measures are 10-point scales, with higher numbers indicating more pain-related interference or pain intensity.

At the 12-month mark, researchers found no significant differences in pain-related interference between the 2 groups (average BPI function scores of 3.4 in the opioid group and 3.3 in the nonopioid group), and a greater reduction of pain intensity among the nonopioid group (average of 3.5 in the nonopioid group vs 4.0 in the opioid group).

When it came to the achievement of what authors called a "functional response"—a 30% or better improvement in a BPI score—the number of participants who achieved that level of improvement in function was roughly equal among groups, with 69 patients in the opioid group and 71 patients in the nonopioid group reaching the threshold. But the difference was notable in pain intensity scores, with 63 participants in the nonopioid group reporting improvement of 30% or more, compared with 48 participants in the opioid group reaching that level of improvement.

The researchers also analyzed group differences by the type of pain treated:

Back pain

- Average score, interference with function: 2.9 in opioid group; 3.3 in nonopioid group
- Average score, pain intensity: 3.7 in opioid group; 3.6 in nonopioid group

Hip or knee OA

- Average score, interference with function: 4.4 in opioid group; 3.4 in nonopioid group

- Average score, pain intensity: 4.5 in opioid group; 3.4 in nonopioid group

Researchers also found that quality-of-life measures did not differ significantly between the 2 groups. The only area in which results from the opioid group bettered the nonopioid group in a notable way was in reduction of anxiety symptoms, although authors point out the only a small number—9% of all participants—reported moderate-to-severe anxiety at baseline.

"Among patients with chronic back pain or hip or knee osteoarthritis pain, treatment with opioids compared with nonopioid medications did not result in significantly better pain-related function over 12 months," the authors wrote. "Overall, opioids did not demonstrate any advantage over nonopioid medications that could potentially outweigh their greater risk of harms."

APTA's award-winning #ChoosePT campaign is aimed at informing consumers that physical therapy is an effective alternative to drugs for the treatment of pain. Members can also learn more about the PT's role in pain management through offerings on PTNow, including a webpage with resources for pain management and an opioid awareness checklist.

www.ncbi.nlm.nih.gov/pubmed/29509867

www.apta.org/PTinMotion/News/2018/03/05/OpioidsQualityOfLife/

www.moveforwardpt.com/ChoosePT

www.ptnow.org/Opioid

APTA's Updated Defensible Documentation Resource Provides Insight, Practical Tips, and More

Physical therapists (PTs) and physical therapist assistants (PTAs) know they can't take their eyes off the ball when it comes to properly documenting care. That's why APTA has revamped and updated its collection of online resources supporting defensible documentation.

APTA's retooled web page includes the latest on best practices in documentation, presented in an easy-to-navigate format. Extensive resources include an overview of the defensible documentation concept, elements of documentation within the patient/client management model, setting-specific considerations,

risk management, and additional resources such as publications from the US Centers for Medicare and Medicaid Services (CMS) and relevant articles from *PT in Motion* magazine.

Also included: tips on defensible documentation and a sample documentation checklist that outlines the process from initial examination and evaluation to completion of the episode of care.

The webpage advises visitors that while the resources offered provide information "as comprehensive as APTA can reasonably make it," PTs and PTAs also need to check specific

compliance requirements of payers, state laws, third-party administrators, and other organizations.

For more information, check out "Defensible Documentation: Critical Documentation from the Payer Perspective," a recording of a January 16, 2018, webinar. Also, coming this summer: a 2-part webinar series on Medicare documentation to be offered August 9 and August 25.

[www.apta.org/Defensible Documentation/](http://www.apta.org/DefensibleDocumentation/)

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<p>MAY</p> <p>19-20 Albuquerque, NM 1&2</p> <p>19-20 San Antonio, TX 1&2</p> <p>JUNE</p> <p>2-3 Framingham, MA</p> <p>2-3 St. Leo, FL 1&2</p> <p>2-3 Novato, CA 1&2</p> <p>9 Albuquerque, NM</p> <p>23 Albuquerque, NM</p>	<p>JULY</p> <p>JUNE 30-1 Albuquerque, NM</p> <p>13-14 Albuquerque, NM</p> <p>21-22 Salem, NH 1&2</p> <p>AUG.</p> <p>4-5 New Hyde Park, NY</p> <p>4-5 Chantilly, VA 1&2</p> <p>11-12 Albuquerque, NM</p> <p>11-12 Novato, CA 1&2</p> <p>11-12 Memphis, TN 1&2</p>	<p>SEP.</p> <p>22-23 Clinton TWP, MI 1&2</p> <p>OCT.</p> <p>26-27 Albuquerque, NM 1&2</p> <p>DEC.</p> <p>14-15 Albuquerque, NM 1&2 L</p> <p>Register for Kinesio Taping Seminars at www.kinesiotaping.com or call 855.488.9273</p> <p>Regular price is \$569 but special pricing for readers is \$369</p> <p>11 CEUs through FSBPT if state approved or 16 through state if not approved through FSBPT.</p>
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OPTP's New Performance Block™ Exercise Support Tool

OPTP has launched the Performance Block—a foam support tool for use in physical therapy as well as fitness training, yoga, and Pilates. It features a patented “dip” shape that supports the user during exercises and is designed to help promote improved strength and functionality throughout the body. Small and lightweight, it's easy to take to the gym or on travels, according to OPTP. The Performance Block comes with a manual illustrating 14 exercises. To learn more or to purchase it, call OPTP at 800/367-7393 or visit www.OPTP.com.



SXSW Movement Tracks Project Features Biodex Gait Trainer

Biodex Medical Systems Inc's Gait Trainer 3 treadmill system is featured in the Movement Tracks Project, a finalist in the 2018 SXSW Interactive Innovation Awards competition. The Movement Tracks Project is a collaboration between therapists and musicians to use biomedical music technology to help people with movement disorders walk again.

For its part in the project, the Gait Trainer 3 combines audio cueing and visual biofeedback to help prompt correct movement during gait training. The instru-



mented deck allows therapists to track various gait parameters and document patient progress. Last year, the Movement Tracks Project produced recordings using principles of music-based therapy for treatment of movement disorders such as Parkinson disease. To learn about the Biodex Gait Trainer 3, visit www.biodex.com/gait.

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Life (as a PT) Begins at 40

A second career fulfills a first love.



Heather Birely, PT, DPT, is an acute care PT at Genesis Medical Center East in Davenport, Iowa.

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

I'll never forget a woman I met during my acute care internship when I was in school to become a physical therapist (PT). She'd sustained a spinal cord injury from a fracture of her T7 vertebra secondary to undiagnosed metastatic breast cancer. Her courage, determination, positivity, and perseverance never wavered. She worked incredibly hard and refused to give up. Within a couple of weeks she'd made it from the acute floor to acute rehab. Three weeks later, she returned home to her family.

She still was in a wheelchair and battling cancer, but she was determined to walk again, and I believe that she eventually will achieve that goal. She thanked me for my role in her journey toward recovery, but she deserved all the thanks. She inspired me every day, affirming why I'd returned to school

decades after postponing my dream of becoming a PT.

The word "postpone" is key. I never quite gave up on that dream. But neither did I have great hope, as time went on, that it ever would happen. The truth is, if anyone had told me 22 years ago that late last year—at age 40 and with

3 sons in college, I'd earn my doctor of physical therapy (DPT) degree, I likely would not have believed it. Throw in the facts that I've now got a great job in acute care, and that all of my kids are working toward becoming PTs themselves, and I'd have been amazed and gratified by our roles in repaying a profession that has given my family so much over the years.

Let's start at the beginning—my high school graduation. I already wanted to become a PT. I'd won a college scholarship and was ready to embark on that path. Life, however, had other plans for me. I fell in love, and my husband Eric and I soon started a family. I gave birth to Cody, Alex, and Kyle in quick succession, and I chose to stay at home with them until they'd all started school.

Next, I entered the workforce. My first career was in retail. It had its rewards, but the hours were long. I was



an assistant store manager for many years, and spent a great deal of time away from home. I missed far too many of my sons' activities. I longed for a career with a better work-life balance.

At the same time, I was constantly reminded of physical therapy's ability to empower people and transform their lives. Over the years, I watched as my grandparents, parents, spouse, and all 3 of my boys required the skills of PTs for various reasons—adhesive capsulitis, rehabilitation of the anterior cruciate ligament, deconditioning due to congestive heart failure, concussion, foot injuries, and low back pain. In each case, I marveled at the PT's ability to establish a collaborative relationship and use his or her skills to help my family member accomplish personal goals and achieve a better quality of life.

One night in fall 2011, I was working the closing shift at a store and had missed yet another chance to be a cheering mom at a soccer game. For years I'd mulled the idea

of returning to school. That night, I decided that the time was now. We had a family discussion about what it would mean to all of us if I were to leave my job and pursue my DPT. Two days later I resigned my position.

I was accepted to St Ambrose University. I earned a bachelor's degree in exercise science, and then, a year and a half later, my DPT. The course load was difficult. Between school and home responsibilities, my energy was drained. Some days I felt very much like an "old lady" in comparison with my much-younger classmates. I didn't simply persevere, though. I loved every minute of it. I was pursuing my first love, career-wise, and that felt great. Also, I was learning—and modeling for my sons—some very valuable life lessons. For example, you're never too old to chase your dreams, and as long as you're willing to put in the work, you can change your life in profound ways.

As proud as I am of myself, I'm ever more so of my

sons. Cody, who receives his undergraduate degree this month and will enter St Ambrose's DPT program this fall, wants to work with children with special needs. Alex, soon to complete his undergraduate studies at St Ambrose, also will enter the school's DPT program this fall. He plans to work in outpatient orthopedics. Kyle, a college freshman, aspires to become a pediatric PT.

I never pushed any of them toward physical therapy, but I always encouraged them to pursue their passion—whatever path they felt would bring them happiness and fulfillment. I probably shouldn't be surprised, then, that all 3 of them, at least for now, have set their sights on a profession that promises great rewards for both patients and practitioners. Whatever they end up doing, I know that service to others is in their DNA. That deeply gratifies me.

As for me, talk about rewards! I love coming to work every day—meeting new people, facing new challenges, and helping

patients tap their inner reserves to overcome setbacks and achieve personal goals. Nothing is more rewarding than seeing the look of astonishment on a patient's face when he or she realizes that a seemingly unachievable task wasn't impossible after all. My patients inspire and motivate me to keep learning and growing—not only as a PT but also as a person.

As far back as my teenage years, I thought it would be great to be a PT. It took me a long time to turn that ambition into a reality. But I've come to discover something that I'd dared not hope during all those years that my dream was deferred. I've found that being a PT is even *better* than I'd imagined it could be.

I recall the woman who inspired me so much when I was in PT school, and I think to myself, what a tremendous privilege it is to partner with patients as they make their journeys of self-discovery and reclamation. ■

By the Numbers



61%

Consumers who would share health information digitally if it reduced office visit wait times; **55%** would share information if it saved them money.

SOURCE

Is Digital the Prescription for Improving Health? Ernst & Young 2018 survey of 1,455 consumers, 152 physicians, and 195 company executives. [http://www.ey.com/Publication/vwLUAssets/ey-is-digital-the-prescription-for-improving-health/\\$FILE/ey-is-digital-the-prescription-for-improving-health.pdf](http://www.ey.com/Publication/vwLUAssets/ey-is-digital-the-prescription-for-improving-health/$FILE/ey-is-digital-the-prescription-for-improving-health.pdf).



142,557

Suspected opioid overdoses among US emergency department visits from July 2016 through September 2017, according to the Centers for Disease Control and Prevention's National Syndromic Surveillance Program. The number of opioid overdose visits jumped 30% from third quarter 2016 (July–September) to third quarter 2017.

SOURCE

Morbidity and Mortality Weekly Report. Centers for Disease Control and Prevention. March 9, 2018. www.cdc.gov/mmwr/volumes/67/wr/mm6709e1.htm?s_cid=mm6709e1_e.

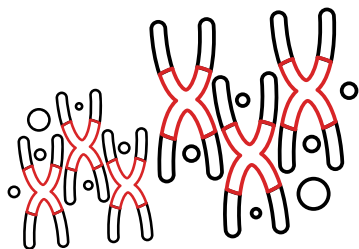
64.25



Overall score (out of 100) of Ohio, ranked the worst state for student debt by WalletHub.com in 2017. Individual ranking categories included average student debt, share of students with debt, debt as share of income, share of students in past-due or default status, share of borrowers aged 50 and over, and grant and work opportunities. Hawaii ranked best with an overall low score of **14.44**.

SOURCE

2017's States With the Most and Least Student Debt. WalletHub.com. <https://wallethub.com/edu/best-and-worst-states-for-student-debt/7520/#main-findings>.



100,000

Participants in a 23andMe study investigating the relationship between genetics and lifestyle factors to determine why people respond differently to exercise and diet for weight loss.

SOURCE

23andMe Launches Massive Landmark Genetic Weight Loss Study. 23andMeBlog. December 28, 2018. <https://blog.23andme.com/23andme-research/23andme-launches-massive-landmark-genetic-weight-loss-study/>.



Physical therapist (PT) APTA members who were Millennials (born 1982–2000) at the end of 2017—now the largest age category of PT members in the association. PTs born before 1946 account for **3%**; PTs born 1946–1964, **23%**; and PTs born 1965–1981, **36%**. (Physical therapist assistant members shifted to a majority of Millennials in 2013 and stood at **47%** at year-end 2017.)

SOURCE

APTA Member Demographic Profile, December 2017.



"Less than half"

Health care providers who clean their hands as often as they should—1 reason the Joint Commission began issuing citations to health care organizations whose employees fail to follow correct hand hygiene guidelines. May 5 is World Hand Hygiene Day.

SOURCES

Hand Hygiene in Healthcare Settings. Centers for Disease Control and Prevention. <https://www.cdc.gov/handhygiene/campaign/index.html>.

Hand Hygiene How Mandatory in All Ambulatory Care Settings. Joint Commission. https://www.jointcommission.org/ambulatory_buzz/hand_hygiene_compliance_now_mandatory_in_all_ambulatory_care_settings/.



56%

Respondents who said "inadequate payer incentives" is the main barrier to transitioning to value-based care, in a survey of 110 health care leaders.

SOURCE

Health Leaders Media Annual Industry Outlook: Exploring Investments and ROI. February 2018. www.healthleadersmedia.com/report/intelligence/annual-industry-outlook-exploring-investments-and-roi.



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