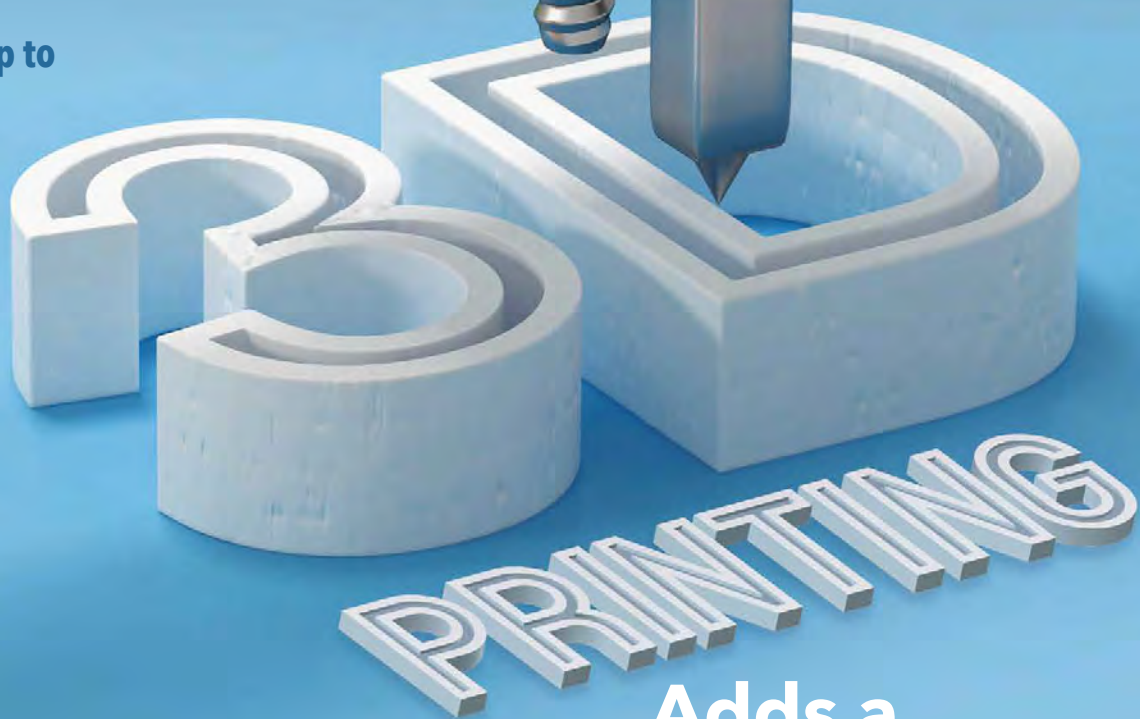


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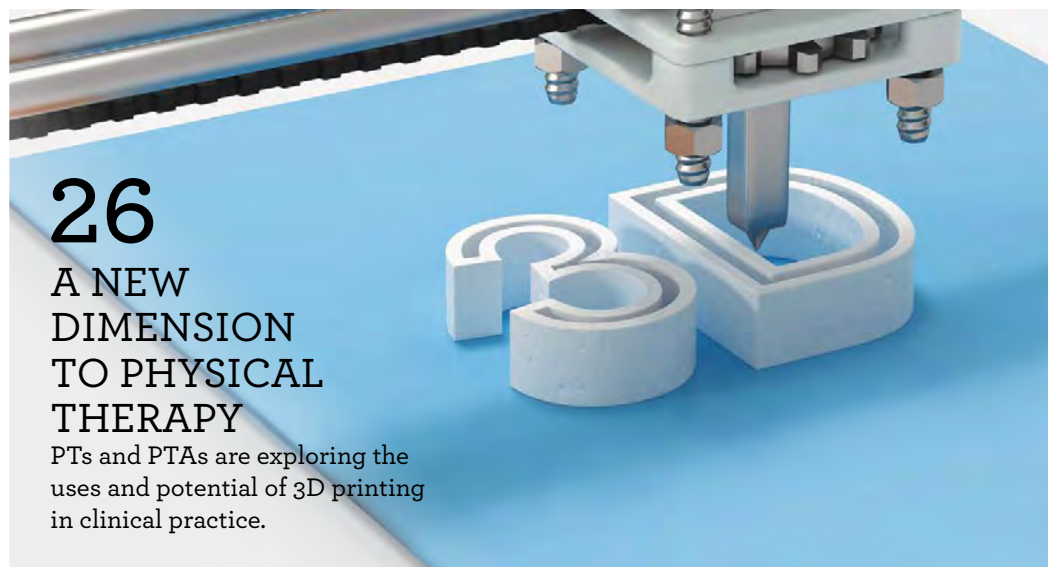
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18 MENOPAUSE: PTs HELP TO EASE ‘THE CHANGE’

Sometimes overlooked, physical therapy can be highly beneficial in helping women through and beyond this phase of life.



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36 HIGHLIGHTS FROM NEXT CONFERENCE AND EXPOSITION 2019

From an inspiring account of one person’s rise from opioid addiction to a discussion of implementing direct-access physical therapist services in a hospital, APTA’s NEXT conference offered sessions, presentations, and networking events for PTs, PTAs, and students. Here are some highlights from the June meeting in Chicago.

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— QUOTED —

If we do not do this, someone else will. I guarantee that the technology of 3D printing is only going to continue to improve, and that the cost to create with this technology will continue to decrease.

ROBERT LATZ, PT, DPT,
IN "A NEW DIMENSION TO
PHYSICAL THERAPY" (PAGE 26)

PT *in Motion*

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Online Comments

PTs and the Consumerism Movement

March 2019

I have a problem with the nomenclature of patients being considered consumers. Should medically necessary health care really be a business commodity? That is what the business-speak infers. Our work as PTs has almost always been based on what the patient needs, not upselling them some service or product without evidence or sound theory.

I have run into patients who think physical therapy is a commercial service where they can pick and choose what they want: They think they know better than the professional and try to demand archaic, passive modalities or "massage" because 20 years ago it worked for them. In my mind, it's borderline fraudulent to use the 20 minutes I get with a patient on semiskilled activities such as modalities when there are other substantiated methods with less risk and a more likely efficient result.

My job is not to placate patients because the rules of consumerism may allow them to dictate their care. Instead, it is to facilitate and then empower them to self-manage in the most efficient way possible. (Home use of modalities as appropriate may be part of this care, but using clinic time for more than educating them on how to use the modality safely becomes unskilled quickly, just like passive range of motion.)

Margaret Thomas

Providing Onsite Physical Therapist Services

July 2019

I love the article! It makes my heart sing, as it hits the nail on the head....treating the person. Helping and serving individuals and companies. I am wondering what the accounting part of it comes down to? Is it all private pay or insurance reimbursed? However, whenever insurance is involved we all know how much goes into over-the-top documenting and filling out forms and other paperwork. What is the pay scale? And I am curious to learn more about the accounting models of the article.

Kristin Nabozny PT, MT, Certified Yoga Therapist

How are these onsite therapists getting credentialed? I tried starting onsite work as part of the company that I own but was unable to get credentialed. How are these therapists providing hands-on physical therapy going from place to place?

Josh Prall, PT, DPT

[The company I work for is] the largest on-site employer in the United States, with more than 600 onsite clinics and expanding. At my site, the client is self-insured and has over 25,000 employees and dependents accessing it. No Medicare, no begging for visits from insurance companies with flip charts. I did that for 21 years at the expense of excellent patient care. Now I can provide optimal care with evidence-based criteria and excellent income. Most of my clients are direct access.

Going on 5 years now, I have been able to provide my services at about 10% of what the orthopedic clinic at my last job was charging for my services. I believe this would be considered value-based care—hired directly by my patients' employer. I hope this is the future and rescues us from a future of failing socialized medicine.

Bruce Knudsen



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The Real Story About Chronic Fatigue Syndrome

September 2017

Quite frankly—with me being a 25-year sufferer of this condition and having spoken to victims over the years—I can speak for all of us in saying that we heartily detest the medical industry, which has made little of a serious disorder for decades and has not cured anything since polio some 64 years ago, while wasting billions of dollars to come up with almost nothing.

Raymond M. George

Beating Burnout

February 2019

The productivity requirement is a huge problem. It causes PTAs and PTs to commit unethical acts that could be considered Medicare fraud.

Roberta Abbott

The Competitive Edge of Adaptive Sports

June 2019

Thanks for a great article on an important topic.

Kristi Hallisy, PT, DSc

Let Her Roll!

June 2019

Thank you for your time and listening to my story! It is an honor to be featured in *PT in Motion* magazine.

Renee Mitchell ("Missy Savage")

Thank you for covering our wonderful sport called Roller Derby! As a skater myself, I have suffered numerous severe injuries and it's refreshing to know that the PT world is starting to really connect to what our rehabilitation needs are to get back to playing what we love quicker and stronger! Thank you for getting us healthy!

"Stevie Bricks" (Diamond State Roller Derby, Newark, Delaware)

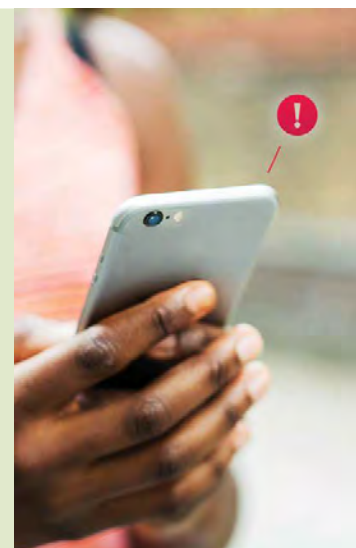
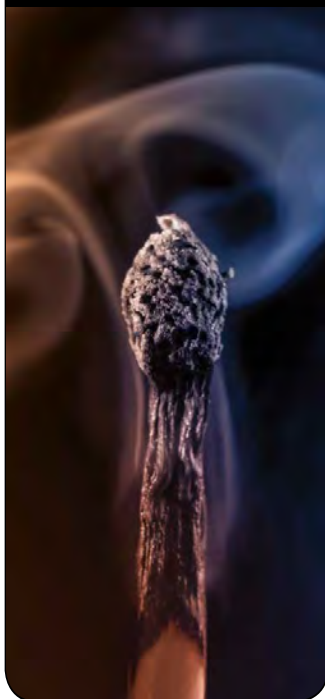
Ethics In Practice: Picture This

May 2019

The scenario involved Kevin, a PT who on his personal time texted a provocative selfie to the receptionist at a referring physician's office, whom he'd recently started dating.

I think Kevin was wrong in his actions and shocked that when confronted he lacked the ability to understand his error. I don't think it would have been an issue at his place of employment if the person involved had not been a client. His age and the societal norms of his peers obviously have a lot to do with his attitudes. More emphasis in ethics should be placed during the education process due to the seriousness of the matter. It was rather shocking that this would be seen as an appropriate behavior for someone on a second date.

Kay Menden





Autonomous Practice Within an Interdisciplinary Team

New students are graduating with the DPT. Most physical therapists (PTs) soon will possess the clinical doctorate. All 50 states now offer direct access—some unrestricted, some provisional or limited.

In this setting, how do we as PTs maximize autonomy?

In your daily practice as a PT, how often have you received an evaluation request from a physician who provided a patient diagnosis of nothing more than “back pain”? How about a prescription with boxes checked for *all* interventions? Have you received a request to provide a treatment for which there is no demonstrated efficacy or effectiveness?

Many physicians are not well-versed in the particulars of physical therapy. It’s up to the PT to ensure that the services provided are reasonable, necessary, safe, appropriate, and efficacious. The PT—not the physician—should be writing the plan of care. Those of us who already practice in direct access states are tasked with educating physicians about advances in PT practice. Those of us awaiting unrestricted direct access also are tasked with educating physicians and preparing them for the inevitability of direct access and PT autonomy.

Looking at this task, we know that each care setting presents its own unique challenges. One growing model of care in which a culture of autonomy has been working is the Program of All-Inclusive Care for the Elderly (PACE— www.medicaid.gov/medicaid/ltss/pace/). It was started 48 years ago to bridge gaps in care for elderly residents and allow them to live longer at home. The original PACE program, On Lok (www.onlok.org), ultimately became full-fledged and funded by Medicare and Medicaid.

Participants who are enrolled in PACE receive medical and nursing care, PT and occupational therapy (OT) services, social services, and mental health services through a day health center where

they also receive supervision, various levels of personal assistance, lunch, and transportation services. Home care services include assistance with light housekeeping and personal care in addition to any skilled home health care that is required.

Physical functioning is tracked by PT and OT assessments every 6 months and compared with an initial baseline established upon enrollment in the program. The goal of the program is to keep seniors in their homes, and out of skilled nursing facilities, for as long as possible. PT and OT services aid in achieving this goal by providing or recommending programs, equipment, and services to help maintain physical functioning and slow the progression of functional impairments.

Within this model, there is an emphasis on team decision-making. Even physician decision-making considers the team’s input. The expertise of each discipline is valued, respected, and weighted equally.

The cornerstone of a functional interdisciplinary team is communication. We all know this, yet in too many settings we’ve seen team meetings devolve into either a cursory event focused on ticking off points to appease regulatory bodies or a disorganized venting session rather than a meaningful discussion of an individual’s plan of care.

In a typical PACE care planning meeting, each team member weighs in on care concerns for which there is not a definitive answer. Clearly, the opinion of the staff member with the greatest expertise in that area carries the greatest and most persuasive weight, but everyone has the opportunity to question that judgment and provide input. Communication occurs throughout the day to ensure that each team member is made aware of changes in condition and changes in the plan of care. This

interdisciplinary model allows for appropriate physical therapist autonomy.

For example, consider a program participant who is reported by staff to have difficulty walking after a fall occurring the same day. The PT, as part of the team communication loop, independently decides to speak with the participant to verify this information and adjust the plan of care as needed. There is no need for a “physician order.” It may be that the participant is screened by the PT and found to have had transient pain and an antalgic gait immediately after the fall, but it has largely resolved already. Rather than having to address an unnecessary physician order for “PT eval and treat for difficulty walking,” the PT has ensured appropriate utilization of services.

Success in this model rests on 2 factors. The first is the support of management within the organization. Management, as with the physician, needs to be aware that the PT is the expert in his or her own field. The second factor is the support of physician leadership. The PT has a much easier road enlisting support in an environment in which team communication and collaboration are hallmarks. The burden then becomes ours: to voice our expertise, to show our sound clinical reasoning, and to share our understanding of practice regulations and coverage guidelines.

In today’s climate of astronomical health care costs, PTs should bear the responsibility and accountability for their own utilization. However, it is unreasonable to expect a clinician to carry that burden without reasonable autonomy in the decision-making process. We, in health care and in the nation, are all looking for better models of care. Programs such as PACE, which promote appropriate levels of autonomy within a strongly collaborative team, are better models.

Julie Jeung, PT

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Why Does This Code Pay This Amount?

A look at the Relative Value Scale Update process.



Carmen Elliott, MS, is vice president of payment and practice management at APTA and is a certified association executive.

A widely anticipated event every summer is the Center for Medicare and Medicaid Services' (CMS) release of its proposed physician fee schedule for the following year—which, once finalized, will determine payment rates for physical therapists (PTs) and other health care providers. (The proposed rule for 2020 has been released, and after CMS considers comments from stakeholders—including APTA—a final rule will be announced before the end of the year.)

One aspect of the fee schedule is the values of the various Current Procedural Terminology (CPT) codes that health professionals use to report the services they provide. Since these values affect how much PTs will be paid in the coming year, members often ask how they are determined.

The federal government uses a standardized

provider payment schedule based on what is called a resource-based relative value scale (RBRVS). In the RBRVS system, payments are determined by the various costs needed to provide each service identified by a CPT code. The cost is divided into 3 parts: provider work, practice expense, and professional liability insurance. Each part is assigned a certain

number of units, called relative value units (RVUs). Payments are calculated by multiplying these combined units by a conversion factor (a monetary amount determined annually by CMS), and adjusting for geographical differences that affect costs.

This column will focus on the provider work component.

Parties Involved in Determining Values

Values are updated each year to account for changes in medical practice. (CMS is required to review the whole scale at least every 5 years.) Two key committees and a review board of the American Medical Association (AMA) are involved in determining relative values for the provider work component of the RBRVS.

The AMA Relative Value Scale Update Committee



(RUC) comprises representatives from specialty health care societies whose members use CPT codes to report the services they provide to Medicare patients and are paid for these services based on the RBRVS payment schedule.

The RUC Health Care Professionals Advisory Committee (HCPAC) consists of 12 organizations, representing PTs, physician assistants, audiologists, chiropractors, nurses, occupational therapists, optometrists, podiatrists, psychologists, registered dietitians, speech pathologists, and social workers. (APTA has a representative on HCPAC.)

HCPAC members, together with 3 physician members of the RUC, compose the RUC HCPAC Review Board, which is responsible for developing relative value recommendations for CPT codes. These recommendations are submitted to CMS for new, revised, and potentially misvalued codes. CMS isn't required to accept the RUC HCPAC recommendations, but it does consider them in its decisions.

The Payment Formula

The formula for calculating the total value of a CPT code takes into account many factors, including geographic practice cost indices to account for cost-of-practice differences among locations. From the viewpoint of the individual provider billing the CPT codes, perhaps the most significant factor is the provider work value component, as it represents approximately 51% of the total RVUs for each service billed to a CPT code. Within the total value of the provider work component are the following factors:

- Provider time required to perform the service
- Technical skill and physical effort
- Mental effort and judgment
- Psychological stress due to the potential risk to the patient

Preservice, Intraservice, And Postservice

In addition, the provider work component is divided into preservice, intraservice, and postservice periods,

representing the time a provider spends before, during, and after a procedure.

Preservice work may include time spent to review records, solicit informed consent, prepare equipment, communicate with other professionals, and position or otherwise prepare the patient.

Using CPT code 97530—therapeutic activities—as an example, preservice includes review of the medical record, including any communication from a referring physician or other health care provider(s), and preparing to see the patient.

Intraservice is the actual performance of the procedure. For PTs, intraservice typically includes the services provided while the clinician is with the patient and/or family or another caregiver. (In the case of, say, surgery, intraservice is considered “skin-to-skin” time or its equivalent for procedures that don't involve incisions. For providers who bill for evaluation and management services, intraservice is “face-to-face” time in an office, or “unit” or “floor” time in a hospital.)

Compliance Matters



For More Information

For additional insights into the RUC process and its relationship to payment, visit APTA's coding and billing page at www.apta.org/Payment/CodingBilling/. There, you'll find links to podcasts, courses, issues and interpretations, and more.

Returning to the CPT code 97530 example, intraservice would include checking the patient's muscle strength, weight-bearing tolerance, balance, and functional level (including, if appropriate, cognitive function); designing, initiating, and modifying activity-based interventions; grading the patient's activity to improve skills or develop compensatory strategies; demonstrating actions to ensure the patient's safety in performing the activities themselves; and instructing the patient in techniques to be continued at home.

Again using the example of CPT code 97530, postservice includes analyzing data collected during the patient's visit, preparing reports, arranging further services if needed, documenting the evaluation or reevaluation and the plan of care, and communicating further with the patient and with other professionals such as the referring physician.

What's in the Package?

Each pre-, intra-, and postservice component of a code is assigned a "time package"—the predetermined, designated maximum time allowed for the component, based on the

procedure type, patient condition, and site of service.

To collect field data that helps the AMA RUC select appropriate time packages for recommendation to CMS, the RUC often conducts surveys that are administered by the professional society representing the providers who use the code being valued. For example, for CPT code 97530, the preservice time is 2 minutes, intraservice is 15 minutes, and postservice is 2 minutes. The code valuation includes 4 minutes of non-face-to-face time per 15-minute unit billed. In other words, every time a PT bills for 15 minutes under code 97530, he or she is being paid for a total of 19 minutes.

Surveys for collecting data on time spent on the specific components of a service are important because they help determine accurate and reasonable rates that Medicare and other payers pay for procedures. APTA has conducted a few of these surveys in recent years—when the new tiered evaluation codes were introduced, and when many physical medicine and rehabilitation codes underwent CMS' routine review of the codes in that category.

Member participation in these surveys is critical to help inform CMS' decisions on code values. APTA disseminates the surveys as part of its commitment to collaborating with AMA and CMS in maintaining the validity of the RBRVS process—and ultimately improving payment of services. ■

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Total Knee, Partial Disclosure?

A PT faces a determination at discharge.



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

Informed consent is the process by which physical therapists (PTs) and other health care providers disclose appropriate information to empower patients to decide whether to accept or refuse treatment.¹ Its elements include the nature of the procedure; reasonable alternatives to the proposed intervention; relevant risks, benefits, and uncertainties of each alternative; assessment of the patient's understanding; and the patient's decision, based on the preceding elements.²

Consider the following scenario, in which another aspect of care—collegiality and consensus among members of the interprofessional care team—comes into play.

Divergent Directions

At Mercy Hospital, an acute care hospital in the suburbs of a large Midwestern city, PTs work in close collaboration with other members

of a multidisciplinary health care team to see that patients are discharged expeditiously but safely, with the tools they need for optimal recovery and minimal risk of readmission. The prevailing atmosphere of mutual respect and camaraderie is what has kept Lara at Mercy, despite a few opportunities in recent years to work elsewhere for higher pay.

On the orthopedic surgery floor, where Lara works, the hospital requires that she and her fellow PTs explain the discharge plan to the patient, then obtain the patient's signed consent to the plan before passing the paperwork along to the physician for final approval.

Communication among members of the health care team is so strong at Mercy, and the sharing of professional viewpoints so robust, that Lara feels she fully understands the reasoning behind each aspect of the discharge plan and can relate it to the patient with full confidence that his or her needs and goals are being met appropriately.

One Friday morning, Lara walks into room 319 to prepare Matt and Jeff for discharge. The roommates are men in their early 70s who have undergone uncomplicated total knee arthroplasty (TKA)—Matt on



his left knee and Jeff on his right. Although they've been at Mercy for only 2 days, the retirees already are well-known and widely liked.

They joke about how they now will combine their "good" knees to create "a single super-mobile dude." They playfully ask the nurses which of them will be the best "bionic golfer." They've held wheelchair races and wielded their canes in an impromptu "duel"—complete with shouts of "En garde!" One of the social workers has dubbed them "Mutt and Jeff," after the comic-strip characters of bygone days. The name has stuck. In fact, Matt has taken to calling himself Mutt—and his wife "Mrs Mutt."

Approaching Jeff first, Lara asks if he'd like to receive his discharge instructions in a consultation so that he'll have full privacy. He responds, "I don't care if

that old geezer is listening," and points to Matt. "Anyway," he adds, "there's a few feet between the beds, so he probably won't be able hear you."

As Lara pulls out the curtain separating the beds, Matt responds, "My ears are sharper than yours, you old coot!"

Lara explains to Jeff that his discharge planner already has set him up with a PT for a week of home care, after which he'll be ready for outpatient visits as his road to recovery progresses. She reviews his discharge exercises with him, answers his questions, and has him sign the discharge plan. The next step, he explains, will be approval by Jeff's surgeon, Jim Ambrose, "and then you'll be good to go."

Now it's Matt's turn. Lara thought she had quickly skimmed his discharge plan before she entered the

room, but she now sees, to her discomfort, that she'd wrongly assumed it would be similar to Jeff's. Matt's surgeon, Paul, has a conservative bent toward rehab and sometimes needs to be convinced that early physical therapy postsurgery is appropriate. But Lara's rapport with Paul is good. She even told one of her fellow PTs recently, "Paul is really getting it. Our conversations about physical therapy are getting shorter and more positive all the time."

Paul's discharge plan for Matt, however, calls for the patient to use continuous passive motion (CPM) for at least 3 weeks—and for physical therapy to be considered only thereafter, if Matt doesn't make sufficient progress. Lara is surprised and bewildered by Paul's instructions. She and he even discussed CPM on one occasion, after he'd told her that he'd seen "good

results" with the machines post-TKA when he worked at another hospital.

Taking care not to directly contradict him, she had cited research favoring early mobilization post-TKA over the costs, inconvenience, and risks of prolonged bedrest associated with CPM. (What she did not say to Paul was that number 4 among the "Five Things Physical Therapists and Patients Should Question"³—per the Choosing Wisely campaign against unnecessary medical tests, treatment, and procedures—is "Don't recommend continuous passive motion machines for the postoperative management of patients following uncomplicated total knee replacement.")

Lara nevertheless dispassionately reviews the discharge plan with Matt, asking him afterward if he has any questions. Before Matt can say anything,

however, Jeff exclaims from the other side of the partition, “It sounds like I’m going to be working my butt off with a PT while Mutt over there is going to be lying around, letting a machine do all his work for him! What’s that about?” Jeff then adds, “I guess it’s because Dr Jim knows that I can take it, whereas Dr Paul has correctly diagnosed that his patient is a bit of a snowflake!”

Matt laughs at the dig, but then challenges Lara, “What *is* that about? I’m tougher than Old Man Jeff any day of the week!”

Choosing her words carefully, Lara explains that different surgeons favor different approaches post-TKA, based

on their experiences with patients and what they feel will best benefit each individual. She concedes that there’s a “school of thought that finds CP problematic,” but she adds that Paul has seen good results in patients who use the machine.

“Let’s cut to the chase,” Matt responds. “Which approach do *you* think is best for me? You know that my goal is get out on the golf course ASAP. Which thing is going get me there faster while still being safe—rehab with a PT or doing a tango with this machine?”

“Tango’s a good word for it,” Jeff interjects from the other side of the partition, “because it sounds like you’re

getting a song and dance, instead of the doc coming right out and telling you that you’re not tough enough to handle physical therapy.” Both men laugh at that remark.

Lara feels conflicted. On the one hand, she doesn’t want Matt to sign the discharge plan without her fully informing him about CPM. On the other hand, however, she knows that Paul will be upset if his patient should refuse to sign off on the discharge plan based on her comments. Lara wonders what the wider repercussions might be for interdisciplinary collegiality on the orthopedic surgery floor. She’s hesitant to risk any perception that PTs aren’t “team players.”

Considerations and Ethical Decision-Making

Lara appreciates the respect that PTs and the profession of physical therapy are accorded by other members of the interprofessional health care team on the orthopedic surgery floor at Mercy Hospital. She fears not being seen as a team player if she provides Matt with all the information he needs in order to provide consent that is truly informed, and he declines to sign the document. But might a decision by Lara not to disclose this information actually reflect poorly on her place in a care model built on principles of interprofessional equality and mutual respect?

Realm. The ethical realm is *individual*—between Lara and Matt, and between Lara and Paul. There are potential implications for the *institutional/organizational* realm as well, given hospital policy on the roles of PTs and surgeons in the patient-discharge process.

Individual process. *Moral courage* is required of Lara, as implementing what she has identified as the appropriate ethical move—ensuring that Matt is in position to give his informed consent—promises to cause adversity with Paul and perhaps with other care team members, as well.

Ethical situation. This is an *ethical distress* for the PT, in that she fears that empowering Matt will adversely affect her and her profession’s standing within the interprofessional care team.

Ethical principles. The following principles of the Code of Ethics for the Physical Therapist provide counsel to Lara:

- **Principle 2C.** Physical therapists shall provide information necessary to allow patients or their surrogates to make informed decisions about physical therapy care or participation in physical therapy research.
- **Principle 2D.** Physical therapists shall collaborate with patients/clients to empower them in decisions about their health care.
- **Principle 3A.** Physical therapists shall demonstrate independent and objective professional judgment in the patient’s/client’s best interest in all practice settings.
- **Principle 3B.** Physical therapists shall demonstrate professional judgment informed by professional standards, evidence (including current literature and established best practice), practitioner experience, and patient/client values.

“So, what do you think?” Matt repeats. “What’s best for me—machine or mortal?”

For Reflection

Paul’s discharge plan reflects his professional judgment of what’s in Matt’s best interest. Lara doesn’t agree with Paul’s thinking, but she must decide whether to share information that may result in Matt rejecting Paul’s plan—with potential implications beyond the surgeon’s displeasure. Have you been in a similar situation? What did you do? How did the matter play out?

For Followup

If you are reading the print version of this column, go online to www.apta.org/PTinMotion/2019/9/EthicsinPractice/ for a selection of reader responses to the scenario, as well as some of 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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resources

At www.apta.org/EthicsProfessionalism/

- 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”

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Menopause: PTs Help to Ease 'The Change'

Sometimes overlooked, physical therapy can be highly beneficial in helping women through and beyond this phase of life.

BY DANIELLE BULLEN LOVE

"We need to educate people to change the perception. It can be a time of opportunity," says Karen Snowden, PT, DPT, a physical therapist (PT) who is board-certified in women's health physical therapy and practices at the Lehigh Valley Health Network in Pennsylvania.

She is speaking about menopause.

Every woman who lives long enough will experience this life transition. Yet many PTs are unaware that their skills as movement experts can help prepare women for menopause, ease some of its side effects, and contribute to a longer, healthier life. Physical therapy for women prior to, during, and beyond menopause is a largely untapped niche for women's health providers and an opportunity to reach patients across the lifespan, say the PTs interviewed for this article.

Menopause occurs when estrogen and progesterone decrease and a woman's ovarian function stops. It's defined as happening when a woman misses menstruation for 12 consecutive months, barring other medical causes. (See "Menopause in Brief" on page 21.) Approximately 6,000 women enter menopause each day in the United States.¹ According to the North American Menopause Society, it occurs most often between ages 45 and 55, with 51 the average.²

Screening Tools

Several screening options are available to providers to gauge the impact of menopause on women's health. Denise Hartzell Leggin, PT, MBA, uses the Menopause Rating Scale.³ Hartzell Leggin, a women's health clinical specialist who practices at

Penn Therapy & Fitness Radnor in Pennsylvania, is board-certified in women's health physical therapy. Using the scale, women rank elements of their sexual, urinary, musculoskeletal, and mental health. Physicians can order bone density scans and share the results with their PT colleagues.

Both Snowden and Karen Litos, PT, DPT—owner of No Mom Left Behind Physical Therapy in Okemos, Michigan—recommend the Fracture Risk Assessment Tool (FRAX®).⁴ That test analyzes osteoporosis risk in postmenopausal women. It can be taken online and includes questions about age, smoking, family history of hip fracture, glucocorticoid (eg, Prednisone) use and arthritis, and femoral neck bone mineral density. If a woman is at a particular risk, the tool suggests treatments.



Litos—who also is board-certified in women’s health physical therapy—and Snowden also recommend SARC-F, a 5-item questionnaire administered by practitioners to predict a woman’s risk of sarcopenia, the loss of muscle mass due to aging.⁵ PTs also use manual muscle testing in the clinic.

PTs and other clinicians can use the results of these various assessments to create personalized treatment approaches. Menopause produces many physiological changes, which generally can be grouped into 2 broad areas—pelvic floor health and musculoskeletal health.

Pelvic Floor Health

“Pelvic muscle function is affected by lifestyle, anatomy, and genetic and reproductive factors, as well as



aging,” notes Hartzell Leggin, who was part of the first cohort of PTs to be board-certified in women’s health.

Pelvic floor dysfunction is an umbrella term “describing pelvic muscles not performing optimally,” Hartzell Leggin says. “This may present as urinary incontinence, pelvic organ prolapse, fecal incontinence, constipation, pelvic pain, and/or sexual dysfunction.” These issues can present throughout a woman’s lifespan, but the normal physiological process of aging, menopause, and lifestyle activities may contribute to these symptoms. For example, work demands such as heavy and repetitive lifting, improper exercise mechanics and voiding patterns, and excess body weight stress the pelvic floor and cause damage over time.

Many effects of menopause are inter-related. For example, constipation

can relate to urinary leakage. Getting up at night to use the bathroom can be associated with injury, as women may slip and fall when they are drowsy or in unlit rooms.

As with various other conditions cited in this article, urinary incontinence is not caused by menopause. It can, however, be exacerbated by pelvic floor weakness as women age. Holly Tanner, PT, DPT, MA, founder of Flow Rehab in Seattle—a practice

specializing in pelvic dysfunction, orthopedic issues, and chronic pain—notes that incontinence and prolapse are not natural results of aging. Tanner is board-certified in both orthopaedic and women’s health physical therapy and is a certified pelvic rehabilitation provider by the Herman & Wallace Pelvic Rehabilitation Institute.

Pelvic floor therapy is recommended as the first defense against urinary incontinence. In the APTA video “Incontinence: Treatment by a Physical Therapist,” Carrie Pagliano, PT, DPT, president of the Section on Women’s Health (SOWH), explains, “The pelvic floor muscles act like a sling between the pelvic bones to help support the bladder.”⁶ Like Tanner, she is board-certified in both orthopaedic and women’s health physical therapy.

The video suggests that biofeedback can assess pelvic floor muscles and determine if they contract when appropriate. PTs can teach women to retrain those muscles.

Pelvic organ prolapse occurs when the colon, uterus, and bladder collapse into the pelvic canal, causing pain and pressure. Loss of estrogen, a naturally occurring feature of menopause, promotes tissue loss and weakens surrounding tissues and muscles. Women who have had at least 1 vaginal birth have a 50% chance of prolapse, which may or may not be symptomatic, says Hartzell Leggin. Pelvic floor issues aren’t as common in women who never had children, but they do exist, she adds.



“Pelvic muscle function is affected by lifestyle, anatomy, and genetic and reproductive factors, as well as aging.”

— DENISE HARTZELL LEGGIN



“Weight gain can affect pelvic health issues such as urinary incontinence and pelvic organ prolapse.”

— HOLLY TANNER

Weighty Matters

Vaginal delivery is not the only factor contributing to organ prolapse. “Weight gain can affect pelvic health issues such as urinary incontinence and pelvic organ prolapse,” notes Tanner.

Weight gain is common in menopausal and postmenopausal women, and the loss of estrogen results in redistribution of weight to the abdomen. It’s a vicious cycle, PTs say, as pressure created by the shifting organs can make exercise uncomfortable. Prolapse also can cause sacroiliac pain, another condition that can discourage working out.

To determine the strength of pelvic floor muscles, PTs can test muscles intravaginally with a digital exam. They then can suggest core exercises to strengthen pelvic floor muscles. In addition, Tanner says, women should be aware of their holding patterns. “Some folks have a habit of creating pressure in their trunk that presses down on the organs in their pelvis,” she points out. “They need to be taught how to manage these pressures, and that can include their pelvic floor muscles.”

Tanner recommends that women be assessed by a PT prior to menopause to gauge strength, coordination, and relaxation.

Sexual Dysfunction

Pelvic floor physical therapy also can improve sexual health as women move through menopause. Tissue thinning caused by estrogen depletion can lead to vaginal dryness, irritation, and pain during intercourse. In the CLOSER (Clarifying Vaginal Atrophy’s Impact on Sex and Relationships) survey, 58%

of women who are postmenopausal cited avoiding intimacy because of vaginal discomfort.⁷

For some women, a topical estrogen cream is helpful. CLOSER reported that 56% of women who used locally applied estrogen therapies experienced less painful sex. For others, however, a more comprehensive approach—including manual therapy, exercise, and perhaps hormones—was needed.

Multiple factors beyond tissue irritation can influence a woman’s sexual health during and after menopause. Low back and hip pain can make it difficult to find a comfortable position for sex. A PT can prescribe exercises to improve hip mobility.

Body image issues are another factor. If women who are menopausal are—or feel—bloated, they might be less interested in sexual activity. Nina Olson, PT, DPT, who practices at Freedom Physical Therapy Services in Wisconsin and earned a certificate of achievement in pelvic physical therapy (CAPP) through the Section on Women’s Health, remarks, “Body changes can be upsetting to women during this time.”

Many women do not approach their health care provider with pelvic floor problems, Olson notes. For that reason, she says, it’s the responsibility of the practitioner to ask about bowel, bladder, and sexual health, and direct women to the right resources.

Losing Bone and Muscle Mass

Loss of estrogen during menopause affects more than pelvic floor health. Bone strength and density decrease

MENOPAUSE IN BRIEF

Menopause is defined as the time when the ovaries cease functioning and menstrual periods stop, marking the end of the reproductive years. A woman is considered to have reached menopause when she has stopped having a monthly period for 12 consecutive months. The North American Menopause Society points out, “It is not a disease. Menopause is a normal, natural event.”¹ It occurs on average at age 51, and most often between the ages of 45 and 55.

A major effect of menopause is a significant decrease in estrogen, which can cause vaginal dryness, night sweats, and hot flashes. Estrogen loss also can increase the risk of certain diseases, such as osteoporosis, which leads to hip, wrist, and spine fractures. Approximately 50% of women over the age of 50 will experience an osteoporosis-related bone fracture.²

Menopause is the culmination of a process that can begin several years before the final menstrual period. The transitional stage leading up to menopause is called perimenopause, which lasts on average about 4 years. While life expectancy has increased over the years, the age of menopause has not changed during the past few centuries.

An estimated 6,000 American women reach menopause every day. With increasing life expectancy—half of all women who reach age 50 will live to be at least 80—many women will spend up to 40% of their life in the postmenopausal stage.

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as a woman ages. Starting with the year before menopause begins and extending until its conclusion, a woman can lose about 6% of her bone mass within a 3-year time period, Litos and Snowden say. Estrogen depletion leads to osteoporosis. As a result, during their lifetimes 50% of women will break at least 1 bone due to osteoporosis.⁸

Olson notes that sarcopenia begins before menopause, usually in a woman's 40s. Thirty percent of women in their 60s experience sarcopenia. As women age, muscle is replaced by fat. By age 70, a woman can lose between 30% and 50% of her muscle mass, as muscles become infiltrated with fat, say Litos and Snowden.

Wellness Education

PTs can help turn the tide with regard to loss of bone and muscle mass.

For one thing, “we support the idea of being proactive,” Snowden says. She encourages PTs to talk to younger women about building bone and muscle strength well before the onset of menopause.

Litos and Snowden presented “Staying Fit Beyond Menopause Through Early Screening and Training” at APTA's Combined Sections Meeting (CSM) earlier this year. They emphasized early intervention for diseases and symptoms associated with hormonal changes brought on by menopause. According to the session handout: “Unfortunately, women miss their best window of opportunity to modify risk factors in the years prior to and immediately following menopause. PTs, as musculoskeletal experts, are in a unique position to help more women through early screening, education, and specific training to maximize bone and muscle strength for improved health post menopause. Specific lifestyle changes can build and maintain bodily strength before, during, and after the menopause transition, positively impacting a woman's health long term.”⁹

“Pilates is fantastic for any age group. Its focus is on improving lower abdominal strength and promoting spine flexibility.”

— NINA OLSON



Building Strength

Exercise improves quality of life of women who are menopausal and postmenopausal. And it's never too late to start, says Jean Irion, PT, EDD, ATC, chair and director of the physical therapy program at Emory University in Atlanta and at Emory & Henry College in Virginia. She notes that studies have found that women who begin an exercise program in their 60s, 70s, or even 80s can slow bone loss.

Exercise also has been shown to reduce other disruptive side effects of menopause, such as hot flashes, insomnia, and painful intercourse, according to Olson.

Irion, who is board-certified in sports physical therapy, points out the benefits of various forms of exercise. Weight gain is common during and after menopause. Aerobic exercise, balance, and resistance training build bone and muscle strength.

Building muscle tissue increases metabolism and burns more calories. Core strengthening activities such as planks improve the stability of lower abdominal muscles.

Cardiac health is important for women who are menopausal and postmenopausal, Irion continues. Changing hormone levels can lead to hypertension, and loss of estrogen causes microvascular changes on the cardiac wall that can contribute to heart disease. Enhancing cardiac health needn't require a solid hour of elliptical or exercise bike training, Irion notes—interval training increases heart activity as well.

At CSM, Litos said, “Heart disease is the leading killer of women premenopause, and estrogen is protective. But postmenopause, women are as affected by heart disease as are men. Women can lower their risk of heart disease by 80% with a healthy lifestyle.”



High-impact activities, such as jumping, put force on bones to encourage their growth. “I want to target big muscle groups, so I do squats and lunges to get the glutes going,” remarks Olson. She also suggests dynamic balance exercises.

Balance is important because women are more susceptible to falls as they age.¹⁰ Combination activities such as yoga, dancing, or tai chi challenge balance and posture and improve proprioception. Hip-strengthening exercises are beneficial because hips are a common site for fall-induced fractures. Resistance training builds bone mineral density.

Some PTs add another element to exercise programs. Olson incorporates Pilates-based interventions into her practice. She explains, “Pilates is fantastic for any age group. Its focus is on improving lower abdominal strength and promoting spine flexibility.”

Pilates cues and strengthens the pelvic floor, Olson says—calling it a “fun way to do Kegels.” Engaging

women in activities that are interesting encourages them to continue with the exercises, she says.

Aquatic Approach

Irion advocates aquatic therapy for women in this phase of life. Her clinical practice emphasizes women’s health, aquatic therapy, sports physical therapy, and occupational health. “When you look at women with a particular diagnosis, you have to ask, ‘Might water offer them a comfortable and safe place to exercise?’” For menopausal and postmenopausal women, aquatic therapy provides multiple benefits.

First, though, the PT must understand the physical properties of water and fluid dynamics—including hydrostatic pressure, buoyancy, cohesion, and viscosity—and how they can benefit patients.

“Working in a gravity-resistant environment on land is challenging,” Irion says. The properties of water enhance movement yet also provide resistance.

muscles and improve bone density, Irion says, adding that this can be especially helpful for those with osteoporosis. Litos adds that aquatic exercise reduces the number of falls that otherwise might occur with vertical high-intensity exercises.

No matter the format, physical activity improves quality of life for women and decreases pain associated with musculoskeletal changes. Litos explains, “Anyone who exercises can reduce their reliance on pain medication. That’s why physical therapy has been shown to be more effective than opioids.” Movement helps manage the pain.

Outreach to and Beyond Physical Therapists

Too often, though, PTs are not the first health care professionals considered by women who are experiencing difficulties from menopause. “We need to educate female patients to change their perceptions and encourage them to engage in proactive health behaviors to reduce their risks,” Snowden says. “We have an opportunity to help women who are in midlife improve their long-term health and quality of life.”

“There are several points of contact that need to be improved,” Tanner says. Education starts with PTs themselves, who may not fully be aware of how they can help with menopause-related issues.

That could be because women’s health education is not covered in detail in most DPT programs, Litos says. She urges that comprehensive coverage of pelvic health be included or expanded in the curricula. And after graduation, PTs with knowledge of women’s health shouldn’t be limited to outpatient orthopedics. Instead, Tanner suggests, pelvic floor therapy needs to be a part of home health physical therapy, inpatient geriatrics, and other settings.



“I love doing balance exercises with women in the water. It’s fun, it’s challenging, and patients don’t have the fear of falling they experience on land.”

— JEAN IRION



In the therapy pool, the challenges of gravity dissipate. The pool can provide an enhanced environment for exercise.

Irion continues, “I love doing balance exercises with women in the water. It’s fun, it’s challenging, and patients don’t have the fear of falling they experience on land.”

In the water, a woman and her PT can work on site-specific strength training. Women can maintain better posture in the pool to strengthen their

Continuing education in this field is vital, say PTs interviewed for this article. Snowden and Litos developed and teach a continuing education course for SOWH called “(Pre) Menopause Matters in Physical Therapy: Early Planning for a Healthier Future” (www.womenshealthapta.org/menopausematters). It was designed, they say, to put PTs and physical therapist assistants at the forefront of menopause practice.

Outreach to physicians and other health care practitioners also bears improvement. “As health care is evolving, we recognize that a collaborative team approach is what’s best for the patient,” remarks Olson. PTs should encourage women to seek out specialists for different aspects of their care. For example, an endocrinologist can help with thyroid issues. A dietitian can get women on a healthy eating track. A mental health professional might be appropriate for patients with anxiety, depression, or body image issues.

Reaching Patients

But perhaps the most important audience is the patient herself. “I have had many patients comment they didn’t know why it took so long to get to a pelvic health physical therapist,” says Hartzell Leggin.

Snowden agrees. “Women are frustrated that health care providers don’t offer more information and support related to menopause.” Patients have asked for help with menopause-related health concerns for years, she says.



PTs, they add, should directly promote their services to the public. Recreation centers, churches, and community fairs are just some places where women’s health PTs can present educational seminars, set up tables to distribute informational materials, and answer questions.

Tanner says, “Patients are our best advocates in terms of sharing information about what we can do.” After experiencing the benefits of physical therapy, menopausal women can advocate for this care to their friends and family.

Statistically, women live a third of their lives or more postmenopause, Litos points out. Early preparation can vastly reduce risks for diseases associated with hormonal changes and aging, maintain bone health and muscle strength, and improve quality of life through the lifespan.

Thirteen years ago, when she was editor-in-chief of the *Journal of Women’s Health Physical Therapy*, Nancy Rich, PT, PhD, wrote, “We must prepare women for menopause. We must educate women in their earlier years about the importance of strengthening the upper body to prepare for the day when the amount of estrogen decreases. Much like the discussions about developing bone strength to prevent osteoporosis, I propose that women should develop muscle strength to possibly prevent musculoskeletal problems.”¹¹

The same holds true today. “Women who have a positive outlook and receive accurate health information about this natural transition in life do well through the menopause transition and beyond,” Snowden says. ■

Danielle Bullen Love is a freelance writer.

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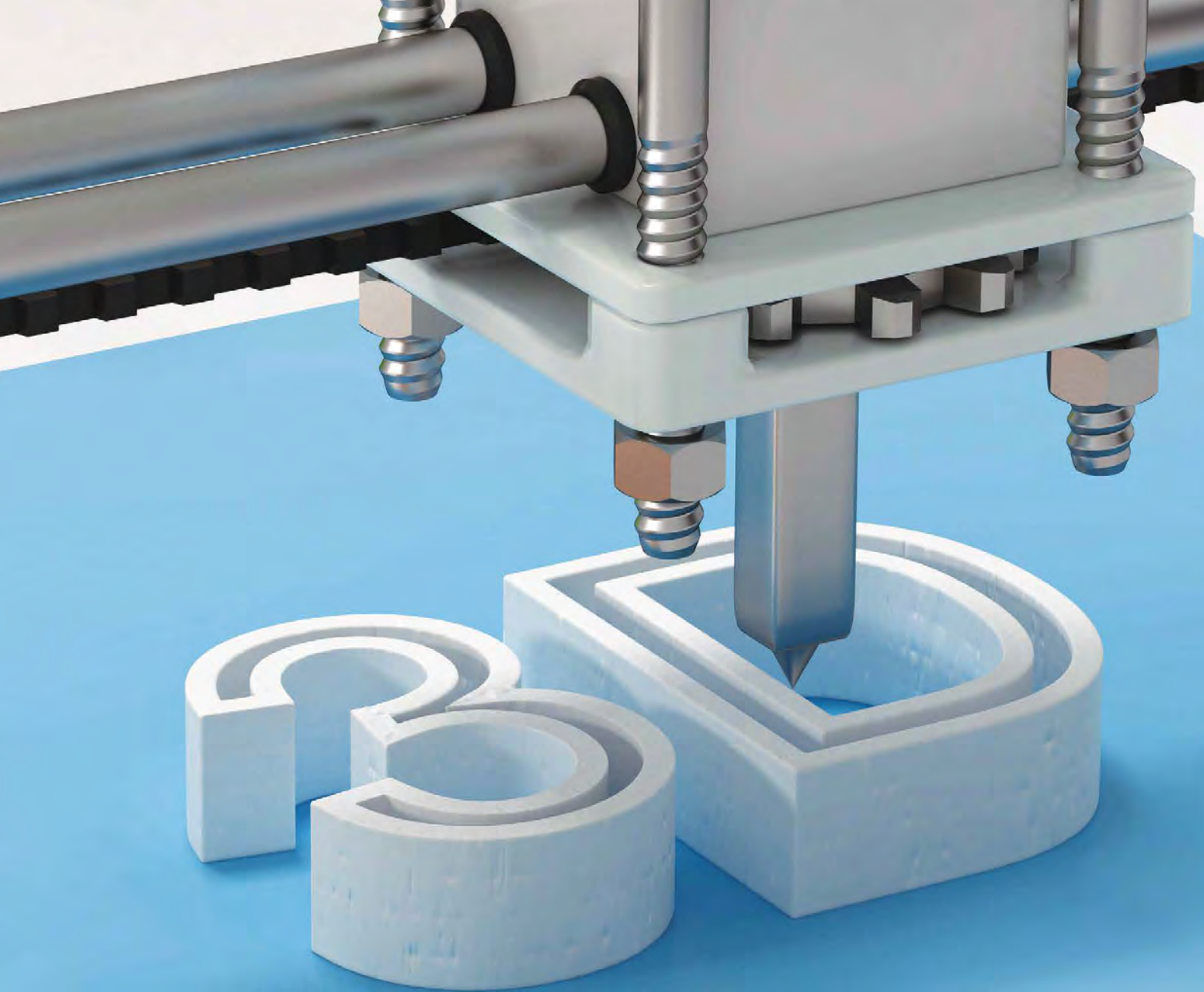
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A New Dimension To Physical Therapy

BY KEITH LORIA



“Several prototypes of an adaptive piece can be printed at low cost until the fit is just right.”

– KAREN GORDES

can produce modifications in line with developmental changes at less cost and faster turnaround time than by traditional methods,” she says.

Gordes was 1 of 4 PTs on this year’s APTA Combined Sections Meeting panel titled “Using 3D Printing in Physical Therapy: Competitive Advantage and Improved Care.” Also on the panel was Robert Latz, PT, DPT, of Trinity Rehabilitation Services in St Clairsville, Ohio. Latz points out that many patients need individualized modifications to equipment, be it a brace or support, or even a tool that makes their daily life a little easier. PTs traditionally have used splinting materials that have been heated and shaped to the patient’s anatomy. 3D printing is, in essence, a refinement of this process.

“As printers become faster, more accurate, and able to print with more materials, their use and function become even more important for us as clinicians,” Latz says. “Separately, physicians are using 3D printing in several ways—from creating bone scaffolding, to printing skin cells, to printing other body tissues. Some of these practices are in research stages. Even so, in physical therapy, we are seeing patients come in for treatment in which 3D modeling or regenerative processes might have been used.”

For example, a few years ago Latz worked with a patient who’d had a total knee replacement. A 3D image of the patient’s knee had been taken prior to surgery. Sizing of the replacement was

determined on the model, and then the surgical process completed. Today, this might be considered routine, but back then the process was just being developed, and Latz found the results impressive.

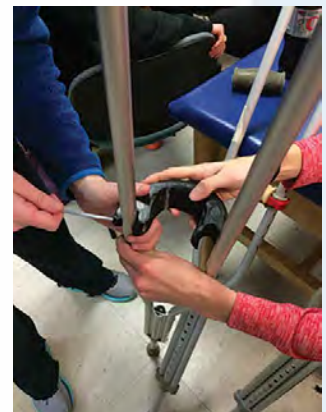
He also sees extensive potential for 3D printing involving insoles or shoe orthotics. In the past, he explains, PTs molded the foot shape, then created a hard plastic orthotic before grinding and smoothing the final product. Today, PTs can use a device that produces 3D images of the foot. Those images are converted into a program that can be read by a 3D printer, which then can print an accurate orthotic with smooth edges.

Outside the clinic, Latz has explored the capabilities of 3D printing with 2 printers he’s personally owned—both desktop varieties that cost him less than \$300.

Many PTs rely on non-PT specialists to deal with the technicalities of 3D design and printing. Drew Aufhammer, a California-based financial analyst, has turned his hobby of 3D printing into a business. He’s been constructing innovative tools for a nearby PT, primarily for use in myofascial release.

“I worked with the PT to model up his instrument ideas in CAD [computer-aided design] software and then 3D print them so he could test them out. He was quickly able to assess the effectiveness of his designs, and, due to the low cost and quick turnaround of 3D printing, he could rapidly refine his designs to produce an instrument that was extremely effective,” Aufhammer says. “The huge advantage of 3D printing here was the ability to quickly iterate designs in a cost-effective way.”

Aufhammer uses 3D printing as a rapid prototyping tool, according to an interview he gave for a YouTube program.² In that program, the PT determines that the cost to produce 2



Karen Gordes has used 3D printing to adapt equipment such as crutches.



What Is 3D Printing?

3D printing takes a digital model—a computerized blueprint of the physical object—and turns it into a physical 3-dimensional object by adding material a layer at a time.

The digital model is created using CAD (computer-aided design) software. Someone using a printer can design a 3D-printable model using CAD software or, frequently, find a model in a rapidly growing online repository.

As a guide from the company 3D Hubs describes the actual function, “The way a 3D printer works varies by process. For example, desktop FDM (fused deposition modeling) printers melt plastic filaments and lay it down onto the print platform through a nozzle (like a high-precision, computer-controlled glue gun).” That’s the most common 3D printing process; other techniques spray material on a surface, use lasers to melt and fuse powder particles, or bond and laminate sheets of material.

Depending on the size of the item and the type of printer, printing usually takes about 4 to 18 hours.

3D printing materials described in this article consist of either plastics—more common—or metals. Among the plastics are polylactic acid (low-cost and good for nonfunctional prototyping), acrylonitrile butadiene styrene, resin, nylon, polyetherimide (an engineering thermoplastic), and thermoplastic polyurethane (which has a rubber-like feel).

Among the metals used in 3D printing are stainless steel, aluminum, and titanium.

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“Just about anything you can think of can be created using a 3D printer, as long as the part is thick enough to support its own weight.”

– JESSICA PEPPER

tools using injection molding could be \$6,000. So, he provides Aufhammer with the information needed to design the tools on a computer. Aufhammer produces the tools using 3D printing, then uses the printed tools to make a silicone mold to produce small quantities of the tool. The PT tests the tools and makes appropriate tweaks.

Aufhammer comments on the video: “To get injection molding tooling for his tools would be a pretty costly investment at this stage, especially as he’s continually changing and iterating these designs. It wouldn’t worth it at this point to do [injection molding right now].”

Speaking of 3D printing in general, Aufhammer says its 2 major advantages for PTs over other manufacturing techniques are the ability to make items that are customized to the patient (such as prostheses, implants, assistive devices, braces, and splints) and the ability to more quickly develop specialized instruments by reducing research and development costs and time.

Jessica Pepper, PTA, who works at Team Rehabilitation Physical Therapy in Livonia, Michigan, has a strong background in computer modeling and rapid prototyping. She believes that barriers to greater 3D printing use by PTs and physical therapist assistants (PTAs) include the cost of a 3D scanner, users’ knowledge and computer skills, and software needed to convert that scan to a printable 3D model.

Still, she thinks it’s an investment worth making, in terms of both time and money.

“Just about anything you can think of can be created using a 3D printer, as long as the part is thick enough to support its own weight,” Pepper says. “It could be used for making a piece of an ankle-foot orthosis [AFO] that

has broken off. Or, you could make the whole AFO based on the amount of pressure in the foot and a scan of the foot.”

Jon Mehlferber, PhD, MFA, a professor of visual arts at the University of North Georgia who heads the university’s 3D printing efforts, says a growing number of PTs are recognizing 3D printing as a valuable tool to help them practice more effectively.

“In 2014, I began working with faculty and students in our PT department to develop 3D-printed assistive devices for children with severe disabilities,” he says. “We came up with solutions that include what could be described as hand braces and foot braces. These were customized based on 3D scans of the children and were printed overnight. Using this technology, we were able to create devices similar to those made traditionally by an orthotist.”

Made in the traditional way, those 4 custom devices would have taken 6 weeks to produce, at a cost of \$8,000, Mehlferber says. By using 3D scanning and printing, the department was able to produce them in 24 hours, at a material cost of \$20.

“When we started, we were more limited by what materials were available and by the scale of the objects we could make,” Mehlferber says. “Now, many more materials are available, and larger-scale prints can be made at a reasonable cost.”

Andrew C. Dragunas, PT, DPT, who works in the department of biomedical engineering and physical therapy at Northwestern University, also is a mechanical engineer, and he has been using 3D printers for several years.

“I would say the relationship between physical therapy and 3D printing is in its infancy,” he says. “A 3D printer is certainly not a common tool that you’d see in every clinic, but I am sure a few are embedded in PT clinics around the country. For the most part, the skills and experience needed to operate a 3D printer fit more into the realm of engineers, fabricators, and prosthetists and orthotists than they do with your typically trained PT.”

Dragunas has been using 3D printing for custom assistive devices, prostheses, and orthoses. But he’s also produced anatomical models for use in patient education. And he’s helped PTs design their own instrument-assisted soft-tissue tools.

“I’ve printed finger splints and flexible finger prostheses,” he says. “I’ve printed anatomical models of the knee joint for potential use in teaching. I’ve used Microsoft Kinect to take 3D scans of my classmates and have printed out 3D busts for their desks.”

Challenges

Like most technologies, 3D printing capabilities advance constantly. Also like most technologies, just because something *can* be done doesn’t mean

it’s easy. There’s a learning curve associated with the technology.

“Manufacturing a 3D-printed product that is safe, reliable, durable, and purposeful for a patient is an advanced skill that requires an investment in training and production time,” Gordes says.

Latz offers this scenario: “We might be able to 3D-print a brace or splint for an individual and give it to him today. However, if the patient does not return for us to check for future swelling or potential skin damage from the splint—or weakness in the materials—we might be better off choosing a more researched process for creating the splint.”

He also raises a concern not directly related to patient management. A PT technically might be able to print 25 ski-shaped tips for walkers and offer



Drew Aufhammer uses 3D printing to develop prototype tools for a PT to use in myofascial release.





them for sale to patients. However, Latz warns, in that scenario, the Centers for Medicare and Medicaid Services could question whether the practice now is acting as a durable medical equipment provider rather than as a PT. And that could lead to complications. As APTA explains: “There are many regulations governing the supply of DMEPOS [durable medical equipment, prosthetics, orthotics, and supplies] items for Medicare beneficiaries. Physical therapists should understand how supplier enrollment, accreditation, and competitive bidding impact their ability to provide these items to their patients.”³

Latz adds that 3D printers are a cutting-edge technology and, as such, may face legal challenges—or encounter liability issues related to items that are “printed.” Therefore, he says, a clinic should have policies and processes in place related to using a 3D printer and to the distribution of any device or tool printed in a clinic.

“We do not want to limit innovation, but we *do* want to encourage PTs and PTAs to protect themselves as much as possible,” he says. “Learn, become aware, and prepare for success for yourself and the patients with whom you have the opportunity to work.”

Material Improvements

New technologies are allowing—and will continue to allow—a greater variety of materials—a growing range of plastics and metals—to be printed.

“The ability to produce 1-off parts is a huge advantage of 3D printing,” Aufhammer says. “This was fairly cost-prohibitive with traditional manufacturing methods. Now parts can be easily customized to the end user and printed on demand.”

For example, a PT now can print a cane handle customized to an individual patient—though Latz notes that this



3D printing allows tools to be modified and tweaked inexpensively to produce 1-off parts, says Drew Aufhammer.

“The more customized the assistive device, the more comfortable it will be, and the more likely the patient will use it regularly.”

– JON MEHLFERBER

is just an extension of what PTs have been doing. “PTs have been creating individualized cane handles for many, many years,” he says. “Sometimes the handles are modified for the effects of rheumatoid arthritis. Sometimes they have incorporated a splint to support the joints. This same process can be replicated with a 3D printer instead of the thermoplastic sheet material we used in the past.”

He adds, “We need to learn and understand the development process a bit further so we know how to make them safer and more functional. This is true for any device we choose to print, whether it’s a brace, support, tool, or cane handle. So when we talk about learning and understanding the development process, PTs and PTAs can benefit from learning more about the types of printers, the types of materials that can be printed, and the process of 3D scanning—all of which

can help maximize the individualization possible with 3D printers.”

Latz explains that a PT could use an inexpensive desktop printer to quickly make a prototype. However, this prototype might or might not be as solid or safe as an actual, refined, finished product would be.

“On the other hand,” Latz adds, “we might choose to jump into the possibilities and purchase a \$50,000 or \$100,000 unit that can print multiple materials in very high resolution at very high speeds. In this scenario, maybe we choose to print a carbon fiber or metal-based splint. In this instance, we could print a safe splint or brace that’s very individualized and could be printed while patients wait.”

Gordes says there are many issues to consider, such as printer size, material selection, and the size of the product to be printed. All those factors influence



Prototyping a device not only is inexpensive, but it's much faster than using injection molding, according to Aufhammer.

how long it takes for something to print.

“Some objects can take hours to days to print,” she notes. “In those instances, it would be unrealistic for a patient to wait at a clinic for the product.”

Mehlferber emphasizes the value of 3D printing’s ability to make devices that are custom-fitted to an individual patient.

“The more customized the assistive device, the more comfortable it will be, and the more likely the patient will use it regularly,” he says. “There definitely is a relationship between ergonomics and safety. For example, left-handed people are more likely to experience accidents and injuries because they live in a right-handed world—from the design of scissors to the location and orientation of doorknobs, and the direction in which doors swing open or closed.”

Including 3D Printing In Physical Therapy Education

When Latz was enrolled in the University of Montana’s PT education program more than 30 years ago, he learned how to make individualized thermoplastic splints. He even had an extra class on the weekend, during which a thermoplastic supplier brought in sheets for the students to practice with. During that class, students talked about adding rubber bands, clips, and stabilizer loops to the splints that were created.

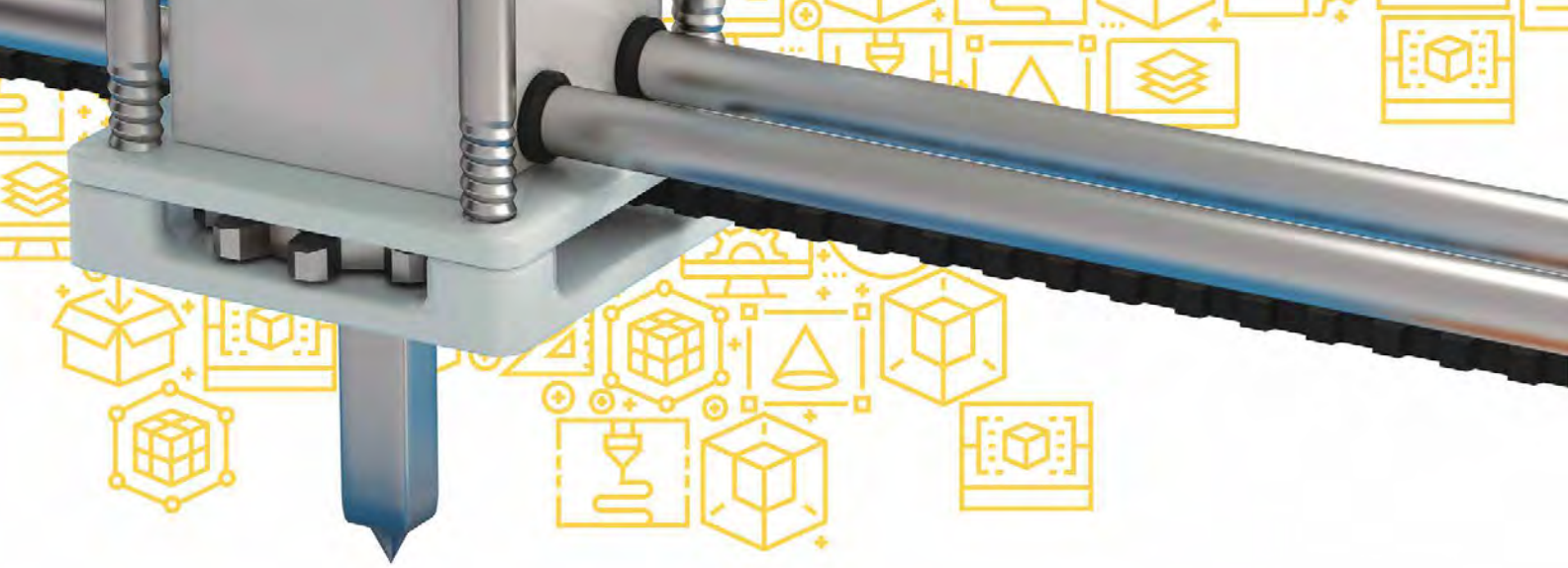
He believes this same development process—centered on 3D printing—should be happening within doctor of physical therapy (DPT) programs.

“We need to learn the technology and apply the development process to this new technology,” he says. “If we do not

do this, someone else will. I guarantee that the technology of 3D printing is only going to continue to improve and that the cost to create with this technology will continue to decrease. We need to educate our DPT students on how they might consider using these printers to improve care, based on critical evaluation of the needs and goals of the patient.”

Mehlferber, too, believes it is essential for DPT programs to introduce their students to this technology. “Every year that goes by without students learning about 3D scanning and printing will make them less able to be effective and competitive practitioners in their field,” he says.

Pepper, who is enrolled in a DPT program, agrees that she and other PT students should be educated about the possibilities and the technology underlying 3D printing.



“There will come a day, I believe, when every office and every PT clinic will have a very good 3D printer available and in constant use.”

– ROBERT LATZ

However, she adds that the DPT program isn't a computer modeling or engineering program, and students aren't programmers, so to be implemented in the clinic the process needs to be user friendly. “For example,” she says, “you might develop a program that could apply patient measurements to premade models.”

Based on the experiences Gordes has had with 2 classes that participated in a 3D-printing pilot program, she says students should be exposed to 3D printing technology but should not be required to demonstrate competence. “There is a significant learning curve to using 3D printing resources for health care needs,” she admits. “This may be an area for specialty practice and less of a requirement for graduating generalists.”

Setting a Clinic Apart

For a PT or PTA who has an interest in the technology and learns how to use the device, a 3D printer can distinguish a clinic from its competitors. Gordes sees a marketing opportunity for clinics to set themselves apart using

3D printing. However, she cautions the practice first to thoroughly assess how the new technology will be incorporated.

The printers could be used for more than building devices used for treatments. For instance, Latz has discussed the possibility of setting up a 3D printer in the reception area of a clinic and printing appointment chips as a visit reminder for the patient.

“One side would have our logo and the other their name. Then we could use a marker to write the date and time on a second chip, which previously had been printed,” he says. “The idea would be to use this as a way to let patients know we are ready to individualize their treatment as needed—even to the extent of making a special tool for them. This might be a tangible way to remind folks that we provide individualized care and that we balance technology and hands-on care.”

Initially, the ability to produce economical assistive devices could offer a practice a significant competitive advantage. But as time passes, those

interviewed for this article predict that the technology will become common practice, and the competitive edge will fade. In fact, patients could in time expect such technology, and facilities that *don't* offer it will be at a disadvantage.

Looking Ahead

Pepper says incorporating 3D printing into physical therapy initially would be helpful for quick fixes and perhaps for splinting. But she doesn't think PTs and PTAs understand the technology well enough yet. Still, she believes its adoption will happen quickly.

Latz says, “There will come a day, I believe, when every office and every PT clinic will have a very good 3D printer available and in constant use.” He notes that the first laser printer was sold in 1969, and the first iPhone was sold in 2007—the same year the market first saw a 3D printer system available for under \$10,000. Latz's point: Given where the iPhone is today, it can happen quickly. ■

Keith Loria is a freelance writer.

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HIGHLIGHTS FROM **NEXT** CONFERENCE AND EXPOSITION 2019



From an inspiring account of one person's rise from opioid addiction to a discussion of implementing direct-access physical therapist services in a hospital, APTA's NEXT conference offered sessions, presentations, and networking events for PTs, PTAs, and students. Here are some highlights from the June meeting in Chicago.



Keynote speaker Justin Minyard used 6 pint glasses of carefully counted candy to illustrate his monthly intake of 3 prescription medications when he was dependent on opioids.

played a role in his use of drugs. “I was not an educated patient; I didn’t ask questions,” he told the audience.

After more than 2 years of attempting to manage his pain through opioids and other medications—and becoming addicted along the way—Minyard began to see options for change.

His last fusion surgery kept him in the hospital for 3 months. Then a physician who called Minyard a “hot mess” offered him another avenue: a pain-management program that involved 9 different professionals, including a psychologist, psychiatrist, a pharmacologist—and a PT. Minyard took him up on the offer,

and moved from what he describes as a “pain-centric to a patient-centric model of care.”

Minyard credits his PT with helping him accept the idea that, yes, he might be in pain for the rest of his life, but he could find ways to manage the pain and make it “more of a footnote, less of a header.” Now, Minyard says, on most days his pain level is moderate but manageable—around a 3 on a pain scale of 10.

Minyard also feels that it wasn’t just about the physical therapy itself. He thinks his relationship with his PT was a major factor in his recovery.

“She wasn’t just my PT, but my psychologist, my sounding board, my marriage counselor, educator of my options, and my kick in the ass,” Minyard said. “She was all of those things.”

His recovery included taking his PT up on a suggestion that he try handcycling. He liked it—so much so that he wound up medaling in traditional upright cycling at the Invictus Games for armed services personnel and veterans.

Even more important for Minyard is how the changed approach to pain management gave him back his life with his family. “I am my 11-year-old daughter’s soccer coach,” he said. “I get to be her coach. I don’t know a damn thing about soccer, but I get to be her coach. I almost lost that. I was this close, multiple times.”

While Minyard credits a single PT with a major role in his own recovery, he told the NEXT audience that the entire profession of PTs and physical therapist assistants (PTAs) should be proud of the life-changing work they do. “You’re going to continue to make such a tremendous impact on countless other patients,” Minyard said. “Choose PT.”

Opening Event: A Moving Account of A Journey out of Pain and Addiction

“I failed my marriage. I failed as a father. I failed my career. And I didn’t even know it was happening.”

That’s how Justin Minyard describes the lowest point in his life: After 2 spine fractures and multiple surgeries, he became addicted to the opioids prescribed to him. He found himself consumed by his pain and his meds—how many he had on hand, when he could take the next one, where to get refills. His addiction led to a suicide attempt and 2 accidental overdoses. But most devastating for Minyard was that his addiction hurt the people he loved the most.

“I let them down,” Minyard said. “You didn’t want to be around me.”

Now things are different. With the help of an interdisciplinary care team that included a physical therapist (PT), Minyard said he learned how to “make pain a footnote, not the header” of his life and defeat his addiction. He became 8 years clean in July.

Minyard’s moving story was delivered as the keynote address at the NEXT opening event on June 12. The retired Army Master Sergeant recounted the injuries he received—first during a rescue attempt at the Pentagon during the 9-11 attacks and then while on a mission in Afghanistan—but focused more on what happened afterward: the multiple fusion and other surgeries, the intense pain, and his eventual slide into addiction.

“I didn’t wake up one day and say, “This sounds great,”” Minyard said of his use of opioids. He believes, however, that his passive approach to exploring treatment options



APTA CEO Justin Moore, PT, DPT, welcomes association President Sharon Dunn, PT, PhD, to the podium for the opening event of the 2019 NEXT Conference and Exposition. In addition to her remarks there, Dunn inspired the APTA House of Delegates earlier in the week with a presidential address that celebrated the association's transformation into a more outward-facing organization while touching on challenges such as the cost of education and the damaging effects of productivity quotas. Watch the video or read the transcript on APTA's #PTTransforms blog at apta.org/Blogs/PTTransforms/2019/6/11/Dunn/.



McMillan Lecturer Outlines Keys to Excellence in the Physical Therapy Profession

Tom McPoil, PT, PhD, FAPTA, said he intentionally wrote the title of the 50th McMillan Lecture—"Is Excellence in the Cards?" as a question to "raise an element of doubt or uncertainty in our quest to achieve excellence." That's because, he said in delivering the address on June 13, he has several concerns.

Before listing them, however, McPoil recognized some of the profession's significant accomplishments since he began his career in 1973. "We no longer serve as a subservient technician in the health care system, our students now obtain an exceptional education and are granted a doctoral degree, we can practice in a variety of specialty areas in multiple practice environments, and we have achieved the ability to practice autonomously with

patients having direct access to our services," he noted.

But, he said, there still is room for improvement from both clinical and academic perspectives. From the clinical standpoint, he described 3 areas.

First, McPoil questioned continued acceptance of examination and management methods that may have been proven to have no evidence to support their use. As an example, he identified what is known as the podiatric model, which classifies foot types based on the concept of subtalar joint neutral position. McPoil said that subsequent studies—including those he and colleagues conducted—showed that "subtalar joint neutral position had no relevance to the typical pattern of rearfoot motion. In short, our results

challenged the validity of the podiatric model."

Yet, he continued, many physical therapist education programs and postprofessional continuing education courses still teach the

model. McPoil expressed hope that the profession will continue to stress the importance of using methods that have been validated with basic science and clinical evidence,



Tom McPoil



especially at entry level and in education programs, “as it is our new doctor of physical therapy graduates who must serve as our profession’s change agents.”

Second, McPoil expressed concern over a lack of acknowledgment of historical research studies that provide evidence for a practice’s continue use. He quoted a 2009 article by Mary Halefi (“Forget This Article: On Scholarly Oblivion, Institutional Amnesia, and Erasure of Research History,” *Studies in Art Education*) noting that “recurring themes, issues, and concerns are part of any field” and that failing to cite them along with more contemporary studies risks the loss of past scholarly endeavors upon

which current research may be based. “Hopefully,” McPoil said, “our professional journals will always perform their due diligence” to retain the contributions of past scholars and researchers.

Inconsistency in the level of care was McPoil’s third area of needed improvement. He noted some probable causes of inadequate care, such as limited patient time resulting from low payment rates, some highly specialized areas of practice that not all PTs are familiar with, and lack of clinical practice guidelines (CPGs) that address needed services. As for specialized areas of practice, he said that physical therapist-to-physical therapist referral is “rare” and that the value of

intraprofessional referral needs greater emphasis during entry-level education.

Concerning CPGs, McPoil argued that while they are important, they cannot always guide the clinician to an appropriate decision and “cannot replace the need for clinical reasoning and practice knowledge.” Such knowledge, he said, “can be achieved only through residency or fellowship training.”

To that end, McPoil said it may no longer be feasible to train a generalist at entry level. The profession must consider allowing specialization to begin before graduation. He identified challenges to developing residency and fellowship programs, such as student loan debt, salaries that aren’t commensurate with advanced clinical specialization, and lack of federally funded support. He expressed hope that the profession will prioritize development of these programs, as needed funding for them won’t occur until they are the expected route after professional graduation. “Our pathway to excellence demands no less,” he said.

McPoil followed up with his thoughts on achieving academic excellence, specifically the need for every faculty member to have “a personal agenda for scholarship that includes publication.”

Poster presentations offered snapshots of hundreds of research results.



Beth Fisher



For Optimal Outcomes, Look Beyond Compensation Patterns, Maley Lecturer Says

“Any movement-related profession—personal trainers, athletic trainers, dance therapists, yoga instructors—who can observe impairments such as a weak muscle can try to fix it,” said Beth Fisher, PT, PhD, FAPTA, in delivering the 24th John H. P. Maley Lecture on June 14. However, too often the “fix” involves the patient compensating with movement patterns that interfere with the ability of an affected limb to improve to its true potential. Fisher argued that with their level of education and skill, PTs can and should identify and help the patient recover that capability.

During her presentation “Beyond Limits: Unmasking Potential Through Movement Discovery,” Fisher said that in earlier clinician practice with patients with stroke and brain injury she continually hit ends points with her patients, but then she realized “these were my endpoints and not the patient’s, [because] at least 1 aspect of the movement abnormalities...were the results of compensation.” Given the brain’s ability to continuously alter its structure and function, and the body’s ability to achieve movement goals in more than 1 way, people with an impairment tend to progress toward the movement pattern that is most efficient—that achieves a goal using the least amount of energy and the fewest body parts. But while a compensatory solution may get the job done, this easy route that comes naturally may not lead to optimal improvement—thus denying the patient the best possible outcome. In fact, “the compensations [patients] choose may be the source of the problem—may actually predispose the problem to occur,” Fisher said, by keeping the patient from exploring better ways to achieve movement goals.

She asked: Is this really the best PTs can do? “If we want to reach someone’s full capacity, then we need to go beyond this limited choice that patients come up with on their own without a physical therapist,” Fisher said. However, she argued, PTs have been academically trained to view movement from an impairment-driven perspective—assuming that a patient’s compensatory movement pattern results from an impairment that is masking his or her capability. So, both PT and patient expect that compensation will provide the best—or only—results.

“If I have minimal expectations,” Fisher asked, “how is that going to impact my patient’s expectations? What

is that going to do for recovery potential?” Instead, as professionals with the expertise to look beyond compensation approaches, PTs must encourage potentially riskier, more-difficult solutions. “With what we know about brain plasticity, it is our job to help patients realize that they have more options,” she said.

By modifying that implicit choice, the PT can help patients discover a capability they may not have even realized they have. “The most rewarding moments I have had in my career have come when I hear ‘I didn’t know my leg (or arm) could do that,’” Fisher said.

She noted that PTs can’t ignore impairment, “but if we are only viewing the problem from that perspective, we and our patients will reach a plateau-minimizing capacity.”

Instead, every student and therapist should consider how a movement choice can mask capacity. “We need to start from the bottom up,” Fisher said, “and teach students to observe movement and hypothesize how implicit choices—not just impairments—may be driving movement faults.” Otherwise, “We have limited patients and their potential to discover other options for movement by a perspective that does not consider the choices they make.”

2019 House of Delegates Sees Important Role for APTA in Professional and Societal Issues

APTA's outward-facing, forward-leaning vision continues to guide APTA's House of Delegates. The policy-making body considered 70 motions during the 75th House session addressing a wide range of issues, but 1 overarching theme was clear: The House believes APTA has the potential to be a change agent for the profession and for society at large.

APTA as Advocate

Delegates approved multiple motions aimed at positioning the association as an advocate for a more diverse, equitable, and inclusive profession, beginning with a general statement

language around the association's commitment to nondiscrimination on the basis of race, creed, color, sex, gender, gender identity, gender expression, age, national or ethnic origin, sexual orientation, disability, or health status; as well as a charge directing APTA to work with stakeholders to advance diversity, equity, and inclusion in all areas of physical therapy, including clinical, educational, and research settings.

The House also voted to add language to the Code of Ethics for the Physical Therapist and Standards of Ethical Conduct for the Physical Therapist Assistant that more clearly describes the duty of PTs and PTAs

document with the APTA vision statement and more explicitly reflect the role of PTs in population health and community engagement. In addition, the House created a single set of core values for PTs and PTAs to replace separate versions, noting in discussion that core values are common to PTs and PTAs but discrete from behaviors, which continue to be appropriately described in the separate ethics documents.

Other profession-focused House actions included unanimous approval of the definition of the movement system as "the integration of body systems that generate and maintain movement at all

levels of bodily function," further describing human movement as "a complex behavior within a specific context...influenced by social, environmental, and personal factors." The definition will further strengthen APTA's efforts to promote the movement system as a critical component of the physical therapy profession's identity.

Societal Issues and Population Health

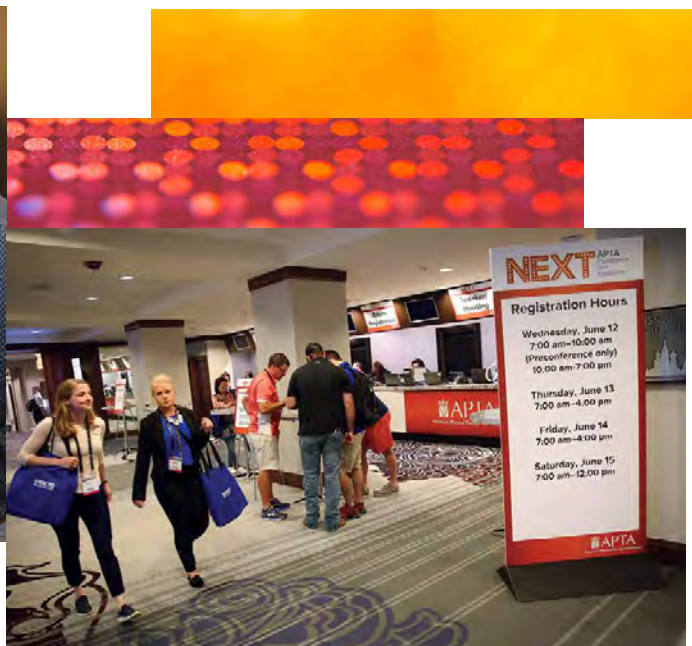
The House passed multiple motions related to the ways both the association and individual PTs and PTAs are connected to larger societal issues. In addition to updating positions on the association's role in advocacy for prevention, fitness, wellness, health

promotion, and population health, delegates voted to broaden APTA's ability to respond to health and social issues. The House provided examples of what those broader

that APTA "supports efforts to increase diversity, equity, and inclusion to better serve the association, profession, and society." The House also unanimously adopted stronger

to report verbal, physical, emotional, or sexual harassment. In addition, delegates approved revisions to the Standards of Practice for Physical Therapy that better align the





efforts will entail, approving motions that support taking a public health approach to gun violence, promoting public participation in vaccination schedules, improving health literacy, and supporting the availability in physical therapy settings of the drug naloxone to reverse the effects of opiate overdose.

New Area of Specialization: Wound Management Physical Therapy

Making it the 10th area of physical therapist clinical specialization, delegates approved the creation of a wound management specialty area for certification by the American Board of Physical Therapy Specialties, a proposal developed by the APTA Academy of Clinical Electrophysiology and Wound Management.

Document Review

Finally, in keeping with APTA's ongoing efforts to follow best practices in governance, the motions deliberated at the House included the second phase of a complete review of all House-generated documents. The review, conducted by a special committee of the House over the course of 2 years, focused on updating, consolidating, and sometimes rescinding documents—resulting in recommendations for changes to more than 100 House policies, positions, directives, and other guidance.

How One Hospital Implemented Direct Access

During a June 13 session, a panel of PTs from the Hospital for Special Surgery (HSS) in New York explained how that institution implemented direct access (DA) to physical therapist services. They then advised attendees how to operationalize DA at their own institutions.

Presenters from HSS were Carol Page, PT, DPT; Mary Murray-Weir, PT, MBA; Robert Turner, PT, DPT; and Jaime Edelstein, PT, DScPT. Also presenting was Aaron Keil, PT, DPT, from the University of Illinois at Chicago.

Keil noted that while DA was achieved in all 50 states and the District of Columbia in 2015, only 18 states have unrestricted access. The other states include limits or restrictions, meaning there still are barriers to DA.

Keil cited a 2015 APTA survey in which nearly 65% of respondents said the major administrative barrier to DA implementation was “My supervisor/facility requires all patients to have a referral.” Keil noted

that this is especially true in hospital-based inpatient and outpatient facilities, as hospitals tend to be more risk-averse and “may be more restrictive than state law.”

Page said that an essential first step to achieving DA was getting buy-in. One key group was physicians—particularly surgeons—who were concerned that their patient levels would drop. Page explained, “We showed that direct access would ‘widen the funnel’ and actually provide them with more patients,” while at the same time screening to send only appropriate patients to the surgeons.

Administrative staff were taught how to screen patients and schedule them with appropriate PTs. They also were made responsible for tracking the timing and number of permissible visits for adherence to state provisions, building on an HSS foundation of training and competency programs it conducts for all staff.

The hospital established criteria for DA PTs that were

more stringent than those required by the state. For example, while New York requires 3 years of clinical experience, HSS further required that experience to be at outpatient facilities. It also required continuing education in certain areas, such as spine, manual therapy, and differential diagnosis.

Turner described the development of a written exam for aspiring DA PTs. Questions were developed following the same item-writing guidelines used by the American Board of Physical Therapy Specialties. A score of 80% is required to pass the test.

HSS also developed a practical examination involving an actual patient. The primary question to be answered is: “Can you take this patient and treat him or her? Or do you refer to a physician?”

The program was made voluntary for PTs since some didn’t initially feel comfortable with it. “Not everyone fits the mold,” Turner said.

Page addressed operationalizing DA, which she divided into 4 categories. The first was resources. She advised those in the audience to search APTA’s website for “direct access” and browse the resources. The second category was billing, which she made clear “is different in a hospital setting” from a private practice and

requires a hospital-wide effort. The team leading the DA program at HSS made a conscious decision not to contact insurance companies in advance and announce their intentions. “We did a soft launch with a small number of patients. We let them know that their interventions might or might not be covered,” Page said, but he found that most insurers did cover the services, and HSS now contacts insurers in advance.

The other elements of operationalizing DA were documentation and marketing. These included developing specific policies and procedures, providing notice of advice for patients, identifying common ICD-10 codes, and developing tip sheets for patients and physicians.



Building Wellness Programs in The Least Likely Places

Sometimes, basic assumptions beg to be questioned. Just ask PTs in the oncology rehabilitation department of Froedtert Hospital and Medical College of Wisconsin, who wondered why prevention and wellness couldn’t be a part of the patient experience from the moment they enter the facility’s doors.

That questioning led to development of an innovative group exercise program for patients in the hospital for chemotherapy and other treatments primarily related to blood cancers. So far, the program seems to be allowing many patients to leave as mobile as, if not more so than, when they arrived. On June 13, the PTs shared their story of how they established and expanded the program, known as the Strength in Numbers exercise class.

The idea behind the program was based on a reality check of the typical path of an oncology patient visiting the hospital for treatment, explained Kelly Colgrove, PT. Unlike patients who arrive with other conditions such as congestive heart failure, “our patients walk in strong and independently.” During the course of treatment, however, they often experience decreased muscle strength, challenging PTs to play catch-up before the patient is discharged.

The Froedtert PTs wanted Strength in Numbers to change that. As it now operates, the program—known as “SIN” to the amusement of patients—offers a 1-hour group circuit training class 2 times a week. Colgrove describes SIN as “a fun environment based on camaraderie and music, but all within the acute care setting.”

Patients are selected for the voluntary program based on their health at the time of check-in, Colgrove explained. Those whose condition is more fragile receive more typical 1-on-1 physical therapy. Patients who qualify for SIN are assessed, given goals, and scheduled to participate in the group. Once in SIN, patients still can choose to return to the more traditional therapy program.

Besides the direct physical benefits to patients, SIN has helped reinforce what the presenters called a “culture of mobility” at the hospital.

The presenters led attendees through their process of developing and maintaining the program, encouraging audience members to envision similar possibilities in their own practice settings. They explained the importance of a solid basis in research, careful consideration of stakeholder concerns, evaluation of current and needed resources, and program metrics to evaluate outcomes, among other areas.

Through their recaps, the presenters demonstrated how flexibility and creativity are key elements in all areas of development, implementation, and evaluation. “Being able to adapt and evolve is going to be key,” explained Alyssa Kelsey, PT, DPT. For SIN, that means seeking ongoing input from patients and staff, as well as conducting monthly check-in meetings to monitor operations and identify future goals.

That flexibility also should include the capacity to question your own assumptions and evaluative measures, explained Colgrove. “Sometimes, the questions you think you want to answer at the beginning of the program may not be the questions you want to answer after a year.”

One question has been consistent throughout SIN: Does it work? So far, the answer seems to be yes. Outcome measures for patients with a length of stay longer than 20 days and more than 50% participation in SIN found that 72% maintained or improved their 5-time sit-to-stand scores, 64% maintained or improved on functional gait assessment, and 53% maintained or bettered their scores related to self-perceived deficits at discharge.

If patient enthusiasm for the program is any measure, SIN also is doing well. According to the presenters, the lone criticism expressed by many patients is that classes are held only 2 days a week.



Above: APTA unveiled a sneak peek of the new logo that will launch officially in mid 2020 as part of the association's branding initiative. (APTA.org/BrandProject)



Left: PTAs' 50th anniversary continued its celebration at NEXT with a flashmob.



Rural Health Care Has Plenty of Challenges but Promising Opportunities

When it comes to rural health, there's no denying that demographic and financial challenges can affect care. But there also are opportunities for improvement, and PTs and PTAs need to be ready to advocate for them and, when necessary, create them. That was the message of a session on rural health care delivered on June 14.

The session explored the factors that make rural health care different from health care in more urban areas—differences that in some instances point to the need to rethink how funding is allocated. Presenters pointed to the possibility that the US Centers for Medicare and Medicaid Services (CMS) might be in the early stages of doing just that. Meanwhile, they said, the potential for better patient access through telehealth needs to be seized.

Presenter Jeremy Foster, PTA, boiled down the status of rural health care to a single sentence: “We have all these conditions that are worse in rural settings, but the money's not there.”

Foster led attendees through a tour of the demographic elements that create challenges, including a higher percentage of people in rural areas who describe themselves as having “fair or poor” health compared with those in urban settings, and a generally older population. Other disparities include higher rates of tobacco use in rural areas, an average annual income gap of \$9,242, and life expectancy that averages 2 years shorter than that of the urban-dwelling population.

Access to care is, of course, a significant problem in rural areas, Foster explained, and although critical access hospitals (CAHs) often provide high-quality, patient-centered care, current funding systems tend to be based on population more than on need. Gaps can arise, therefore, when

a smaller population begins to experience conditions that lead to worse health conditions.

This must change, Foster said, because CAHs are providing much-needed care and economic benefits that are worth supporting, including contributing more than \$7.1 million to local communities annually through wages and benefits, and providing needed care—an average of 39 million outpatient visits, 809,000 adult hospital admissions, and 82,000 infant deliveries per year.

“There needs to be a lot more research around rural health care,” Foster said, but he added that providers in the rural setting have a responsibility to be “trustees of the money we receive.”

Brendon Larsen, PTA, BS, took a deeper dive into the current state of CAHs and rural health care in general, saying that rural health providers are challenged to care for a population that is considered “older, sicker, and poorer” than its urban counterpart.

CAHs' challenges include an aging infrastructure and a workforce shortage that isn't limited to clinicians, Larsen said, with CAH leaders reporting a 61% shortage in applicants for nonclinical and administrative support positions. At the same time, the type of services provided by CAHs is evolving, with outpatient treatment now making up 60% of CAH gross revenue. The problem, he explained, is that many funding assumptions regarding rural health care are rooted in inpatient care. When those factors are added to ever-increasing regulatory burdens, CAHs and other rural health providers find themselves struggling to stay afloat when the need for better patient access is increasing—including the need to respond to the nation's opioid crisis.

But could some relief be on the way? Maybe, said Larsen: CMS has formed a Council for Rural Health that is looking at developing a rural health policy initiative. The idea, Larsen explained, is to apply a “rural lens” to CMS programs, to maximize providers' scopes of practice, empowering patient decision-making in rural areas, supporting new partnerships, and further expanding telehealth opportunities in rural areas.

Of those potential improvements, telehealth could be of the most immediate benefit, said Carmen Cooper-Orguz, PT, DPT, MBA, who rounded out the program by describing the promise of telehealth, and specifically telerehab, for improving patient access to care.

“There are more ‘cans’ than ‘cannots’ when it comes to telerehab,” Cooper-Orguz told the audience while running through a list of assessments and treatments that could be accomplished remotely.

The problem, she explained, is that while most providers understand the potential for telerehab, the on-the-ground conditions for providing it need to improve. That will take action from the physical therapy community to advocate for changes to payment policies, state licensing laws and regulations, and provision of rural broadband.

Cooper-Orguz said one of the most important ways for PTs and PTAs to pave the way for better policy around telerehab is to press for adoption of the Physical Therapy Licensure Compact in all states. By dismantling geographic boundaries to practice, the compact opens up the possibility for increased use of telerehab—but only if compact adoption is accompanied by licensing laws and regulations that permit remote practice, she added.



As is typical during a NEXT Oxford Debate, audience members move noisily from one side of the room to the other to express their agreement with a panelist.

Oxford Debaters Argue: Is Social Media Hazardous?

The verdict is in.

The results of the 12th annual Oxford Debate found that social media is hazardous to the profession. That was the ruling of the debate’s moderator, Charles Ciccone, PT, PhD, FAPTA, who presided over the event on June 14.

Debating the pro position—arguing that social media is hazardous to the profession—were Jimmy McKay, PT, DPT (team captain); Jarod Hall, PT, DPT; and Karen Litzy, PT, DPT. Taking the opposing position were Ben Fung, PT, DPT, MBA (team captain); Jodi Pfeiffer, PTA; and Rich Severin, PT, DPT.

Leading off for the pro team—all of whom were dressed in bright yellow hazmat suits—was Litzy. She explained, “Our job isn’t to say that social media is good or evil, but that it’s hazardous. People there bitch and moan, sell pseudoscience, and attack others. This is where social media becomes hazardous. There’s misinformation and disinformation. Misinformation is false, whether or not the intent is to mislead. Disinformation is deliberately false. CAPTE [the Commission on Accreditation in Physical Therapy Education] acknowledges that the use of social media should be included in the curriculum. As a profession, we have to work for the good. We should improve our media literacy and fact-check so that we don’t spread misinformation.”

The con team—in a tip of the hat to NEXT 2019’s Chicago locale and the movie “The Blues Brothers”—consisted of Fung and Severin dressed as the Jake and Elwood Blues, and Pfeiffer as the nun Sister Mary Stigmata. Pfeiffer led off,

arguing, “Social media is vital. It’s how we communicate with each other. Some people disseminate misinformation on social media. How do we correct it? On social media. We will use it to get rid of the misinformation. Social media is addressed in APTA’s Code of Ethics because we need it. We need to reach the Millennials. It’s what they read. We use social media to tell everyone what great work we are doing and to promote the profession.”

Hall responded, “One study said that, across social media, young professionals spend 116 minutes a day.” Borrowing the concept of *schadenfreude*—defined as pleasures derived from the misfortunes of others—Hall referred to “schaden-Facebook.” “It’s where you relate the great things you said to Mrs Jones and ignore the stupid things you said to 50 others. Sometimes the grass looks greener because it’s fake.”

Fung, however, insisted that social media does more good than harm, asking, “Which is more hazardous to our profession—that questions are being asked or that we’re not part of the conversations? One study found that only 1 in 10 people who need physical therapy will receive physical therapy. If you want to get the average person away from the screen, you have to be part of the conversation. The greater issue is that when people ask questions, we’re not there [on social media] in their time of need.”

Audience participation followed, with a near-even split of 7 for the pro position and 6 for the con. Among the comments:

- Anything can be hazardous. If we’re not using social media, we’re missing an opportunity.

- How many people have met people on social media?
- How many of you have met people at NEXT and other APTA events?
- For me, it's about the human connection.

Attendees also made their views known by using clappers, running from one side of the room to the other as a debater made a persuasive point, and enthusiastically cheering.

Severin summarized for the con team: “PTs are the movement experts. But people have an outdated image of physical therapy. #ChoosePT changed many views about physical therapy. The Day of Service, under the brand of physical therapy, has helped. Social media is key to that movement. Illinois and Texas recently adopted direct access legislation, and social media was vital in that effort. Social media has removed hazards to the profession. It’s where we create communities. In addition, it’s where patients and the next generation of PTs are going. We need to engage with our communities on social media.”

McKay summarized for the pro team: “My job isn’t to show that social media is good or bad, just that it’s hazardous. Social media leads you to do things you’d never do in person. APTA has policies regarding the dangers of social media. Social media is how the anti-vax science goes viral. This is how Flat Earth Society thought goes around the world. Social media filters and distorts information. That’s hazardous. But social media is not going away. So we must be safe when using it.”

After weighing the arguments and presentations, Ciccone found in favor of the pro team by a score of 29-23.



This souped-up Mustang was one of many ride-on cars that were customized as childrens’ mobility devices during the very hands-on Go Baby Go session.

NEXT Attendees Rebuild Toy Cars to Aid Children’s Mobility

PVC ratchet cutters, screwdrivers, and wire strippers may not be among the tools usually used by PTs and PTAs. But at the NEXT 2019 session “Go Baby Go: Mobility Research, Design, and Technology,” those and other devices—such as electrical tape, collections of screws, a power drill, and myriad other items—were part of a clinician’s toolbox.

Jason Craig, PT, DPhil, and Skye Donovan, PT, PhD, led the session, which addressed the importance of mobility for young children. The program—conducted on June 13 and 14—primarily focused on converting 9 battery-powered

children’s ride-on cars into effective, affordable mobility devices. Go Baby Go is a national program developed by Cole Galloway, PT, PhD.

The cars that arrive from the toy manufacturer are designed to be operated with a foot pedal. But, Craig explained, “Most kids can’t operate a pedal, so we have a large button that can be positioned anywhere on the car.” Usually the button is on the steering wheel—which was where conference participants placed them in the 9 onsite cars—but the location can change based on the child’s need.

“We’ve placed it behind the head when the goal

is to improve a child’s posture,” Craig said. “We placed one on the seat so the car would move only when the child stood up; it stopped as soon as he sat down.”

In addition to enhancing interventions, the modified toys serve another purpose. “This is about providing the children an experience they haven’t had. By providing these cars, the children can explore the world,” he said.

It’s also affordable. The cars as modified cost approximately \$150, “versus thousands for a motorized wheelchair.”

Pointing to an array of unmodified, rideable



cars on tables in the room, Craig then told the session attendees: “We need you to build these, because the kids are coming in later today for their cars.” Each car was accompanied by an information sheet on the child—including his or her name, age, diagnosis, and interests.

Session attendees worked in teams of 4 to 6 to modify the cars—disconnecting the pedal power control and connecting the large red plastic button the size of a small plate to the center of the steering wheel. The task was challenging not only because many PTs weren’t familiar with the hardware tools and wiring schematics but also because of variations in both the cars and the needs of the children.

About an hour into the session, the children and their parents began arriving, with the children telling the PT team working on “their” car what customizations and decals they wanted. Most of the cars were finished that day—a few needed additional work—and the session ended with the children test-driving their cars around the room and down the hotel’s halls.

Understanding Personality Types Can Enhance The PT-Patient Relationship

Understanding one’s own personality, as well as the personalities of coworkers and patients, can make PTs and PTAs more successful in both their workplace and home life, according to Jacky Arrow, PT, DPT. Arrow presented “He Said, She Said: How Personality and Communication Can Improve Patient Education” on June 14.

She pointed out that in communication between the PT and the patient, “It’s not their responsibility to come to us or to meet us halfway. It’s our responsibility to meet them.”

Arrow first recommended that attendees determine their own personality types. She mentioned several tests but focused on the Myers-Briggs Type Indicator, which places a person on 4 scales: extraversion vs introversion, sensing vs intuitive, thinking vs feeling, and judging vs perceiving.

For example, Arrow explained, an introvert typically waits to be asked a question and then needs time to construct an answer. Extraverts, on the other hand, tend to be talkative and fast-paced. Regarding body language, extraverts tend to lean forward and talk with their hands, while introverts pause before answering and often sit back, sometimes with arms crossed. When

treating patients who are introverts, she suggested, provide information in advance or tell them you plan on asking specific questions either later in a session or at the next session. A strategy to working with extraverts includes active listening, thinking out loud, and planning talking points.

Another example Arrow provided related to judgers vs perceivers. Judgers respect rules and deadlines such as structured activity, she said, and they prefer a specific plan of care, with milestones. Perceivers tend to be flexible with rules and deadlines and are open to adjustments in a plan of care. For those reasons, judgers do better with a written program calendar, while perceivers like to link progress to big-picture goals. To illustrate, she suggested that if the goal is to have a patient do an exercise for 30 seconds, tell a judger to exercise for 30 seconds. Tell a perceiver to sing the song “Twinkle Twinkle Little Star” to gauge the elapsed time.

Understanding the personality types of colleagues also can be beneficial. “Knowing the other personality types fosters better working relationships. And it allows PTs and PTAs to practice their skills with those of other personality types,” Arrow said. ■



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HEALTH CARE HEADLINES

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



Another Study Supports the Effectiveness of Telerehab

A recent study found an entirely remotely delivered rehab program to be as effective as an equal amount of clinic-based sessions for patients who have experienced arm impairments poststroke. The study, from *JAMA Neurology*, compared delivery of a 6-8 week rehabilitation program in an outpatient clinic setting with the same program delivered virtually and found that both groups improved at about the same rate. The authors wrote that the 36 70-minute sessions may be more than what many patients receive in the normal outpatient setting but that the numbers may be achievable—and possibly less costly—via telerehab. The findings lend further support to the ideas behind APTA's efforts to increase telehealth opportunities for PTs and their patients—a significant component of the association's current public policy priorities.

www.apta.org/PTinMotion/News/2019/07/05/JAMATelerehabPoststroke/

A Strong Majority of PTs Believe Administrative Burden Is Affecting Clinical Outcomes—and Contributing to Clinician Burnout

The results of a recent APTA survey of physical therapists (PTs) nationwide reveal that nearly 3 in 4 believe overreaching documentation and administrative mandates negatively affect patient outcomes—and 8 in 10 cite excessive requirements as contributing to clinician burnout. The findings reinforce APTA's ongoing efforts to advocate for more reasonable requirements, particularly regarding prior approval and appeals of denied claims. The results are available as a downloadable infographic on APTA's Administrative Burden webpage.

www.apta.org/PTinMotion/News/2019/07/01/AdminBurdenSurvey/

Are PTs Doing Enough BP and HR Measurement?

Despite the frequency with which PTs in outpatient settings encounter patients who have or are at risk for cardiovascular disease (CVD), rates of blood pressure (BP) and heart rate (HR) screening remain "significantly inadequate," say the authors of a new study published in *PTJ (Physical Therapy)* based on a nationwide survey of PTs. The survey reveals that only 14.8% of respondents reported measuring BP and HR upon initial examination of new patients, even though nearly 7 in 10 said they encountered a new patient with or at risk for CVD at least twice a week. The authors say the results indicate the need for better PT education on the importance of the screenings, and more-explicit clinic policies supporting regular use of the measurements.

www.apta.org/PTinMotion/News/2019/07/08/BPAndHRScreens/



APTA LEADING THE WAY

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



APTA House Reinforces The Association's Role In Professional and Societal Issues

The association's outward-facing, forward-leaning vision continues to guide APTA's House of Delegates (House). During its 75th annual session in June, delegates approved multiple motions that position the association as an advocate for a more diverse, equitable, and inclusive profession with a connection to larger societal issues. Topics addressed by the House included increasing diversity, equity, and inclusion in the profession; taking a stronger stance against all types of harassment; and adopting clearer language on APTA's commitment to nondiscrimination. Societal issues addressed by the House included taking a public health approach to gun violence, improving health literacy, and supporting the availability in physical therapy settings of the drug naloxone to reverse the effects of an opioid overdose. Delegates also approved the creation of a wound management specialty area for certification by the American Board of Physical Therapy Specialties. (Read more on page 42.)

www.apta.org/PTinMotion/News/2019/06/14/HODRecap2019/

Collaboration Between APTA and UnitedHealthcare Results in Increased Access to PT Services

In June, UnitedHealthcare (UHC) announced a pilot program in 5 states that will waive the cost of copays and deductibles for 3 physical therapy sessions for patients with low back pain (LBP) who live in Connecticut, Florida, Georgia, North Carolina, and New York. Other states will join the program in 2020 and 2021. The pilot follows a multiyear collaboration between APTA, OptumLabs, and UHC that included publication of a study in the *American Journal of Managed Care*. The study affirmed that higher copays and payer restrictions on provider access may steer patients away from more conservative treatments for LBP, including physical therapy and chiropractic services.

www.apta.org/PTinMotion/News/2019/06/24/UHCPilotAndStudy2019/

An APTA-Backed Bill to Provide Diversity-Based Scholarships and Stipends Is Introduced in Congress



A bill introduced in the US House of Representatives in July seeks to provide \$5 million per year in scholarships and stipends aimed at increasing the number of students from underrepresented populations in physical therapy and other allied health education programs. Known as the Allied Health Workforce Diversity Act of 2019, the legislation would set aside money in the Health Resources and Services Administration specifically for use by accredited education programs in

physical therapy, occupational therapy, audiology, and speech-language pathology. Those programs would, in turn, issue scholarships or stipends to students from underrepresented populations. APTA, the American Occupational Therapy Association (AOTA), the American Speech-Language-Hearing Association (ASHA), and the American Academy of Audiology were instrumental in crafting language for the bill.

www.apta.org/PTinMotion/News/2019/07/10/WorkforceDiversityActIntroduced/

APTA, AOTA, ASHA Issue a Guide to Habilitative and Rehabilitative Insurance Benefits

APTA, AOTA, and ASHA have collaborated on a guide to assessing benefit adequacy that emphasizes transparency, access, and affordability across benefit plans that can vary widely. The guide, available on APTA's Essential Health Benefits webpage, forgoes offering a laundry list of specific benefits in favor of establishing a set of principles that the associations believe lead to appropriate coverage.

www.apta.org/PTinMotion/News/2019/07/02/HabAndRehabBenefitsGuide/

STUDENT FOCUS

APTA's student blog, *The Pulse*, is written by students for students, but it includes worthwhile reads for everyone in the profession. The following is excerpted from a post by recent graduate Samuel Kelokates, PT, DPT, about the need to avoid discrimination against people with physical disabilities.

Health Care Needs More Providers With Disabilities



I couldn't wait to become a physical therapist (PT). The only thing standing between me and my career was an annual physical exam conducted by a general practitioner and then a little paperwork. I'm young, healthy, and physically active, so this exam didn't worry me at all.

I met with a new physician and the assessment went well. But as I was leaving my appointment I spotted a note in the restrictions section: "Cannot lift more than 50 lbs."

I was furious. "Why did you write this on my form?" I asked the physician. She

looked puzzled. "I just don't think it's safe for you to lift more than 50 pounds with your condition," she said.

The "condition" she was referring to is my missing right hand. I was born this way. I have a forearm, a wrist bone, and little nubbins on the end of my limb.

Without performing a test that would prove her theory, the physician made an assumption about my abilities. She had never seen me transfer a patient, lift weights, play sports, or be physically active. Yet she felt confident enough to pin limitations on me. I don't think she intended to be discriminatory.

She just couldn't see beyond my physical impairment.

Lots of people struggle to do that, actually, and 1 reason is that people with disabilities often are lost in the shadows. We don't look quite like everyone else, and so we're overlooked.

Nearly 20% of the population has a physical disability. That's 1 out of 5 people. If that's reflected in health care professions, we certainly hide it well. No wonder my physician didn't think that I can lift 50 pounds safely. She obviously doesn't have someone in her daily work life who can prove otherwise. But it's not our able-bodied health care providers who most need to see what caregivers with disabilities can do—it's our patients and clients.

Our profession routinely encounters disabilities. Imagine how much it would mean to differently abled consumers to be cared for by someone who faces some of the same challenges. Someone who they're confident understands them. Someone who is a living reminder of all that can be done with a physical disability, despite certain limitations.

I'm not saying it's easy. As a physical therapist providing manual treatment, my body is part of my toolbox. I have had to adapt. I am conscious of my limitations. But I'm just as aware of my potential.

The bottom line is that it's possible to be a successful PT or physical therapist assistant with a physical disability. I'm living proof of that. Our media and culture are making progress in reflecting a more inclusive world. It's time for health care to catch up.

Read the full story from April 24, 2019, in *The Pulse*. www.apta.org/ProvidersWithDisabilities/

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Your APTA membership entitles you to more than just the inherent benefits of being part of your professional association. You also have access to out-of-pocket savings on many products and services of value you to professionally and personally.

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A new addition to APTA's Member Value Programs is MedBridge, a leading provider of health care continuing education. MedBridge offers APTA members \$175 off the regular price of \$375 for its courses, available through the APTA Learning Center.

Take full advantage of your APTA membership by exploring these options!

www.apta.org/ValuePrograms



Career Resources

Another member benefit is APTA's Red Hot Jobs career site—an excellent resource that has helped thousands of physical therapy professionals land their dream positions. Search for a job, post your resume anonymously, and control who is able to contact you. In addition to thousands of job postings specifically in physical therapy, the site links to resources to help you advance your career—including a job search resource center with resume-writing and interviewing tips.

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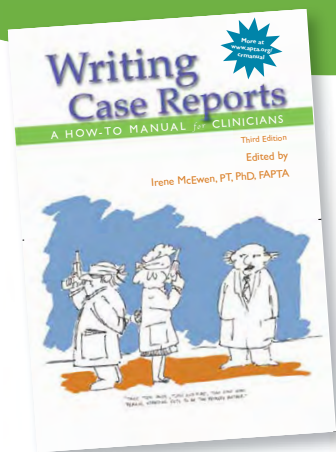
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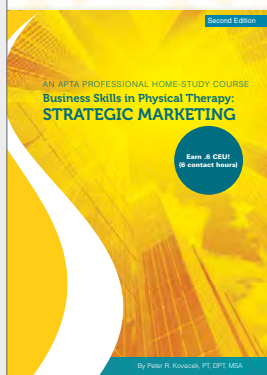
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Net Health, a provider of cloud-based software for specialized outpatient care, is acquiring Optima Healthcare Solutions, a provider of cloud-based electronic medical record software for contract therapy companies, skilled nursing and assisted living facilities, outpatient therapy clinics, home health therapy providers, and hospice organizations. The combined company will serve patients in more than 14,000 facilities across North America in specialized clinical settings throughout the continuum of care, from the hospital to the patient's home. Net Health will continue to be based in Pittsburgh, Pennsylvania, with office locations in 6 states.

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Michelle McGuire, PT, MPT, is the coordinator of the Division of Occupational Therapy and Physical Therapy at Cincinnati Children's Hospital.

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

When I was growing up, I spent a lot of time in dance studios with teachers who were true mentors. They taught me not only the joys of dance, but also how to care for myself physically and emotionally. It was hard and disciplined work, but dance wasn't approached like a competitive sport. It was, rather, a means of self-expression and community. I tended to be shy and reserved back then, but I always was comfortable in my own skin when I was dancing.

During my high school years—a time when I was consumed with dance—my grandfather had an accident on his farm that required extensive rehabilitation. I observed the restorative work of the caring and motivating physical therapists who were instrumental in his recovery. That experience and my love of dance together

led me toward a career in physical therapy, because I wanted to help others move their bodies freely. I did not want to let go of my artistic pursuits, though. So, while I pursued my prerequisites for physical therapist education as an undergraduate at Centre College in Kentucky, I danced as part of a major in dramatic arts.

In graduate school, I quickly realized that I wanted to pursue a career in pediatrics. I'd had more than 30 cousins in my extended family when I was a kid. I always loved playing and interacting with them, and I'd been a nanny to several children over the summers. I felt that pediatrics would be the perfect outlet for sharing with young people the creativity I'd developed through dance and in my liberal arts education.

I was fortunate to land a position with Cincinnati Children's Hospital right after completing the masters of physical therapy program at the University of Cincinnati. I loved my job, but I wanted to merge my twin passions for dance and pediatric physical therapy. I just didn't know how to do it. Then, a mentor alerted me to a *New York Times* article about an



adapted dance program for children with disabilities. “This is it!” I thought. “This is what I want to do!”

But first, I knew, I’d need to learn and grow in my new role as pediatric physical therapist. While I was doing so, I stayed active in dance by taking DanceFix—a high-energy dance workout class offered by the Cincinnati Ballet Company (CBC). Those classes kept me connected to the dance community while providing me with great stress relief.

Through DanceFix, I could step away from my rewarding but intense job a couple of hours a week to immerse myself in joyful movement.

Six years later, in 2014, Cincinnati Children’s Hospital’s Department of Occupational and Physical Therapy was approached by Julie Sunderland, CBC’s director of education—who I knew at the time as a DanceFix instructor—about collaborating with CBC to create an adapted dance program. As you might

imagine, I jumped at the opportunity! That was the start of Ballet Moves—a program designed to encourage creative expression and foster love of dance in children with special and specific needs.

I’ve been involved with the program ever since, and I’ve watched it—and our dancers—grow and develop. In fact, Ballet Moves has been much more successful than I’d initially dared imagine it could be. At first, I’d envisioned the program

Defining Moment



primarily as giving participants an alternative to traditional physical therapist services. I saw it as a place where students could develop their gross motor skills in a fun and engaging environment. But Ballet Moves has become so much more. It has reinvigorated and amplified everything I cherished about dance when I was a young girl—the spirit of community, the opportunity for self-expression, the thrilling release of movement—and it’s allowed me to share all of it with people who seldom have access to such opportunities.

I’ve been particularly touched by one of our dancers who has been part of the program from the beginning. She is primarily nonverbal and uses sign language to communicate. Because of her issues with expressive communication, many people assume that she also has receptive language difficulties—that she doesn’t understand what’s being said to or asked of her. But that’s not the case. She needs a little extra time to process things, but she gets everything.

In Ballet Moves, she’s given all the extra time she needs, and she’s encouraged to be independent and is challenged to try new things. She has the freedom she

needs to grow and develop. She has seized on those opportunities to thrive.

Her strength and confidence have grown dramatically. She has no problem expressing herself physically. She knows all the dance moves. In fact, she will dance for hours if you let her. She never loses focus or becomes fatigued. Not only that, but she’s taken the skills she’s gained in class and transferred them to other pursuits. She’s participated on a cheerleading team and has performed in a CBC production. This once largely disengaged young woman dances with such joy and enthusiasm that she lights up the room. But her transformation is just one of many.

Earlier this year, some dancers who have been with the program from the onset had the opportunity to perform in the Cincinnati Ballet Academy’s spring production. Watching them onstage—smiling, having fun, and engaging with the audience—and seeing the pride on their parents’ faces, I thought to myself, “This is what it’s all about.”

Ballet Moves has deeply moved *me* by allowing me to share with our dancers something that has greatly enriched my own life from a very early age. ■

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PT in Motion Asks...

What 1 thing would encourage more patients to seek physical therapist services?

a: Making potential patients and clients aware of how physical therapy can contribute to healthy aging.

– MOHAMED HASSAN, PT



a: Ease of entry. Although we have direct access in all states, there are limitations, and many insurances—Medicare and Medicaid included—require referral. If people with a minor or recurrent issue could make an appointment within 24 hours to be seen for 1-2 visits, they would be more likely to take advantage.

– LAURA COVILL, PT, DPT

a: Aside from getting the word out that we should be their provider of care for musculoskeletal concerns, we need to shift to more proactive care—for example, provide a free annual check-up for our patients and their families. This ultimately would change the dynamics of our profession.

– MICHAEL BRENNEMAN, PT, DPT



What is the most significant change you've seen in physical therapy in the past 10 years?

a: We've seen growth toward truly becoming one profession, within which all members advocate for our vision statement together.

– ANDREW WILCOX, PTA



a: Electronic medical records have changed the way we document to better reflect the care we provide our patients. Documentation is clearer, we have the ability to quickly add outcome and other measurements, and other health professionals and insurance companies can more easily review patient and client information.

– MICHELE SULWER, PT, DPT

a: The profession has gained a lot of respect. It's valued now as a legitimate approach to pain management and seen as an alternative to surgery and opioids.

– KAITLIN NAUGHTON, SPTA

a: More medically complex/unstable patients are being sent to subacute rehabilitation, as insurance companies expect decreased lengths of stay.

– MELANIE WELLS, PT

APTA encourages diverse voices. To give members a chance to share their insights and wisdom with colleagues, *PT in Motion* poses questions that any member is invited to address, and publishes selected answers. To participate in "PT in Motion Asks...", log in to the APTA Engage volunteer platform at <https://engage.apta.org> and create a profile. Find the "APTA National—PT in Motion Magazine Member Input" opportunity, review the rules for submitting, and click the Apply Today! button. You'll see a list of the questions and can respond to as many or as few as you wish in the space provided. We look forward to hearing from you and sharing your comments in future issues.

Responses may be edited for clarity, style, and space, and do not necessarily reflect the positions or opinions of *PT in Motion* or the American Physical Therapy Association.



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