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I’ve seen the difference in my clients when their sleep issues have been identified and addressed. Everything comes together. Their movement patterns are better. They’re paying closer attention and remembering to do their exercises.

Kara Schuft, PT, DPT, in “Promoting Sleep: Not a Leap” (page 14)
It’s all sunshine when you have a tool that knows exactly what you need.

A specialized rehab therapy solution takes the guesswork out of PT/OT/SLP documentation, compliance, reporting, and billing. So, go confidently and do what you love, care for patients.
Creating a Written Portrait

“Documenting value-based care” simply means painting a clear picture of the good things you’re doing as a PT.

Previous Compliance Matters columns have looked at the keys to effective documentation and at documenting the CPT® code descriptors that took effect on January 1, 2017—97161, 97162, and 97163 for evaluation, and 97194 for reevaluation.¹ ² This article takes the discussion full circle by recapping that information, further contextualizing it, and sharing some setting-specific considerations from an updated APTA document.

It’s easy to get caught up in terms such as “quality” and “value” when we talk about documentation, without stopping to think about what those words really mean. Sure, there are implications for billing and reimbursement, and, yes, there’s even a specific Quality Payment Program under Medicare that has an array of component parts (see “Resources” on page 8). But the bottom line, and best way to think about what documentation is, is this: It should tell the clear and complete story of everything that’s been done by the physical therapist (PT) and physical therapist assistant (PTA) to ensure that patients and clients achieve their best possible outcomes.

Documenting is much more than simply the means to a payment end. It’s a written record that, properly completed, serves you, your patient or client, and the entire health care system by ensuring continuity of care and contributing data that will facilitate improved future access to physical therapy by chronicling its worth with facts and figures.

Effectiveness Keys

What’s the purpose of the patient medical record? As noted in one of the previous columns,³ it plays several important roles.

It has an important clinical purpose, serving both to refresh the memory of the writer and to make sure that any PT filling in fully understands the patient’s issues and maintains the plan of care prescribed by the evaluating PT. It meets a payment objective by supporting the billed services. It meets a legal need by showing the appropriateness

Wanda K. Evans, PT, DPT, MHS, is senior payment specialist in the Department of Payment and Practice Management at APTA.

Matt Elrod, PT, DPT, MEd, is lead specialist in the association’s Practice Department. He is a board-certified clinical specialist in neurologic physical therapy.
of care against professional liability. It contributes to clinical research by providing data useful in determining best practice. It’s a tool, as well, that payers use during utilization review before authorizing payment for additional services.

Documentation must clearly establish the link between physical therapist services provided and the patient’s function—supporting medical necessity, showing measurable progress toward achievement of functional goals or maintenance of existing function that otherwise might have declined, providing a timeline, and explaining any lack of progress and presenting alternatives. The writing should be clear and easy to understand by nonclinician claim, utilization, and peer reviewers.

Coding Considerations

The CPT evaluation codes adopted in 2017 are tiered to reflect the complexity of evaluation—low, moderate, or high—as a previous Compliance Matters column noted. A chart accompanying that column described the components of low-, moderate-, and high-complexity physical therapy evaluations. They are (1) the number of personal factors and/or comorbidities impacting the plan of care; (2) the number of elements examined and assessed from a list that includes body structures and functions, activity limitations, and participation restrictions. This cumulative number “is a key determinant of the level of complexity.” The point was made, too, that “clinical decision making is not a separate component; you demonstrate it through effective documentation of your evaluation findings” and that it “reflects your judgment and multidimensional thinking.”

Every Word Counts

In a practical if not a literal sense, when it comes to documentation, if it wasn’t written down, it didn’t happen. That is, without a complete written record, there is no evidence—in a legal sense or even just to jog your own memory—of precisely what you did, when you did it, and the purpose it served.

Insufficient documentation doesn’t just cause payers to reject claims. It hurts patients, clinicians, and the health care system. The word “insufficient” here is key, because if you think you are adequately and appropriately documenting your actions and decision-making process when you jot down such brief notations as “Same as previous note,” “Did this with patient last week,” or “See flowchart,” you are...
Compliance Matters

mishandled. Put yourself in
the reader’s place—whether
that individual is a payer,
reviewer, or colleague. Why
would anyone deem valuable
such imprecise remarks—
which place the onus on the
reader to make a connection
or to track down a piece
of information? How does slow-
ing down the care process,
encouraging miscommunica-
tion, endangering payment,
and stymying data-collection
serve the needs of patients,
the profession of physical
therapy, and society?

Accordingly, APTA has com-
piled a variety of resources
detailing the properties of
optimal documentation—as
well as such related matters
as ethical and professional
considerations, documenta-
tion’s connection to develop-
ment of the Physical Therapy
Outcomes Registry, informa-
tion on the evolution and
importance of health care’s
movement from volume- to
value-based care, and advice
on how best to ensure integ-
rity in practice. (Again, see
“Resources” below.)

Of particular note is the
recent addition of a dedicated
section within the associa-
tion’s “Defensible Documen-
tation” webpage. Noting
“Depending on the setting,
there may be additional
regulations by payer, state,
local facility, or accrediting
organizations”—and adding
that “various clinical settings
have different norms, pro-
cesses, and influences that
often are outside the control
of the PT or physical ther-
pist assistant”—this resource
calls attention to these
factors and offer suggestions
for appropriate documenta-
tion. The settings addressed
are acute care hospitals;
prevention, wellness, fitness,
and prevention; home health;
outpatient services; skilled
nursing facilities/long-term
care; inpatient rehabilitation
facilities; long-term care
hospitals; pediatric settings
(early intervention and
school-based); state physical
therapy practice acts; and
workers’ compensation.

The document’s section
on acute care hospitals, for

resources

CENTER FOR INTEGRITY IN
PRACTICE
http://integrity.apta.org/
A product of APTA’s Integrity in Prac-
tice campaign, the center is designed
to help PTs, PTAs, educators, students
of physical therapy, and leaders better
understand fraud, abuse, and waste
in health care and the impact these
abuses have on the profession of
physical therapy, on individual practi-
tioners, and on freedom to practice. The
site links to resources for upholding
integrity, reducing risk, and improving
practice—including documentation—to
avoid fraud, abuse, and waste.

DEFENSIBLE DOCUMENTATION
www.apta.org/Defensible
Documentation/
This site takes a detailed look at all
the elements of a patient/client visit,
explaining—with illustrative exam-
pies—how best to document each
element to reflect best practice and
meet legal regulatory, and payer
requirements.

ETHICS & PROFESSIONALISM
www.apta.org/EthicsProfessionalism/
This page links visitors to association
resources on professionalism for the
PT, values-based behaviors for the PTA,
integrity in practice, core ethics docu-
ments, ethical decision-making tools,
dispute resolution, and legal matters.

PHYSICAL THERAPY OUTCOMES
REGISTRY
www.ptoutcomes.com
Launched last year to provide a user-
friendly system for collecting uniform
data of patient and client outcomes, the
Registry will help guide best practice,
help providers meet regulatory report-
ing requirements, generate benchmark-
ing reports, and help shape payment
policy. Learn more about it here.

QUALITY PAYMENT PROGRAM
www.apta.org/QPP/
Created through the Medicare Access
and CHIP (Children’s Health Insur-
ance Program) Reauthorization Act
of 2015, QPP reforms Medicare Part
B payments for more than 600,000
clinicians in all areas of health care. Its
2 participation tracks—the Merit-based
Incentive Payment System (MIPS) and
advanced Alternative Payment Models
(AMPs)—are described on this page.
Look for an article on the pending addi-
tion of some PTs to mandatory MIPS
participation in the November issue of
PT in Motion.

TIERED PHYSICAL THERAPY
EVALUATION CPT CODES
www.apta.org/PaymentReform/New
EvalReevalCPTCodes/
This site is dedicated to the tiered CPT
code system, with quick guides on
using the correct code, online courses
and webinars for more in-depth guid-
ance, and a new podcast series that
covers 4 of the most common coding
issues that APTA staff have been asked
to explain.

VALUE-BASED CARE
www.apta.org/VBC/
This site features a video explaining the
evolution and importance of the shift
from volume- to value-based care, infor-
mation on how PTs can best demon-
strate value, links to a self-assessment
quiz and a podcast series, and more.
example, notes that PTs and PTAs working in that setting “contend with many factors that may complicate the provision of care,” such as “varying patient caseloads, frequent cancellations due to tests and other activities, short lengths of stay, and shifting or unanticipated insurance changes and hospital discharge plans.”

The document specifically advises home health PTs, meanwhile, to avoid using such vague or subjective descriptions of the need for skilled care as “Patient tolerated treatment well,” “Caregiver instructed in medical management,” or “Continue with POC [plan of care].” PTs in home care instead should “adequately describe the reaction of a patient to the PT’s skilled care” and provide “a clear picture of the treatment, as well as the next steps to be taken.”

To cite another example, the APTA resource notes that early intervention services provided to children from birth to age 3 under Part C of the Individuals with Disabilities Education Act typically are provided within the child’s natural environment and are meant to be family-centric. This requires that documentation be “family friendly”—written in lay language, with minimal medical or technical terminology, to ensure that it is “meaningful to all team members, including the family and nonmedical professionals.”

While that advice is setting-specific, it’s an excellent rule of thumb for documentation in any clinical setting. The importance of documenting in a way that ensures understanding by any reader of the document—whatever his or her familiarity may be with physical therapy or the jargon and written shortcuts that PTs tend to favor—cannot be overstated. Words such as “quality” and “value” can sound vague and lofty, but their core meaning is as straightforward as your documentation should be.

Document with the objective of charting progress and creating a record of everything your patient and you have achieved together. Do not document solely to please the payer. Ensure that your record is clear, complete, and easily digestible in describing patient complexity, the worth of your interventions, and the outcomes you attained, or why they could not be reached. Once you’ve done that, the heavy lifting is complete. You have documented quality and demonstrated value-based care—simply by serving the patient’s needs and writing it all down.

REFERENCES
1. Evans WK. The keys to effective documentation. PT in Motion. 2016;8(7):8-12.
Hard to Reconcile
A case in which "old school" won’t do.

Once licensed, physical therapists (PTs) are free to practice in the setting of their choice, per their personal and professional interests. With that privilege, however, comes the responsibility of meeting current practice requirements. Consider the following scenario, in which a PT questions the need to possess a certain skill.

Dragged Into the 21st Century
Eleanor has been a physical therapist (PT) for more than 40 years and has worked in the home health setting for the past quarter-century. Her favorite part of the job is the opportunity each and every week to help people regain function and optimal mobility within their home environment. There are many things about her practice setting that she appreciates as an employee, too—the independence, the flexibility, and, frankly, insulation from wider changes in the profession that strike her as sometimes being detrimental to patients and clients, or simply faddish and of dubious value.

Granted, documentation has become much more detailed and time-consuming over the years—as it has in every practice setting. It dismays Eleanor, too, that the health care system increasingly sends people home from hospitalization and rehabilitation “sicker and quicker.”

At the same time, however, she doesn’t face the kinds of productivity demands that so often seem to burden her colleagues in other settings. Eleanor appreciates the fact that she treats just 1 patient at a time, sets her own schedule, and won’t be called on the carpet should traffic snarls delay her arrival at a residence.

While the veteran PT sometimes shakes her head in disbelief at how different things are from the days when she handwrote notes and called her agency from payphones, in many ways she feels as if her job has changed little over the years. Yes, she carries a laptop computer and uses a smartphone, but every time she attends a professional conference she feels inundated by an alphabet soup of new practice-related acronyms, and a bit intimidated by all the ways in which the profession seems to be expanding.
its focus beyond its traditional core. “I’m very happy to be in my own little professional bubble,” she confides to her husband. Eleanor’s stance is that she excels within her niche and that’s what’s important. She focuses her continuing education on subjects that help her be the best home health PT she can be—not on techniques and trends she’s unlikely ever to use or personally experience.

One health care trend that does upset Eleanor in her chosen setting, however, is the reduction of services that individuals in home health receive. In the “old days,” patients in home care might have services provided to them by a PT, an occupational therapist, a speech language pathologist, and/or a nurse. Increasingly, however, only 1 or 2 of those services tend to be authorized. Sometimes Eleanor is the only health care professional on a given case. Where this has proven most problematic to her is in the area of medication reconciliation. That wasn’t covered when Eleanor was in school. It’s beyond her skills set, so she’s been calling her agency to assign a nurse to applicable cases to perform this task.

**resources**

At [www.apta.org/EthicsProfessionalism/](http://www.apta.org/EthicsProfessionalism/)

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

At [www.apta.org/PTinMotion/2006/2/EthicsinAction/](http://www.apta.org/PTinMotion/2006/2/EthicsinAction/)

- “Ethical Decision Making: Terminology and Context”

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What Eleanor deems an appropriate response to the problem of underassignment of services is called into question, however, during her annual evaluation. Her supervisor notes that Eleanor has the highest rate of what the company considers to be unnecessary referrals to other services. The reason, she’s told, is because several times she has asked a nurse to do what should be her job.

Eleanor’s supervisor, Pat, notes that for several years the state physical therapy act has listed medication reconciliation as being among the skills that all entry-level practitioners should have. Pat adds, to Eleanor’s even greater surprise, that APTA—of which both Pat and Eleanor are members—years ago issued an official statement on the role of PTs in medication management.

Pat reads Eleanor a key passage of that statement: “APTA believes, and it has been acknowledged in federal guidance, that it is within the scope of the physical therapist to perform a patient screen in which medication issues are assessed even if the physical therapist does not perform the specific care needed to address the medication issue.

Considerations and Ethical Decision-Making

Self-reflection is a critical quality in any health care provider. Am I capable in all ways of providing what my patient or client needs—mentally, physically, and emotionally—with the bounds of my professional role? If not, what must I do to address my deficiencies and ensure competence? In the instance of medication reconciliation, Eleanor’s approach has remained consistent, but times and needs have changed.

**Realm.** The realm here is **individual.** The ethical focus is squarely on Eleanor.

**Individual process.** Moral judgment is required of the PT in this case, as she must decide between the right and wrong actions of, respectively, meeting the requirements of her profession or trying to continue to delegate a responsibility that is properly hers. Moral motivation also applies, in that Eleanor must prioritize her profession’s interests over her personal desire to maintain the status quo.

**Ethical situation.** This is an ethical problem for Eleanor that can be addressed by taking the necessary steps to resolve it—presumably with her agency’s full support.

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

- Principle 2A. Physical therapists shall adhere to the core values of the profession and shall act in the best interests of patients/clients over the interests of the physical therapist.
- Principle 3C. Physical therapists shall make judgments within their scope of practice and level of expertise and shall communicate with, collaborate with, or refer to peers or other health care professionals when necessary.
- Principle 6B. Physical therapists shall take responsibility for their professional development based on critical self-assessment and reflection on changes in physical therapist practice, education, health care delivery, and technology.

The physical therapist is competent and qualified to serve as case manager and facilitate coordination of care with physicians and nurses.”

Eleanor says nothing, but is taken aback. She feels strongly that placing medication reconciliation in the hands of a nurse is the right thing to do for her patients, and she inwardly balks at the idea that this is an appropriate role for a PT. Sometimes when she’s at professional conferences Eleanor wonders if the profession isn’t somehow subtracting from PTs’ core strengths by asking them to be “all things to all people.” She feels that way now, as Pat asks her what she intends to do to reduce unnecessary referrals.

For Reflection

Is it enough to do what you always have done well as a PT or physical therapist assistant? Or, is it reasonable to expect that, regardless of your practice setting, you possess all of the baseline knowledge and skills described in your state’s practice act?

For Followup

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

If you are reading the print version of this column, go online to www.apta.org/PTinMotion/2018/10/EthicsinPractice/ for a selection of reader responses to the scenario, as well as my views on how the situation might be handled. If you are reading this column online, simply scroll down to the heading “Author Afternote.”

Be aware, however, that it generally takes a few weeks after initial publication for feedback to achieve sufficient volume to generate this online-only feature.
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Promoting Sleep: Not a Leap

When PTs snooze on broaching the subject of sleep health, patients and clients lose.

BY ERIC RIES
“There may not be a single body system that can’t be improved by getting sufficient sleep.”

— Keith Poorbaugh

Keith Poorbaugh, PT, ScD, gets poetic when he talks about the power of shuteye.

“Sleep,” he says, “is one of your own personal riches. It’s yours to invest in or give away.”

He invokes philosophy. In a blog post last fall titled “Sleep: The Body Mechanic’s Workplace,” Poorbaugh wrote, “My favorite quote is from Plato: ‘The cure of the part should not be attempted without treatment of the whole.’ Whether it’s recovery from surgery or healing from a chronic injury,” he continued, “sleep is a necessary element of the healing process. Once we have emerged alive and awake from the tissue trauma, the long journey ahead is far less difficult if we develop good sleep behaviors.”

Poorbaugh owns aptly named Northern Edge Physical Therapy in Wasilla, Alaska. Ask him about the effects of the Last Frontier’s boom-and-bust daylight cycles on his fellow Alaskans’ sleep habits, and he sounds equally concerned and frustrated.

During the “midnight sun” months, Poorbaugh says, “There’s so much available daylight that people stay up until all hours doing ‘Alaskan things.’ It’s a badge of honor.” He continues, “How much can I get done by going to work early and staying up late working on projects? It’s a challenge to me as a physical therapist, trying to get patients and clients to understand the value of a good night’s sleep. They don’t think there’s any penalty.”

But there’s a toll, all right, Poorbaugh wants those both-ends candle-burners to know.

“There may not be a single body system that can’t be improved by getting sufficient sleep,” he says—or that, conversely, can’t be compromised by insufficient sleep. He cites a wide body of evidence that was laid out last year in an article published in Physical Therapy (PTJ), APTA’s scientific journal. The authors of the perspective piece, titled “Sleep Health Promotion: Practical Information for Physical Therapists,” emphasized sleep’s relevance to physical therapist practice.

“Sleep is critical for immune function, tissue healing, pain modulation, cardiovascular health, cognitive function, and learning and memory,” the authors wrote. Insufficient sleep, they added, can result in “increased pain perception, loss of function and reduced quality of life, depression, increased anxiety, attention deficits, information processing disruption, impaired memory, and reduced ability to learn new motor skills,” as well as “increased risk for accidents, injuries, and falls.”

Poorbaugh opened his clinic 5 years ago, after a dozen years in the orthopedic realm, because he felt the need to “bridge” that area of physical therapist practice with wellness approaches to health and healing. His integrative efforts include asking every patient or client a few basic questions about their sleep quality and habits. He proceeds to screening and referral if sleep issues such as chronic insomnia, obstructive sleep apnea (OSA), or restless legs syndrome (RLS) are suggested, and he shares strategies for optimizing sleep.

Poorbaugh acknowledges the “1 more thing” argument—the concern that physical therapists (PTs) have more than enough on their plates already without also plumbing such arguably peripheral concerns as people’s sleep habits. He counters, however, that it takes little time and effort to gain sleep insights that may yield highly significant results for both patient and PT.

That’s an equation that other PTs interviewed for this article endorse, as well. And they have the patient stories to back it.

NUMBERS AND NEED

APTA recognizes sleep’s importance to physical therapist practice in the House of Delegates’ position “Health Priorities for Populations and Individuals.” Sleep health, the position notes, has been designated as a “health priority” in the National Prevention Council’s National Prevention Strategy. To support sleep health, the position further states that PTs should “provide education, behavioral strategies, patient advocacy, referral opportunities, and identification of supportive resources after screening.”

Look at the statistics, and it’s not difficult to see the impetus to action.

According to the National Institutes of Health (NIH), an estimated 50 million to 70 million Americans “chronically suffer from a disorder of sleep and wakefulness, hindering daily functioning and adversely affecting health and longevity.” The “deleterious consequences,” NIH continues, include “increased risk of hypertension, diabetes, obesity, depression, heart attack, and stroke.”

Further dissecting the numbers, an estimated 10% of American adults have chronic insomnia (difficulty falling or staying asleep at least 3 times per week for at least 3 months), 34% of American men ages 30 to 70 and 17% of American women in that age group have OSA, and at least 5% have RLS. “Hundreds of billions of dollars are spent and/or...
lost annually as a result of poor or limited sleep” that contributes to everything from workplace injuries to automotive accidents, NIH states.4

The American Academy of Sleep Medicine and the Sleep Research Society recommend that adults get 7 or more hours of sleep per 24-hour period, with the minimum number increasing as age brackets get younger.6,7 Youth ages 13 to 18, for example, are urged to get 8 to 10 hours of sleep, and 6- to 12-year-olds are advised to sleep for 9 to 12 hours per 24-hour period.

The National Sleep Foundation’s 2018 Sleep in America Poll8 found, however, that while a majority of American adults (65%) believe that sleep contributes to next-day effectiveness, only 10% prioritize it over other aspects of daily living—it lags behind such activities as work (27%) and hobbies and interests (17%), and is essentially on a par with social life (9%) among daily-living priorities.

Katie Siengsukon, PT, PhD, has long seen insufficient sleep among Americans as a serious health issue. As a new graduate working in an outpatient clinic in 2002, she says, “I saw people with all sorts of different diagnoses, and I was surprised by how many of them simply brought up the fact that they were having difficulty sleeping—I didn’t even have to ask them.” Beyond advising those patients on positioning to minimize pain they were experiencing, “I didn’t know what to do with them,” she says—adding, “I got zero information about sleep in PT school.”

Those experiences started her on a quest for answers. She focused her PhD a few years later on the role of sleep in motor learning in individuals who’d had a stroke. Now an associate professor in the University of Kansas’s (KU) Department of Physical Therapy and Rehab Science, Siengsukon directs the school’s Sleep, Health, and Wellness (SleepWell) Lab and conducts research on how sleep affects physical and cognitive function, learning, and overall health in adults both with and without neurologic injury or disease. She was the lead author of the aforementioned PTJ piece.

Siengsukon describes her interest in sleep health and its promotion by PTs as a “crusade.” PTs, she says, “should be talking about ways to promote sleep health in our clients—every single one of them—and referring those individuals if a sleep disorder is suspected.”

Kara Schuft, PT, DPT, heartily agrees. She always asks her patients and clients if they’ve been having any trouble sleeping. Like Poorbaugh, she has posted a list of “healthy sleep habits” on her clinic’s blog—it starts with “Go to bed at the same time every night” and includes such tips as cutting off caffeine after 3:00 pm, nixing electronic device screens at least a half-hour before bed, establishing a relaxing bedroom routine that might include taking a warm shower or reading a book, using the bed for sleep and sex only, and creating a sleep-conducive room environment in terms of temperature, darkness, and noise.

“Sleep is vital,” says Schuft, an owner of Whole Body Health Physical Therapy in Portland, Oregon. “It’s such an important time, not only for physical healing but also for mental well-being. I’ve seen the difference in my clients when their sleep issues have been identified and addressed,” she adds. “Everything comes together. Their movement patterns are better. They’re paying closer attention and remembering to do their exercises. All of these things that were barriers—that I might have documented simply as ‘poor home exercise adherence’ if I hadn’t delved into what was really going on—fall away.”

“I often find sleep deficit to be significant factor in what’s happening with an individual who comes to see me for physical therapy,” Schuft says. “That’s why I feel so strongly that we, as PTs, need to take the time to start that sleep conversation.” The discussion can be spaced over several visits, she adds, if the individual is lukewarm to making behavioral changes or dubious that Schuft’s suggestions will yield benefits.

“Sometimes people tell me, ‘I tried that before, and it didn’t work,’” Schuft says. “I don’t want them to feel unheard or not validated, so I try to keep the conversation open-ended and ask if there’s anything else they might be interested in trying—such as a ‘night shift mode’ on their phone to reduce blue light exposure—or if they might consider revisiting an approach they’ve explored.”

That subsequent sleep conversation may turn out to be the driver, Schuft says, of a “cascading effect in which all of these changes occur that help you achieve better outcomes with that patient.”

Every PT is busy, Siengsukon acknowledges, referencing the “1 more thing” concern. “We have so much to cover already. But if we’re not addressing sleep,” she believes, “we’re doing our patients a huge disservice. We’re potentially limiting their ability to heal and recover, and perhaps compromising their quality of life.”

KEY QUERIES
The PTJ article stated that sleep disturbances “are likely present in many individuals receiving physical therapist services, which may exacerbate or perpetuate their condition, slow recovery, and impact their outcomes.” Authors Siengsukon, Mayis Al-dughmi, PT, PhD, and Suzanne Stevens, MD, also noted that sleep is “frequently altered” in the presence...
of neurologic conditions such as stroke, Parkinson disease, Alzheimer’s disease, multiple sclerosis (MS), and spinal cord injury—with implications for both ability to learn and recovery. Sleep disturbances also are common, the authors wrote, in people with neck and back pain.

All of this warrants “a focus by PTs on integrating sleep health into wellness and health promotion interventions,” Siengsukon and her colleagues wrote. They outlined a 6-step process that begins with assessing overall sleep health—asking sleep-related questions—and screening for risk of sleep disorders.

The authors recommended that PTs ask the following questions during the patient interview portion of their examination. The final 3 are designed to determine if screening for chronic insomnia, OSA, and RLS may be indicated:

1. How much sleep do you typically get?
2. Do you feel well-rested when you wake up?
3. Is the condition that brought you to physical therapy affecting your sleep? If so, how?
4. How would you rate your sleep quality?
5. Does being sleepy during the day interfere with your daily functioning?
6. Do you have difficulty falling asleep, returning to sleep if you should wake up during the night, or waking up too early?
7. Do you snore loudly or frequently? Has anyone observed you stop breathing while you sleep?
8. Do you have a strong urge to continually move your legs while you are trying to sleep?

Speaking with PT in Motion, Siengsukon suggests the list is adaptable to the individual PT’s treatment style, reading of the patient, and time concerns. “At very least,” she advises, “ask generally, ‘How are you sleeping?’ If the person says ‘Great,’ it may be that no further exploration is necessary,” she says. “But if the person answers negatively, that can open up a conversation.”

Siensukon suggests 2 basic sleep questions that should be on a standard intake questionnaire: “How many hours of sleep do you usually get?” and “Do you feel rested upon waking?”

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“It sometimes can be difficult to decipher if depression and anxiety is the sleep problem, or if the sleep problem was first.”

— Perry Brubaker

Perry Brubaker, PT, DPT, owner of Brubaker Prevention & Health Promotion in Peachtree City, Georgia, asks what she believes is a “safe” question to get at possible sleep issues with her patients and clients, who she visits and treats in their workplaces and homes: “Tell me about the tempo of your day.”

“People don’t really know what you’re driving at,” he says, “so they’ll take you through their daily schedule and tell you about all the things they need to do in the course of the day. It gives me a good sense of how busy they are. From there, it’s easy to ask, ‘What time do you find yourself getting to bed?’ Their answer to that question, then, informs where I go from there.”

Also, rather than having her patients and clients complete a standard medical history, Brubaker distributes a “health behaviors assessment” that asks medical questions but also includes lifestyle-related queries. The form she uses is designed by the Academy of Prevention and Health Promotion Therapies, of which she is a member, but any PT can get basically the same feedback, she advises, by adding to the standard intake form such questions as “How much sleep are you getting?”, “How many fruits and vegetables are you eating?”, and “How much water are you drinking on a daily basis?”

Joe Tatta, PT, DPT, covers the insomnia, OSA, and RLS bases with his patients and clients through 3 questions that appear on his intake form: “Do you regularly have difficulty falling or staying asleep?”, “Do you snore or make choking noises at night?”, and “Do you have tingling or a sensation like ants crawling on your legs that affects your sleep?” Should the individual answer “Yes” to any of those questions, he gives that person a 30-question sleep questionnaire that he designed. It takes only about 3 minutes to complete, he says, and covers such areas as sleep hygiene (behaviors that promote good sleep), exercise, stress, medications and sleep aids, and nutrition. Tata, a board-certified clinical specialist in orthopaedic physical therapy and a board-certified nutrition specialist, maintains a private practice in New York City.

If an individual’s responses to sleep-related questions suggest that screening is appropriate, Siengsukon and her colleagues suggested in PTJ that PTs use the following tools—while keeping in mind certain considerations or recommendations:

For insomnia, administer the Insomnia Severity Index—while considering whether the patient’s current condition may be contributing to insomnia symptoms and if treatment of the underlying condition might resolve the insomnia.

For OSA, use the STOP-Bang questionnaire—while being mindful when counseling about sleep position, as sleeping supine can exacerbate OSA.

Rather than screen for RLS, refer patients to their physician if they answer “yes” to the question, “When you try to relax in the evening or sleep at night, do you ever have unpleasant restless feelings in your legs that can be relieved by walking or movement?” Consider the patient population, however. Individuals with MS, for example, may answer “yes” due to such non-RLS factors as spasticity, altered sensation, and lower extremity pain. In those cases, have the physician determine if RLS is present or if treatment of comorbid systems that are disrupting sleep is warranted.

The second of the authors’ 6 steps to integrating sleep health into physical therapist practice is “Refer for additional assessment if individual is identified as at increased risk for a sleep disorder.” That referral typically is to a physician, who may suggest the individual undergo a sleep study to confirm or rule out a sleep disorder. But Brubaker notes that many of her patients with sleep issues—typically women in their 40s and 50s—show signs of depression that merit a different referral destination.

“It sometimes can be difficult to decipher if depression and anxiety is the sleep problem or if the sleep problem was first and now that person is depressed and anxious,” she observes. “But either way, when sleep is an issue and the mitigating interventions that I’m doing in physical therapy—exercise, positioning, instilling healthy sleep habits—aren’t helping, that’s a red flag that this person needs to see a
behavioral specialist about a possible mood disorder.”

**HIGHLIGHTING HYGIENE**

The third step to integrating sleep health into physical therapist practice is “Provide sleep hygiene education.” Siengsukon defines sleep hygiene as “the behaviors and environment that promote good sleep quality.” They mirror the advice Schuft shared in her blog post— involving such factors as bedtime routine, exercise, diet, and sleep environment. In her discussion with *PT in Motion*, Siengsukon elaborates on points PTs should discuss with patients and clients in conversation:

➤ “If you’re having difficulty sleeping at night, the recommendation is not to sleep during the day,” Siengsukon says. “Some of my research clients with MS have so much fatigue that a brief nap may be needed. But even there, I emphasize the word ‘brief’: it should last no more than 20-30 minutes and should happen in the early afternoon at the latest.”

➤ “I encourage people to find a relaxing bedtime routine that works for them, such as reading a book,” she advises. Siengsukon adds, “I’m interested in a technique called cognitive behavioral therapy for insomnia, or CBT-I. It’s the gold-standard nonpharmacological intervention for that condition because it gets at the behaviors that perpetuate it, such as a having a variable sleep schedule and spending extra time in bed in hopes of getting additional sleep. CBT-I also addresses thought processes that perpetuate insomnia, such as having a ‘racing mind’ and worrying excessively. My CBT-I intervention for people with MS includes breathing techniques that promote relaxation, mindfulness instruction, and muscle relaxation—the goal being to get both the mind and the body ready for sleep.”

➤ “The sleep environment is important,” Siengsukon notes. “Make the bedroom conducive to sleep. Make sure it’s as dark as it can be—put up curtains if you need to, or wear a sleep mask. Use earplugs or a white noise machine to block out sounds that aren’t soothing. Make sure your mattress and pillow are comfortable.”

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“Alcohol might help you get to sleep,” she warns, “but it’s antithetical to deep, sustained, restorative sleep. So, limit your alcohol intake to a drink or less per night. Limit your intake of all liquids before bedtime, in order to reduce overnight bathroom visits.”

“Medication is something that’s worth discussing with people,” Siensukon advises. “If people are taking over-the-counter medications such as Tylenol PM or Benadryl to help them sleep, discuss with them why those apparent ‘fixes’ can cause problems.”

Mike Karegeannes, PT, LAT, MHSc, urges his patients and clients to disengage from all lighted screens at least 1 hour before bedtime—or, failing that, to deploy features available on newer smartphones and other electronic devices that dim the glow.

Another tip: Have an old-school pen and piece of paper handy at bedside. “Write down whatever’s rattling around in your brain, so you can put it to rest and not have to worry about remembering it tomorrow.”

Karegeannes owns Freedom Physical Therapy Services, with 4 clinics in the Milwaukee area. He’s not sure how accurate the growing array of wearable and mobile sleep-tracking devices are, but he observes that if they prompt users to value their sleep health more highly, that’s a good thing.

That observation jibes with the findings of the PTJ authors. On one hand, they wrote that “there is insufficient evidence to recommend [that] wearable devices or sleep apps be used to provide valid or reliable information regarding sleep.” On the other, they cited studies indicating that such devices “may provide the benefit of increasing public awareness of the important health benefits of sleep.”11 and may “encourage personal empowerment.”12

THE EXERCISE ELEMENT

Providing an “appropriate” exercise program is the fourth aspect cited in the PTJ piece on sleep health promotion by PTs. A meta-analysis, the authors wrote, “indicates that acute and chronic exercise has a moderate positive benefit on sleep characteristics by increasing slow-wave [deep] sleep and total sleep time, and decreasing sleep onset latency.”13,14 The time of day the exercise takes place may not matter, the authors added, citing the experiences of respondents to the 2013 Sleep in America poll.15

Where “appropriateness” comes in lies in tailoring the exercise program specifically to the condition that brought the individual to physical therapy, and how it is affecting that person’s sleep.

“For example,” Karegeannes says, “if you feel that weakness of the gluteus medius is contributing to back pain that is affecting sleep, don’t focus your exercise program only on knees-to-chest and pelvic-tilt exercises, but also on strengthening the glutes. Similarly, if neck pain is compromising sleep, consider exercise to address weakness in the deep cervical neck flexors or extensors that may have gone unnoticed.”

POSITIONING FOR SUCCESS

Rounding out the list of sleep-promotion steps enumerated in the PTJ piece are 2 interrelated ones—“Consider positioning to promote sleep quality” and “Address bed mobility issues.”

The authors offered this example in the PTJ article: “An individual with low back pain may benefit from instruction to sleep side-lying with a pillow between his knees, or to sleep supine with pillows under his knees to reduce lordosis of the back.”

The authors continued, “If a patient has difficulty with transfers and bed mobility, the therapist should address the underlying impairments causing the functional deficits,” because “adequate bed mobility is needed to change position while sleeping, and improved ease changing position during sleep may reduce sleep disruptions.”

To the PTJ authors’ first point, Karegeannes notes that “sleeping on one’s stomach can put the low back into increased extension, narrow the spinal canal and intervertebral foramen, and increase low back or neck pain.” So, he says, he may advise people to sew tennis balls into a T-shirt or to buy one of the various products in the marketplace that are designed to prevent sleepers from rolling onto their stomach.

“Often,” Karegeannes adds, “I ask my clients to wear a lumbar or cervical roll around their low back or neck to help keep their spine in neutral and avoid irritating a compressed nerve.” Because women tend to have a narrower waist but wider hips than do men, women who sleep on their side may wake with pain because their lumbar or cervical spine has shifted toward the mattress, compressing a nerve. “By getting them to wear a lumbar or neck roll, I can help them avoid that situation and sleep without interruption,” he says.

“MIRACULOUS” RESULTS

Schuft happily recalls the experience of a man who had come to her with a diagnosis of chronic low back pain and radiculopathy (pain radiating into his legs). Beyond those issues, he’d been experiencing difficulty sleeping and had in fact already been urged by his physician to undergo an overnight study for suspected OSA. But Schuft’s patient dreaded confirmation of OSA and the resulting prospect of being tethered to a continuous positive airway pressure (CPAP) machine every night to aid his sleep.

Karegeannes
“There’s a lot of stigma around CPAPs,” Schuft notes. “My patient was worried that it would constrict his movement, feel strange, and look ugly to his partner. So, he didn’t want any part of the sleep study.”

Knowing what she did about the machine’s potential impact on his overall health and well-being, as well as his physical therapy outcomes, she encouraged him to go ahead with the study. “This really could change your life,” she told him. Still skeptical but bolstered by Schuft’s enthusiasm, he underwent the sleep study. His fears were confirmed—he had OSA and would need a CPAP machine. But Schuft’s forecast also held true. “The change was miraculous,” she says. “His cognition and ability to pick up and retain new information improved immensely once he started sleeping with the CPAP. His mood was more upbeat. He was more engaged in his physical therapy. He had more energy in the clinic, which mirrored what he reported to me about his energy level in general. He was, in a way, a new man.”

Sometimes, Siengsukon reports, simply taking the initiative to discuss sleep with a patient can have a profound impact. She recalls a woman with MS who was deeply moved by Siengsukon’s interest in her sleep patterns, remarking that no member of her health care team had thought to broach the subject in the 10 years since her MS diagnosis. “She told me, ‘You’re the first person in all that time to talk to me like I’m a whole person. The others talk about things like my medications or my balance, but you ask me about nutrition, exercise, and 1 of the things that’s most important to me in my life—sleep.’”

The 2 women met once a week for 6 weeks as part of an ongoing research study Siengsukon is conducting. It is a CBT-I intervention that aims to control or eliminate negative thoughts that often keep a patient awake at night and to encourage behaviors that instill good sleep habits. Afterward, Siengsukon said, the woman “slept better, felt better, was more productive at work, and had the energy and improved mood to go out with friends more and engage with the world.”

Tatta recently asked a patient with fibromyalgia about her sleep. She told him she sometimes sleeps just an hour a night. Stunned, he looked into her medical history. “I discovered that she was on a muscle relaxer, an opioid,
benzodiazepine, and an antidepressant,” he says. “The opioid-benzodi-
azine combination was potentially lethal, and the combination of all those
drugs was having a devastating effect on her sleep.”

Tatta apprised the woman’s primary
physician of the situation. She subse-
quently was weaned off the opioid and
muscle relaxer and now is on the road
to better sleep and energy. The PT
improved the quality of her life—and
may even have saved it. It’s a role
Tatta believes his colleagues should
be increasingly prepared to play—par-
ticularly as the profession promotes
#ChoosePT as a safe alternative to
opioids for pain management.

“In the future,” he says, “I believe we’re
going to play more of a role in helping
people taper off medications they don’t
need, as they are introduced to physical
therapy and other lifestyle interven-
tions that work without the dangers that
tose narcotics pose.”

GROWING AWARENESS

Like Siengsukon, Poorbaugh wasn’t
exposed to sleep’s importance during
his studies to become a PT. “I went
to the Mayo Clinic, and I don’t recall
any areas of well-being such as sleep
or nutrition being mentioned in the
curriculum,” he says.

But that’s changing. “DPT programs are
starting to incorporate courses
dedicated to prevention and health
promotion,” Siengsukon observes,
“with sleep often being a component
of that instruction.” As a result, she adds,
new graduates tend to be more attuned
to asking the kinds of questions and
initiating the types of conversations
that the PTs interviewed for this article
say are needed.

That’s certainly been Poorbaugh’s
experience.

“I’ve got 2 new grads working with me
now—one’s a year out of school, the other
only a few months. They definitely are
receptive to taking a broader wellness
approach to patient and client inter-
views,” he says. “I find that they’re eager
to expand their focus to all the different
aspects of getting people better.”

Brubaker acknowledges that discussing
sleep and other lifestyle aspects with
patients and clients tests the comfort
zone of some PTs.

“It can feel scary to ask about things
for which there might not be a ‘fix’
within our scope of practice as physical
therapists,” she says. “But 1 of the main
things that PTs should understand
about sleep issues is that they don’t
have to fix it. They just need to talk
about it.” Sleep education, appropriate
exercise, and positioning are well
within PTs’ scope of practice, she notes,
and referral is appropriate when sleep
disorders are suspected.

The “beautiful” thing about sleep,
Brubaker says, is that PTs can play
important roles in bringing issues to
the surfaces and ensuring that patients
and clients get the help they need, but
that, “Strictly speaking, we don’t need
to have the ‘answer.”

Rather, those interviewed for this
article say, the key lies in asking the
questions.

Eric Ries is the associate editor
of PT in Motion.

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WHERE DO YOU WANT TO PRACTICE?

BY DONALD E. TEPPER
Every state has much to offer physical therapists and physical therapist assistants. It may be quality of life. Employment opportunities. Regulatory and business friendliness. Or any of dozens of other features. Where you decide to practice depends on which factors mean the most to you. Here is *PT in Motion*’s annual analysis of the criteria that may make a state attractive for employment.

What’s makes a state a desirable place to practice physical therapy?

The answer of course depends in part on what you value. How important is salary? Quality of life? Future job prospects? Regulatory restraints? Demographic characteristics (such as age and health) of the state’s residents? And so on.

Many rankings of “best states,” in fields ranging from health care to retirement, use some combination of these factors. *PT in Motion*’s analysis uses dozens of data sources to build on 8 criteria:

1. Well-being and future livability
2. Literacy and health literacy
3. Employment and employment prospects
4. Business and practice friendliness
5. Technology and innovation
6. Physical therapist (PT), physical therapist assistant (PTA), and student engagement with APTA
7. Compensation and cost of living
8. Health and financial disparities

To evaluate states in each category, the average ranking nationwide is assigned a score of 10. Above-average states are awarded additional points; the more they exceed the average, the more points they receive. Other states receive fewer than 10 points, based on how much below average they scored. Reader response to past surveys suggests that all 8 factors are important. You, however, might personally rank one higher than another, while your colleague might do the opposite. For *PT in Motion*’s 2018 report, therefore, we cite the states that ranked highest for each factor, allowing you to adjust the rankings to your personal preferences.

### 1. Well-being and Future Livability.

Quality of life—as it relates to PTs, PTAs, and the general population—and the overall health of the population are included here, as are projections on future living conditions. *PT in Motion* uses 4 data sources. Two—dealing specifically with well-being and future livability—are compiled by Gallup. Each, in turn, is based on multiple inputs. The third is life expectancy at birth—a measure of overall health and well-being. The fourth, which reduces well-being, is drug overdose death data compiled by the Centers for Disease Control and Prevention (CDC).

**Leading states for well-being and future livability**

1. Minnesota
2. Hawaii
3. North Dakota
4. South Dakota
5. Nebraska

### 2. Literacy and Health Literacy.

Both forms of literacy reflect the ease and effectiveness with which health care providers can communicate with patients and clients. *PT in Motion*’s measures of general and health literacy have multiple inputs: Percent of population in poverty (source: Census Bureau), literacy—level of basic prose literacy skills (source: US Department of Education), home access to the internet (source: US Census Bureau), percentage of population with graduate or professional degrees (source: US Census Bureau), high school graduation rate (source: US Census Bureau), and health literacy rankings compiled by the University of North Carolina.
Drug-overdose deaths in 2016 in the United States. The highest rates per 100,000 population were in West Virginia (52.0) and Ohio (39.1). The lowest rate was in Nebraska, at 6.4 per 100,000 residents. The greatest number of deaths occurred in Florida (4,728) and California (4,654).

SOURCE

MISSISSIPPI
The state with the lowest cost of living, at 84% of the national average. Other less-expensive states are Oklahoma (88.3%), Michigan (88.7%), Arkansas (88.8%), and Alabama (88.8%). The state with the lowest health care cost of living is Arkansas, at 88.0%.

SOURCE

BEND-REDMOND, OREGON
Best-performing small city—an index measuring a city’s job creation power and financial sustainability. Tourism, health care services, and high-tech sectors often contribute. Other high-performing small cities are St George, Utah; Gainesville, Georgia; and San Rafael, California.

SOURCE

$102,860
Mean (average) wage for PTs in Nevada, the highest in the country. Other high average wages were reported in New Jersey ($99,420), Alaska ($97,150), and Texas ($95,920).

SOURCE

SOUTH DAKOTA
State ranking highest in “well-being,” which reflects residents’ feelings about purpose, social relationships, finances, community, and physical health and energy. Also ranking high: Vermont, Hawaii, and Minnesota.

SOURCE

54%
PTAs in Alaska who belong to APTA, the highest rate in the country. Other states with high shares of APTA-member PTAs include South Dakota (30%), Nebraska (23%), and Hawaii (21%). In terms of numbers, Florida has the most PTA members, at 649.

SOURCE

31.3%
Projected increase in PTA employment from 2016 to 2026, with annual job openings greatest in Ohio (1,010) and Florida (930). The largest percentage changes are expected in Colorado (43.4%) and Oregon (35.4%). During the same period, the projected increase in physical therapist employment is expected to be 28%. The largest percentage changes are expected in Utah (46.2%) and Colorado (44.4%).

SOURCE
Leading states for literacy and health literacy
1. New Hampshire
2. Minnesota
3. Utah
4. Vermont
5. North Dakota

What’s the job situation? This calculation is based on state population and projections for the percentage growth in physical therapy jobs. We used Department of Labor projections for PT employment from 2016 through 2026, current state population estimates, metropolitan statistical area estimates from the US Census Bureau, and a report titled “2017 Best-Performing Cities” compiled by the Milken Institute.

Leading states for employment and employment prospects
1. Utah
2. Colorado
3. Florida
4. Georgia
5. Texas

4. Business and Practice Friendliness.
Many health care professionals say it’s desirable to practice in a state that is friendly toward business. *PT in Motion*’s rankings use 4 sources. The first is the 2017 Thumbtack.com Small Business Friendliness Survey. The second is CNBC, which ranks all states based on more than 60 measures of competitiveness, using input from business groups, economic development experts, companies, and the states themselves. The third source, specific to PTs and PTAs, is APTA’s “Levels of Patient Access to Physical Therapist Services in the States.” The fourth source is a current listing of state status in adopting the Physical Therapy Licensure Compact.

Leading states for business and practice friendliness
1. Utah
2. Colorado
3. Oregon
4. Nebraska
5. Massachusetts
5. Technology and Innovation.

Health information technology (IT) and maintenance of electronic health records (EHR) is increasingly important in the practices of PTs and other health care providers with whom they interact. We use 5 rankings: state telehealth laws and reimbursement policies published by the Center for Connected Health Policy,15 EHR incentive program measures for physicians and hospitals published by the Office of the National Coordinator for Health IT, the US Department of Health and Human Services, and state technology and innovation rankings published by CNBC16 and the Milken Institute.17,18

Leading states for technology and innovation
1. Minnesota
2. Colorado
3. Texas
4. Illinois
5. Washington

6. PT, PTA, and Student Membership in APTA.

Greater involvement suggests stronger commitment in time and money to current and future professional development, and activity in state and national regulatory and legislative issues. Rankings are based on APTA data showing the percent of PTs and PTAs within a state who are association members.19

Leading states for APTA Membership
1. Alaska
2. District of Columbia
3. South Dakota
4. North Dakota
5. Vermont

7. Affordability.

How much is a PT paid annually? How far does the compensation stretch, as measured by a state’s cost of living? This rating was calculated by dividing average salary for PTs within a state by the state’s cost of living. Data for annual rates of pay are from the Bureau of Labor Statistics.20 Cost of living data are from the Missouri Economic Research and Information Center.21

Leading states for affordability
1. Mississippi
2. Michigan
3. Oklahoma
4. Alabama
5. Texas
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These data consider the amount of financial and health care variation within a state with regard to income, health, and women’s health. States with less variation received higher scores than did those with greater variation. Each state’s disparity score comprises 5 elements. Four are health-related: obesity rates among non-Hispanic whites versus non-Hispanic blacks, mammogram rates within the past 2 years among non-Hispanic whites versus non-Hispanic blacks, prevalence of arthritis by county, and prevalence of obesity by county. The fifth is income-related: ratio of average income of the top 5% of the population within a state to average income of the population in the lowest quintile.24

Donald E. Tepper is editor of PT in Motion.

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STARTING A PRACTICE?

To provide a little more food for thought, we combined business friendliness and projected growth to look at states that may offer characteristics desirable for starting a practice. Consider starting a practice in...

1. UTAH
2. COLORADO
3. TEXAS
4. IDAHO
5. SOUTH CAROLINA

Leading states for lack of disparities
1. Utah
2. Connecticu
3. Hawaii
4. Minnesota
5. Maine

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MOVING AWAY FROM OPIOID RELIANCE
An APTA white paper analyzes the opioid crisis and outlines how physical therapy can contribute to the solution.

BY CHRIS HAYHURST

It’s time to recognize that physical therapy has a key role to play in the fight against opioid addiction. That’s the message not only from APTA, which in February released a new opioid-awareness video as part of its ongoing #ChoosePT opioid awareness campaign, but also from national organizations and federal agencies, including the Centers for Disease Control and Prevention (CDC).

Opioids, the CDC recently stated in its “Guideline for Prescribing Opioids for Chronic Pain,” come with too many side effects and are far too addictive to be a first-choice treatment for chronic pain. Clinicians, the agency recommends—pointing to physical therapy as 1 of several proven alternatives—“should consider opioid therapy only if expected benefits for both pain and function are anticipated to outweigh risks to the patient.”

As any physical therapist (PT) or physical therapist assistant (PTA) is well aware, physical therapy has a long history as an essential component of interdisciplinary pain management. Still, given the rise of prescription painkillers in recent decades and the belief of many patients that surgical intervention offers a 1-stop solution to their pain-related issues, the profession has struggled to establish its authority in this area.

As 1 patient put it in a 2017 video hosted by Net Health and inspired by #ChoosePT, “My doctor prescribed me a prescription for physical therapy, which I thought was BS.” That patient had tried a pain medication for his injured leg but experienced side effects, including hallucinations, that led him to give it up. He eventually underwent 11 surgeries before beginning the physical therapy that successfully managed his pain. (Watch the video at www.nethealth.com/choosept-living-an-active-life-without-pain-medication/)

The good news, says Alice Bell, PT, DPT, senior payment specialist at APTA, is that such stories have become a lot more common—with the tide finally turning as a result. “Across the profession,” she says, “we’re seeing more and more patients who are accessing physical therapy before opioids are prescribed, or who’ve been on opioids but realize they aren’t helping to treat or manage their underlying conditions.”

In addition, Bell says, she knows of several PTs who are working with patients who are recovering from addiction. “In most cases the PTs are part of an interprofessional team, helping patients learn either to live with their pain or to manage it without opioids use.”

To keep that momentum going, Bell and others at APTA have intensified their opioid-awareness efforts. She represented the association earlier this year as part of an “opioid stewardship action team” assembled by the National Quality Forum (NQF)—a leading nonprofit health care and advocacy group aimed at improving American health care—to create what it describes as a “playbook” focused on “improving

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The US opioid crisis reflects the unintended consequences of a nationwide effort to help individuals control physical pain.

Since the mid-1990s, the health care system has adopted an approach to pain management that focuses on pharmacological masking of pain, rather than on treating the actual cause(s) of the pain when its source can be identified.

This strategy has resulted in a dramatic increase in opioid prescribing, misuse, and addiction.

Opioid-centric solutions to dealing with pain at best mask patients’ physical problems and at worst may be dangerous or even deadly.

Moving forward, the health care system must change its approach to pain—including how causal factors are identified, which tools or measures are used to quantify its impact, and how well the treatment approach aligns with the patient’s goals and values.

The opioid epidemic has had, and continues to have, a devastating impact on patients, their families, and the nation.

Physical therapy is an essential component of the multidisciplinary undertaking required to improve patient outcomes and alter the trajectory of this public health crisis.

prescribing practices and identifying strategies and tactics for managing care of individuals” at risk of opioid dependence. The playbook, Bell told PT in Motion News, “highlights the importance of incorporating a multidimensional approach to pain management, including physical therapy, as a critical component of addressing this epidemic in a meaningful way.”

APTA itself earlier this year convened a panel discussion on pain management featuring 7 experts, including Bill Hanlon, PT, DPT, a staff PT working in addiction recovery at St Joseph Institute in Port Matilda, Pennsylvania; Sarah Wenger, PT, DPT, an associate clinical professor at Drexel University’s College of Nursing and Health Professions in Philadelphia; and Steven Stanos, a medical director at Swedish Medical Center in Seattle and president of the American Academy of Pain Medicine.

The discussion, which streamed live on Facebook on February 5 and already had been viewed more than 20,000 times through July, also served as a platform for APTA to debut its latest public service announcement (PSA)—a 1-minute video titled “Treating Pain Takes Teamwork.” “When it comes to your health,” the spot’s narrator concludes, “you have a choice: Choose more movement and better health. Choose physical therapy.” (See “Resources” on page 40 for links to the panel and video.)

Also, Bell notes, APTA has developed a white paper on physical therapy’s role in pain management for distribution to professionals across the health care spectrum, including policymakers, payers, and physicians. “Beyond Opioids: How Physical Therapy Can Transform Pain Management to Improve Health” will help inform those in position to make a difference “that opioids aren’t the only option,” Bell explains. “Our goal is to let them know that numerous studies have shown the efficacy of physical therapy for pain management, and that we’re here, as experienced and qualified health care professionals, not only to help individual patients, but also to help end the opioid epidemic.”

What follows are excerpts from “Beyond Opioids: How Physical Therapy Can Transform Pain Management to Improve Health,” interspersed with comments from participants in the recent panel discussion. (For space purposes, citations for references within the white paper aren’t included. See “Resources” on page 36 for a link to the white paper’s full text, which includes the reference list.)

**Introduction**

The presence of pain is one of the most common reasons people seek health care. National surveys have found that chronic pain—defined as pain lasting longer than 3 months—affects approximately 100 million American adults and that the economic costs attributable to such pain approach $600 billion annually.

Pain has been described in the medical literature as a “uniquely individual and subjective experience” and “among the most controversial and complex” medical conditions to manage. The source of pain for any individual can vary, whether it’s an underlying illness such as heart disease or cancer, an injury experienced recently or long ago, or the lingering effects of a medical procedure. Regardless, a report on the subject by the US Department of Health and Human Services (HHS) notes that pain and its treatment “can be a lifelong challenge at the individual level and is a significant public health problem.”

Moreover, there may not always be a peripheral source of persistent pain. Changes in the central nervous system perpetuate persistent pain, as in the case of individuals who have
had both legs amputated feeling pain in their feet.

The treatment of pain, particularly chronic pain, often requires an integrated, multidisciplinary approach due to the many variables that may contribute to a patient’s perception of pain and response to treatment. These variables can include the underlying cause(s) of the pain and the anticipated course of that condition, the available and accessible options for pain prevention and treatment, and the patient’s personal goals, values, and expectations of health care. When individuals enter the health care system because of pain, their prospects for recovery—both immediate and long-term—are highly dependent on the system’s response.

Nationwide, HHS reports, patients with pain “face many systemic hurdles to appropriate care.” Evidence suggests, the department adds, “that wide variations in clinical practice, inadequate tailoring of pain therapies to individuals, and reliance on relatively ineffective and potentially high-risk treatments such as inappropriate prescribing of opioid analgesics...not only contribute to poor-quality care for people with pain, but also increase health care costs.”

That evidence, in fact, was the driving force behind recent recommendations by the US Centers for Disease Control and Prevention (CDC) in its “Guideline for Prescribing Opioids for Chronic Pain.” The CDC states that “Non-pharmacologic therapy and non-opioid pharmacologic therapy are preferred for chronic pain.” The report expands on this thought, suggesting that “many non-pharmacologic therapies, including physical therapy...can ameliorate chronic pain.”

Physical therapy is a dynamic profession with an established theoretical and scientific basis for therapeutic interventions capable of restoring, maintaining, and promoting optimal physical function. Physical therapists work both independently and as members of multidisciplinary health care teams to enhance the health, well-being, and quality of life of their patients, who present with a wide range of conditions including those that commonly cause pain. The CDC’s recommendations point to “high-quality evidence” that treatments provided by PTs are especially effective at reducing pain and improving function in cases of low back pain, fibromyalgia, and hip
and knee osteoarthritis. Additionally, a number of studies show the efficacy of physical therapist interventions in preventing, minimizing, and, in some cases, eliminating pain in patients postsurgery, in patients with cancer, and in other clinical scenarios.

Modern society too often puts a premium on quick-fix solutions to complex problems. This is evidenced by prescription drug consumption in the United States. According to the CDC, approximately 9 out of every 10 Americans who are at least 60 years old say they have taken at least 1 prescription drug within the last month. Children in the United States are 3 times more likely to be prescribed antidepressants as are children in Europe. When it comes to pain and prescribing opioids, this desire for a quick fix not only can be counterproductive, it also can be dangerous. Often when individuals experience pain, nonopioid options are safer, more effective, and longer lasting. Incorporating such options as standards of practice should be a central tenet in addressing the opioid crisis.

“Interdisciplinary programs, like our program at Swedish, involve patients who are evaluated first by a physician—a pain management specialist—for an hour. They also see our pain psychologist. The pain psychologist does a great 1-hour assessment of the patient’s risk and what they’re going through: depression, anxiety, sleep problems.... Patients are enrolled in groups of 4, and they’re there 5 hours a day. They have a round robin of physical therapy for 1 hour, occupational therapy, pain psychology, and relaxation training.”

—Steven Stanos, Medical Director, Swedish Pain Services; Medical Director, Occupational Medicine Services, Swedish Medical Center; and President of the American Academy of Pain Medicine

To be clear: opioids have a role in addressing pain. While we examine the use of opioids as an inappropriate first strategy for too many patients, we also must ensure that we do not limit access to opioids for patients for whom they are a needed component of care. Just as a failure to effectively manage and treat pain is not solved by prescribing too many pills, limiting access to medications for those who genuinely need and benefit from them is not a person-centric or appropriate course of action.

This report describes the opioid crisis and explains how PTs can contribute to its solution. It presents evidence documenting the effectiveness of physical therapist interventions in treating pain and preventing the onset of chronic pain, thus quite likely reducing opioid use. This report also lists recommendations to providers, payers, and others who are in a position to change the way the system works. It is time for health care to look beyond opioids—and to use proven nonpharmacological strategies, including physical therapist treatment, to transform pain management in an effort to improve the health of those at risk for developing or living with chronic pain.

The Opioid Problem

When the CDC issued its guideline for prescribing opioids in 2016, it did so against the backdrop of a national crisis. That year alone, more than 42,000 people in the United States died from an opioid overdose, including more than 17,000 whose deaths were attributed to prescription opioid overdoses. Deaths caused by overdose of prescription
opioids have quadrupled over the past 15 years, noted CDC director Thomas Frieden in a New England Journal of Medicine article that accompanied the guideline’s release. “We know of no other medication routinely used for a nonfatal condition that kills patients so frequently,” he wrote.

“Opioids don’t help you recover. They don’t help you get your range of motion back. They don’t help you make the progress that you need to make to get your strength back and return to your life.”

~Joan Maxwell, patient and family advisor for John Muir Health

How the health care system arrived at this point—in which a class of drug once marketed as a way for patients to reclaim their lives from chronic pain was leading so many to an early death—has been well documented in numerous publications. As the CDC itself has reported, the opioid overdose epidemic has progressed in 3 “waves”:

1. Increases in deaths involving prescription opioids starting in 1999
2. Increases in deaths involving heroin starting in 2010
3. Increases in deaths involving synthetic opioids since 2013

So what led to that first surge in deaths? The push to increase the use of prescription opioids began nearly 3 decades ago in response to the identification of an unmet need: Many people—young children, older adults, and minority populations in particular—were struggling with “undertreated” pain. In fact, as far back as 1986, a statement by the National Institutes of Health Consensus Development Program noted that “a large number of persons experience pain,” including acute pain and chronic malignant and nonmalignant pain. “Unfortunately,” the statement concluded, “even when pain is reported and assessed, it may...
The American Pain Society, a professional organization of scientists and clinicians, began to argue that a new approach to pain assessment and treatment was needed. In a 1990 editorial in the *Annals of Internal Medicine*, the society’s president, Mitchell Max, MD, recommended that clinicians be held accountable for pain management and that quality assurance standards be created toward that end. Following his lead, the following year the society created standards and established a system for rating pain intensity and relief. Eventually, in 1995, James Campbell, MD, who followed Max as president of the American Pain Society, suggested in a speech at the organization’s annual meeting that pain should be evaluated as a “fifth vital sign.”

In 2001, the Joint Commission on Accreditation of Healthcare Organizations (now The Joint Commission) published new standards requiring that clinicians in hospitals and medical centers assess pain in all patients. Included among those standards were the following statements:

- “Patients have the right to appropriate assessment and management of pain.”
- “Pain is assessed in all patients.”

In rolling out the standards, The Joint Commission listed a number of ways that health care organizations might implement them, including considering pain to be “a ‘fifth’ vital sign in a hospital’s assessment of patients. That is, pain intensity ratings were to be recorded during the admission assessment along with temperature, pulse, respiration, and blood pressure.”

As the conversation around pain assessment and management continued, the focus remained on pain as a primary condition rather than a consequence of disease or injury. This focus created a marketing opportunity for pharmaceutical companies to tout how their products could eliminate pain, and it led clinicians to increase their opioid prescribing in well-meaning attempts to provide rapid and long-term pain relief.

A 2017 report by The Joint Commission noted, “Immediately after the release of the standards in 2001, some raised concerns that the standards could lead to inappropriate use of opioids.” The report points out that opioid prescriptions “had been steadily increasing in the US for at least a decade” before the standards were published, climbing from 76 million in 1991 to 97 million in 1997 “likely due to advocacy work by pain experts.”

Between 1997 and 2013, opioid prescribing increased more rapidly, possibly as a result of the FDA’s 1995 approval of Purdue Pharma’s OxyContin, which contained the opioid oxycodone. The labeling the FDA approved for this sustained-release opioid claimed addiction to the drug was rare, and abuse was unlikely. These same claims were used in marketing campaigns to physicians and in more than 40 all-expenses-paid national pain-management and speaker training conferences conducted by Purdue.

“If you think of all of the commercials, everything we’re exposed to on a daily basis is, ‘you take your pill, you run down the beach, and you’re smiling.’ And ‘let pain be your guide; if you have pain, stop.’ I mean, all those things we’re telling them is the wrong thing. So in some patients we don’t even ask them what their pain score is. ‘You wake up in the morning, what do you do?’ And you walk through and see from a functional standpoint what they’re doing throughout the day. We have to change the way we talk to people.”

—Steven Stanos
The issue, as a 2003 report to Congress by the US General Accountability Office (GAO) spells out, was that many of these claims were misleading or false. Oxycodone, GAO noted, “is twice as potent as morphine, which may have made it an attractive target for misuse.” OxyContin and other opioids, such as Vicodin and Percocet, were now prescribed so frequently (often through “pill mills”—pain management clinics that treated pain strictly with prescription opioids) that they became increasingly available for illicit purchase on the black market. By 2011, the CDC revealed that prescription painkiller overdoses had hit “epidemic levels,” killing more Americans than did heroin and cocaine combined. Among the CDC’s statistics:

- Sales of prescription painkillers to pharmacies and providers had increased 300% since 1999.
- In 2010, 12 million people ages 12 and older reported using prescription painkillers “non-medically.”
- More than 40 people were dying each day from overdoses involving prescription opioids.

Media outlets reported that patients had begun crushing OxyContin tablets and either snorting the powder or dissolving it in water and then injecting it to negate the drug’s slow-release properties.

From this point the situation only worsens: By 2013, a few years after an abuse-deterrent formulation of OxyContin was introduced that made it more difficult to snort or inject, studies were showing a correlation between the use of prescription opioids and heroin use. “While efforts to reduce the availability of prescription opioid analgesics have begun to show success,” noted a report by the National Institute on Drug Abuse, “the supply of heroin has been increasing.” In 2014, more than 750,000 people in the United States were receiving substance-abuse treatment for prescription opioids, and the number of those getting treatment for heroin was twice what it has been in 2002. In 2016, the latest year for which statistics are available, the CDC reported that more than 3 out of 5 drug overdoses involved an opioid, that overdose deaths from prescription opioids...
and heroin had increased 5-fold since 1999, and that 40% of the year’s 42,000-plus opioid-related deaths overall were from prescription opioids.

“A small (estimated at 4%) but growing percentage of persons who are addicted to prescription opioids transition to heroin, mainly because heroin is typically cheaper and in some instances easier to obtain than opioids.”

—The New England Journal of Medicine, 2016

Opioid dependence takes a toll not only on the user but upon their finances and their families. The national price tag is also significant. Prescription opioid misuse has been estimated to annually increase health care and substance abuse treatment costs by $29.4 billion, increase criminal justice costs by $7.8 billion, and reduce productivity among users who do not die of overdose by $20.8 billion. The total nonfatal cost of $58 billion divided by the 1.9 million individuals with a prescription opioid disorder in 2013 results in an average cost of approximately $30,000. Today, with studies showing that health care costs associated with individuals who abuse opioids are significantly higher than those of individuals who do not, and with families and communities affected by the opioid crisis demanding an end to the epidemic, some providers are finally changing their approach to pain management.

There is a role for opioids, but there also needs to be a focus on prevention of addiction. In addition, providers must understand—and convey to their patients—that the use of opioids comes with significant risks and that effective nonpharmacological solutions to pain management are available. The best way to prevent opioid abuse and addiction? Prevent exposure to opioids in the first place when they are not the optimal or appropriate choice for an individual patient.

Physical Therapy Can Contribute to the Solution

Ending the opioid epidemic will require collaboration among patients, families, providers, payers, and professionals across the continuum of health care settings, from primary care practices and pharmacies to hospitals and behavioral health facilities. Physical therapists, who engage in an examination process that focuses on not only the symptoms of pain but also the movement patterns that may be contributing to pain, must become central to this multidisciplinary strategy.

“If we’re going to transform society, it’s going to take all of us, not only in our profession, but an interdisciplinary approach to make a difference.”

—APTA President Sharon Dunn, PT, PhD

The Role of PTs in Treating Pain and Preventing Chronic Pain

Pain has been defined as “an unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage.” Acute pain typically comes on suddenly as a result of a specific incident such as surgery, childbirth, a fracture, or trauma. Acute pain serves a useful biologic purpose and is self-limited. Chronic pain, on the other hand, serves no biologic purpose and has no recognizable endpoint. Chronic pain can be considered a disease state and can persist for months or years. When PTs work with patients in pain, they use tests and measures to determine the causes of that pain and to assess its intensity, quality, and temporal and physical characteristics. PTs also evaluate individuals for risk factors for pain

RESOURCES

APTA white paper “Beyond Opioids: How Physical Therapy Can Transform Pain Management to Improve Health” (full text plus reference list)

Facebook Live panel “Beyond Opioids: Transforming Pain Management to Improve Health”
https://business.facebook.com/AmericanPhysicalTherapyAssociation/?ref=page_internal

#ChoosePT public service announcement “Treating Pain Takes Teamwork”
www.youtube.com/watch?v=zAaf_wqeDck

Net Health video #ChoosePT: Living an Active Life Without Pain Medication
www.nethealth.com/choosept-living-an-active-life-without-pain-medication/
to help prevent future pain issues. Some of these risk factors might include:

- **Disease history.** Conditions such as cardiovascular disease, osteoporosis, and rheumatologic disease can affect an individual’s nociceptive experience.

- **Cognitive and psychological factors.** Disorders such as anxiety, depression, catastrophizing, fear, and post-traumatic stress disorder can be risk factors for the development of chronic pain.

- **Beliefs.** Negative beliefs surrounding one’s condition can contribute to persistent pain and a belief that hurt equals harm.

“By increasing physical activity you can also reduce your risk of other chronic diseases.”

APTA PUBLIC SERVICE ANNOUNCEMENT

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RECOMMENDATIONS FOR A SOLUTION

APTA concluded “Beyond Opioids: How Physical Therapy Can Transform Pain Management to Improve Health” with a list of recommendations the association believes can help solve this health crisis.

1. The federal government should develop and implement a comprehensive public awareness campaign targeting health care providers, payers, regulators, employers, and the general public on pain assessment and options for pain management.

2. Public and private health plans should include benefit design, reimbursement models, and integrated team approaches that support early access to nonpharmacological interventions, including physical therapy, for the primary care of pain conditions.

3. Private and public health plans should remove barriers to effective care by reducing or eliminating patient out-of-pocket costs and by increasing access to and payment for person-centered, nonpharmacological pain management and treatments interventions.

4. Public and private health plans should educate primary care providers and physicians on the value of nonpharmacological, person-centered interventions and how to appropriately assess, treat, and refer patients with pain.

5. Federal and state policymakers should identify and finance the replication of effective models of pain management care, including reducing or eliminating patient out-of-pocket costs and allowing for bundled payment methods for multidisciplinary programs.

6. Federal and state student loan repayment programs should incentivize health care professionals, including physical therapists, to work in underserved communities disproportionately affected by the opioid crisis.

- **Sedentary lifestyle.** There is a strong association between immobility and pain; people who are overweight or obese often have conditions such as low back pain, headaches, fibromyalgia, and pelvic pain. Once the contributors to a patient’s pain are identified—and the patient’s functional and mobility goals are clear—the PT designs an individualized treatment program combining the most appropriate techniques, including but not limited to exercise, manual therapy, and patient education to address the underlying problem(s).

- **Exercise.** Studies have shown that people who exercise regularly experience less pain. PTs develop, administer, modify, and progress exercise prescriptions and programs to address poor conditioning, impaired strength, musculoskeletal imbalances, or deficiencies that may lead to pain.

- **Manual therapy.** Manual therapy involves hands-on manipulation of joints and soft tissue to modulate pain, reduce swelling and inflammation, and improve mobility. Research shows that manual therapy techniques are effective at reducing low back pain, discomfort associated with carpal tunnel syndrome, and other sources of pain.

- **Stress management.** Interventions such as mindfulness, relaxation, visualization, and graded exposure to stress-producing events can help patients reduce pain and improve their functional capacities.

- **Sleep hygiene.** Individuals with persistent pain often complain of sleep disturbances. Evidence has shown that sleep deprivation can increase sensitivity levels and contribute to increased stress and pain. PTs can help educate patients regarding appropriate sleep hygiene to help combat the vicious cycle of persistent pain.

- **Pain neuroscience education.** Individuals who don’t understand the mechanisms and contributors to their pain may be more likely to seek pharmacological treatment for that pain. PTs can educate patients about modern pain science that highlights the processes involved in pain. The adage “know pain, know gain” can empower patients and provide hope and encouragement in their journey to overcome persistent pain.

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**Physical Therapy Is Effective in Treating Pain and Preventing Chronic Pain**

Studies have established the efficacy of physical therapy in treating and reducing pain as well as preventing chronic pain. For example:

- **Low back pain.** A review of more than 60 randomized controlled trials evaluating exercise therapy for adults with low back pain found that such treatment can decrease pain, improve function, and help people return to work. The American College of Physicians states that “non-pharmacologic interventions are considered first-line options in patients with chronic low back pain because fewer harms are associated with...”
these types of therapies than with pharmacologic options.”

> **Before and after surgery.** A review of 35 randomized controlled studies with a total of nearly 3,000 patients found that in patients undergoing total hip arthroplasty, preoperative exercise and education led to significant reductions in pain, shorter lengths of stay postoperatively, and improvements in function.

> **Arthritis.** Studies have shown that therapeutic exercise programs can reduce pain and improve physical function among individuals with hip and knee osteoarthritis.

> “When you’re telling a patient who’s taking opioids and has pain to stop taking the pain medicine, it is totally counterintuitive for that patient. So it’s really about sitting down and having a very earnest conversation. You have to build trust, and you have to build credibility.”

> –Sarah Wenger

Meanwhile, research on the efficacy of opioids for long-term pain management shows they often result in unwanted side effects. Evidence also shows that the use of opioids can decrease a person’s response to naturally occurring rewards.

> **Low back pain.** One review of the literature found that “opioids do not seem to expedite return to work in injured workers or improve functional outcomes of acute back pain in primary care.” And for chronic back pain, there is “scant evidence of efficacy...Opioids seem to have short-term analgesic efficacy for chronic back pain, but benefits for function are less clear.”

> **After surgery.** Research shows that surgical patients who are prescribed opioids are at increased risk for chronic opioid use. “New persistent
opioid use is more common than previously reported and can be considered one of the most common complications after elective surgery,” notes a 2017 investigation in JAMA Surgery.

> Arthritis. Studies have shown that use of opioids to treat arthritis leads to higher risk of bone fracture and increased risk of cardiovascular events, hospitalization, and mortality. The author of a recent study on opioid use for pain management among spine osteoarthritis patients pointed to concerns around the “potential for misuse, dependency and increased adverse events,” including death. “Growing evidence demonstrates little if any clinically significant benefit of opioids for OA [osteoarthritis] pain, particularly when compared to other medications,” he said.

“It really does work…People who never thought ‘I could live without opiates,’—they just thought they’d be on opiates the rest of their lives—are opiate-free and doing well. They may not be pain-free, but it’s very manageable, and they’re more active and functional than they’ve been in years.”

–Bill Hanlon, PT, DPT

A Complex Issue

Along with the NQF playbook, other programs also have been launched to help bring the opioid crisis to an end—ranging from an event led by the Academy of Integrative Pain Management called the “Integrative Pain Care Policy Congress” to APTA’s own #ChoosePT opioid awareness campaign, which encourages consumers and prescribers to follow the CDC’s opioid-prescription guideline.

The bottom line is that the opioid epidemic is a complex problem that will be solved only through multidisciplinary collaboration, and that individuals with chronic pain must be offered interventions that not only control pain but also address the causes of pain. The CDC, NQF, and other major health agencies and organizations all have affirmed that nonpharmacological and nonopioid therapy can be effective in managing chronic pain. It’s time for the health care system to look beyond opioids to options such as physical therapist interventions that treat pain and combat chronic pain by addressing its sources.

Chris Hayhurst is a freelance writer.

REFERENCES


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Health Care Employment Rose 16,700 in July

Health care added 16,700 jobs in July, following an increase of 25,200 in June and 28,900 in May. So while health care continued to grow, its growth slowed substantially during those 3 months, according to the US Bureau of Labor Statistics (BLS). As of July there were 16,037,900 people nationwide employed in that field.

Ambulatory health care services added 9,900 jobs, down from 13,500 jobs added in June. That includes an increase of 1,500 in physician offices, 4,300 in outpatient care centers, and 5,600 in home health care services. Hospital employment added 6,800 employees. Community care facilities for the elderly added 2,400 jobs. Nursing care facilities lost 2,500 jobs, following a loss of 1,500 jobs in June.

During the past 12 months, health care added 285,500 jobs.

Total nonfarm payroll employment increased by 157,000 in July. Employment grew in several sectors—including professional and business services, manufacturing, and health care. Employment was flat in mining, wholesale trade, transportation and warehousing, information, financial activities, and government.

Meanwhile, according to payroll services company ADP’s monthly National Employment Report, private sector employment increased by 219,000 in July, up from 177,000 in June. ADP, which uses a different methodology from that of BLS, calculated that employment in health care and social assistance increased by 49,000.

Other large gainers included leisure/hospitality (37,000), trade/transportation/utilities (21,000), and administrative/support services (28,000). Information and education were the only sectors to lose jobs, losing 1,000 each.

Companies of all sizes reported gains. Small businesses (1-49 employees) added 52,000 jobs, medium businesses (50-499 employees) added 119,000 jobs, and large businesses (500+ employees) added 48,000 jobs.

According to Ahu Yildirmaz, vice president and co-head of the ADP Research Institute, “The labor market is on a roll, with no signs of a slowdown in sight.” Mark Zandi, chief economist of Moody’s Analytics, said, “The job market is booming, impacted by the deficit-financed tax cuts and increases in government spending. Tariffs have yet to materially impact jobs, but the multinational companies shed jobs last month, signaling the threat.”


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At the State Level, a Very Good Year for PTs and PTAs

With the dust settled around most state legislatures’ 2018 sessions, APTA, its state chapters, and supporters are assessing how the practice and payment landscape has changed at the state level for physical therapists (PTs), physical therapist assistants (PTAs), and the patients they serve. The news is good.

“This has been an extremely busy year for physical therapy-related legislation in many states, and the hard work and collaborative efforts of chapters and APTA have paid off,” said Angela Shuman, director of state legislative affairs for APTA. “We have a lot to be proud of.”

Among the highest-profile wins is the steady expansion of states joining the Physical Therapy Licensure Compact (PTLC), the system that allows PTs and PTAs licensed in 1 state to obtain practice privileges in other participating states. As of August, here’s where PTLC participation stood: Mississippi, Missouri, North Dakota, and Tennessee officially had enacted the compact system. Other states had passed the necessary legislation either this year or last and were preparing to flip the switch on the compact, bringing the total number of compact states to 21. A bill to adopt the compact was pending in Pennsylvania.

But that’s not all that’s been happening. Here’s a rundown of some of the big issues addressed across the country.

**DIRECT ACCESS**

**Bottom line: Direct access provisions are expanding.**

Illinois could be strengthening its direct access provisions by permitting PTs to provide physical therapy without a referral as long as the PT notifies the patient’s treating health care profession within 5 business days after the first visit. The bill is pending the governor’s approval. California’s legislature is considering a bill that would permit direct access to a PT for wellness services and services provided as part of an individualized education or family service plan.

**THE OPIOID EPIDEMIC AND ACCESS TO NONOPIOID PAIN MANAGEMENT**

**Bottom line: States are pressing payers, providers, and policymakers to take action.**

Connecticut will convene a work group to investigate the efficacy of physical therapy, acupuncture, massage, and chiropractic care in reducing the need for opioids for individuals with chronic pain. Florida, Oklahoma, West Virginia, and Tennessee will put more pressure on physicians to educate themselves and their patients on nonopioid options for pain management, with Tennessee requiring providers to obtain informed consent from patients acknowledging that they have been offered information on reasonable alternatives to opioids.

Vermont will require reductions in copay amounts for physical therapy services under certain health plans and has established a work group to study insurance coverage for nonopioid approaches to pain management—including cost-sharing for physical therapy. West Virginia will require that health plans, including Medicaid and state plans, provide coverage for 20 physical therapy visits when related to treatment of chronic pain, with deductibles prohibited from being higher than deductibles for a primary care visit; Delaware is taking similar action, pending the governor’s approval. The Massachusetts legislature is considering establishing a commission to make recommendations on nonpharmacological strategies for pain management; that commission would include a representative from the state’s APTA chapter.

**DRY NEEDLING**

**Bottom line: More states have added or may add dry needling to their physical therapy practice acts.**

In Idaho and South Dakota, where dry needling by PTs had been prohibited, language now is in place permitting them to perform the treatment. The New Jersey legislature is considering a bill to allow dry needling. Colorado has added it to its physical therapy practice act, effectively ending a debate and legal challenge over dry needling rules that the Colorado licensure board had enacted several years ago.

**CONCUSSIONS IN SPORTS**

**Bottom line: States are recognizing the PT’s role in making return-to-play determinations.**

Arizona and Oregon have cleared the way for PTs to provide clearance for student athletes to return to play after a concussion or suspected concussion. Arizona’s law limits that ability to only PTs with a sports specialist certification, while Oregon’s law permits all PTs to make such determinations. A similar concussion bill also is pending in New Jersey.

**TELEHEALTH**

**Bottom line: States are acknowledging the validity of telehealth and including PTs in the mix.**

Illinois has added PTs to the state’s telehealth act, authorizing delivery of services through telehealth if the PT is licensed to practice in the state and is acting within scope of practice in the PT licensing law. Iowa and Kentucky adopted laws requiring health plans to cover telehealth services.
CERTIFICATION OF DISABILITY BY A PT
Bottom line: States are recognizing the PT’s role in disability certification.
Kentucky and Michigan became the latest states to add PTs to the list of providers who may provide certification of disability for purposes of parking placards and license plates. In Kentucky, PTs can make determinations for temporary parking placards. In Michigan, PTs can make determinations for temporary parking placards, license plates, and free parking stickers.

MORE WINS
▶ Connecticut: Use of the titles “DPT” and “Doctor of Physical Therapy” now are protected by law.
▶ New Mexico: A group has been commissioned to investigate whether state workforce incentives, including student loan repayment assistance, are adequately incentivizing PTs and PTAs to relocate to and remain in the state. The group includes representatives from APTA’s New Mexico Chapter and the state’s physical therapy licensing board.
▶ New York: The annual visit limit for physical therapy under Medicaid has been expanded from 20 to 40.
▶ Ohio: The legislature is considering a bill to modernize the definition of physical therapy, including a clarification that diagnosis is a part of physical therapist practice.
▶ Utah: Licensed radiologic technologists now are permitted to accept an order from PTs for plain radiographs and magnetic resonance imaging if the PT designates a physician to receive the results and the physician agrees to accept them.
▶ Washington: Health care payers no longer are permitted to impose prior authorization requirements for initial evaluation and up to 6 treatment visits for chiropractic, physical therapy, occupational therapy, East Asian medicine, massage therapy, or speech and hearing therapies provided the services meet standards of medical necessity and are subject to quantitative treatment limits.

www.apta.org/PTinMotion/News/2018/07/27/StateRoundup2018/

SNF, IRF Final Rules Shift SNF Payment Systems, IRF Reporting Requirements

The final 2019 rules for skilled nursing facilities (SNFs) and inpatient rehabilitation facilities (IRFs) are substantially similar to what the Centers for Medicare and Medicaid (CMS) proposed in the spring, but the situation is far from a “same as usual” scenario—at least for PTs in SNF settings, who will be facing a dramatic change in how payment is determined.

The new rules, set to go into effect in October, include increases in payment of 2.4% for SNFs and 0.9% for IRFs, but the heart of the changes has less to do with payment increases and more to do with how payment will be determined and what needs to be reported. For PTs in IRFs, the reporting process could become a bit less burdensome, while PTs in SNFs will need to get up to speed with an entirely new payment system that does away with the Resource Utilization Groups Version IV (RUG-IV) process.

SNFs: Hello Patient-Driven Payment Model (PDPM)
The biggest takeaway from the proposed SNF payment rule was the adoption of the PDPM, and the same is true of the final rule. In doing away with the RUG-IV process, CMS adopted a model that bases payments on a resident’s classification among 5 components, including physical therapy. Final payment is calculated by multiplying the patient’s case-mix group with each component (both base payment rate and days of service received), then adding those up to establish a per diem rate.

IRFs: Goodbye Functional Independence Measure (FIM)
As in the proposed rule, the final rule for IRFs drops the FIM and 2 quality-reporting measures related to methicillin resistant staph aureus (MRSA) infection and flu vaccine rates. According to CMS, data associated with FIM are being captured through other parts of assessment, while the costs of gathering data on MRSA and flu vaccines outweigh the benefits.

The rule also allows for postadmission physician evaluation to count as one of the required face-to-face physician visits and removes requirements for admission order documentation (but not the orders themselves). Additionally, under the new rule physicians will be allowed to lead team meetings remotely—a change that, when proposed, prompted APTA and others to ask CMS to extend that allowance to all team members. CMS stated in the final rule that it will evaluate how the new policy is working out and will consider expanding flexibility.

www.apta.org/PTinMotion/News/2018/08/01/FinalSNFIRF/
Common Activity Trackers May Be Inaccurate for Patients With PD

It’s important for PTs to encourage patients with Parkinson disease (PD) to stay physically active. It would seem as though commercially available fitness trackers would be a good way to do that, by allowing the PT and patient to set home goals and track progress through step counts. But new research suggests that PTs may want to think twice about the data they get from the devices.

In an article published in the August issue of *PTJ*, APTA’s scientific journal, researchers in Boston analyzed data from 4 fitness trackers—2 worn on the wrist and 2 that attach at the waist—to see how the tracker step reports stacked up against videos that allowed PTs to visually observe and count steps taken. The trackers in question were the wrist-worn Fitbit Surge and Jawbone Up 2, and the waist-worn Fitbit Zip and Jawbone Up Move.

A total of 33 patients with mild to moderate PD were recruited for the study, which involved tests of both continuous and discontinuous walking while wearing all 4 activity trackers, with the wrist trackers worn on the less-affected arm. The continuous walking tests involved 2 rounds of 2-minute walks around a 92-meter rectangular track—the first lap at a comfortable speed, the second at a fast speed.

The discontinuous walking tests consisted of an “obstacle navigation course” and a “household” course in which patients were required to walk to different areas to perform typical household tasks such as taking off and hanging up a coat, washing and drying hands, throwing away trash, and picking up and setting down a glass. In addition to recording tracker data, the tests also were video-recorded so that a pair of PTs could count steps taken.

Researchers then compared tracker data with the results of the video monitoring. Here’s what they found:

- Overall, the trackers were reasonably accurate at recording steps taken during continuous walking, with the waist-worn Fitbit Zip showing the highest accuracy, followed by the wrist-worn Jawbone Surge, the wrist-worn Fitbit Surge, and the wrist-worn Jawbone Up 2.

- Tracking discontinuous walking proved to be less accurate, with authors of the study describing all 4 trackers as “generally inaccurate” in both courses. The Jawbone Up Move proved to be the least reliable device, with a mean absolute percent error rate approaching 60% in the household course. The Fitbit Zip was the most reliable, but its error rate in the household course was close to 30%. The devices fared somewhat better in the obstacle negotiation course but still produced error rates ranging from about 10% to 20%. All of the devices underreported steps taken.

The authors speculated that the inaccuracies may have something to do with a lack of tracker sensitivity to steps taken “in environments with greater discontinuity, where starting, stopping, and turning occur frequently.” The longer, more symmetrical step lengths associated with continuous walking are better suited to the device’s abilities, whereas the “smaller, slower, shuffling steps” taken by participants during the discontinuous walking tests tend to be missed by the devices, they wrote.

As for waist-worn versus wrist-worn devices, the authors speculated that the higher accuracy of the waist-worn devices may be because the device is closer to an individual’s center of mass, which allows for more accurate measurement. Wrist devices worn by patients with PD may be less accurate due to the effects of tremor, dyskinesia, extraneous upper extremity movement, and reduced arm swing often associated with individuals with PD, they said.

Another common feature of PD—freezing of gait—also may come into play as a factor affecting device accuracy, according to the authors. Although only 1 participant in the study experienced freezing during the tests, that individual’s devices produced an aggregate 60% error rate in the household course and 20% error rate in the obstacle negotiation course. “In general, the magnitude of this error exceeded that observed among nonfreezers,” they wrote.

The overarching problem, the authors wrote, is that none of the devices studied performed reliably in the setting that arguably would be the most important one for PTs treating patients with PD—the patient’s home. “Other mechanisms of monitoring discontinuous walking, such as time spent walking, may be better options when the goal of intervention is focused on increasing physical activity in the home environment,” they wrote.

APTA members Nicholas Wendel, PT, DPT; Chelsea Macpherson, PT, DPT; Tamara DeAngelis, PT, DPT; and Cristina Colon-Semenza, PT, MPT, were among authors of the study.
2018 ELI Fellows Class Brings APTA’s Educational Leadership Program Past 100 Graduates

Sixteen seasoned physical therapy educators have deepened their knowledge and skills over the past year, thanks to the APTA Education Leadership Institute (ELI) Fellowship. The latest cohort pushes the program past the 100-graduate mark. They made up ELI’s seventh cohort of ELI fellows when they graduated in July.

The ELI Fellowship strives to provide developing and aspiring program directors in physical therapist and physical therapist assistant education programs with the skills and resources they need to be innovative, influential, and visionary leaders who can function within a rapidly evolving, politico-sociocultural environment.

Partners who help promote and support the ELI Fellowship include the American Physical Therapy Association, the American Council of Academic Physical Therapy, the Academy of Physical Therapy Education, and the PTA Educators Special Interest Group.

The program is accredited by the American Board of Physical Therapy Residency and Fellowship Education, the accrediting body for postprofessional residency and fellowship programs in physical therapy. See the list of 2018 ELI graduates at www.apta.org/ELI.

www.apta.org/PTinMotion/News/2018/08/14/2018ELIGrads/

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**ACUETE CARE**  
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- Future Momentum: Pushing Limits on Simulation to Maximize Student Preparation  
- Deductive Reasoning in Acute Care Physical Therapy Diagnosis: Solving the Differential Puzzle

**AQUATICS**  
- Benefits of Aquatic Therapy in Early Intervention  
- Aquatic Therapy for the Lower Extremity: Applying CPG Recommendations Into Practice  
- Aquatic Exercise: Opportunities for Wellness With Neurologic System Dysfunction

**CARDIOVASCULAR AND PULMONARY**  
- Strategies to Optimize ICU-Based Rehabilitation With Invited MDs Dale Needham and Peter Morris  
- Exercise-induced Blood Flow Patterns in Patients With Coronary Artery Disease. 2017 Cardiovascular and Pulmonary Section Grant Recipient Presentation  
- Interesting Case Studies: How Do I Get the Best Outcomes?

**CLINICAL ELECTROPHYSIOLOGY AND WOUND MANAGEMENT**  
- Show Me the Value: Evidence Base for Biophysical Agents in Postacute Practice (preconference)  
- The Skin and Aging: Impact on Wound Prevention and Management  
- Decoding the Shoulder Problem: Neural vs Nonneural Pathology

**EDUCATION**  
- Designing Residency and Education Programs to Drive Clinical Quality Improvement  
- Competency-Based Education: Exploring Opportunities for Our Future  
- The Pauline Cerasoli Lecture: Developing Habits of the Heart

**FEDERAL**  
- Osseointegration at a Military Medical Center  
- Get Out There! Advanced Wheelchair Skills Training Empowers Optimized Mobility  
- Effect of Body Composition on Physical Performance and Injury Rates

**GERIATRICS**  
- Interprofessional Pain Management for Older Adults With Cognitive Impairment  
- Geriatric Low Back Pain: Managing Influences, Experiences, and Consequences  
- Fall Prevention for Older Adults With Amputation: Getting Down and Back Up Again

**HAND AND UPPER EXTREMITY**  
- Evaluation and Treatment of Upper Extremity Injuries in Tennis Players  
- Remapping Neuroplasticity and Pain in the Clinic  
- Neuromusculoskeletal Pathology: The Insidious Complication of Diabetes Mellitus

**HOME HEALTH**  
- Hot Topics in Home Health  
- The Ten Commandments for Fear of Falling: Evidence-Based Management Strategies

**HEALTH POLICY AND ADMINISTRATION**  
- Developing Your People: Preparing a Workforce for Value-Based Reimbursement  
- From Lightly Salted to Seasoned: Implementing Early Professional Development  
- TechnoPalooza: A Tech Playground—Clinical, Assistive, and Educational Technology

**NEUROLOGY**  
- Can You Believe It? Error, Ethics, and Evidence in Publication of Research Evidence  
- Why We Love and Hate Our Robots: Implications for Everyday Clinical Practice  
- Anne Shumway-Cook Lectureship: A Journey Through Time

**ONCOLOGY**  
- Cultural Competence in Palliative and Hospice Care Physical Therapy  
- Intentionally Breaking the Skin: A Dry Needling Approach to the Lymphatic System  
- The Heart of the Matter: Advocating for Physical Therapy in Oncology Survivorship

**ORTHOPAEDICS**  
- Spotlight on Research: Translating Rotator Cuff-Related Research Into Practice  
- Physical Therapist Management of Foot and Ankle Pain From Head to Toe  
- Pain Talks: Conversations With Pain Science Leaders on the Future of the Field

**PEDIATRICS**  
- Moving Technology to Clinical Practice: Sensors and Real-World Activity Assessment  
- Infant and Child Development: Innovations and Foundations for Rehabilitation  
- Puzzling the Pieces Together of Sensory Processing Disorders, Autism Spectrum Disorders, and Idiopathic Toe Walking

**PRIVATE PRACTICE**  
- Private Practice Section Model Contract Checklist: Negotiation of Key Provisions in Payer Agreements  
- The Real World: How Therapists Can Thrive in Value-Based Care  
- Success Strategies: Metrics That Matter for Private Practice Owners in 2019

**RESEARCH**  
- ACE Talk: Virtual Reality to Improve Mobility—Not Just Pretty Pictures  
- Fostering Better Patient Decisions: The Third Pillar of Evidence-Based Practice  
- Biomechanics Matters: Solving Clinical Problems With Biomechanics

**SPORTS**  
- Opioid Issues in Athletes  
- The Brain Has an ACL Problem  
- Building Athletes for Life: What’s the Model?

**WOMEN’S HEALTH**  
- Pelvic Health Considerations in the Transgender Client  
- Global Volunteerism: From Organization to Boots on the Ground  
- Staying Fit Beyond Menopause Through Early Screening and Training

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Registration Fees

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<th>Advance Registration Deadline: December 5</th>
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Early Bird Registration Deadline: October 24
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Full Conference Rates Begin December 6 – January 26

Spargo Inc will handle registration for CSM 2019.

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  [www.apta.org/CSM/Registration](http://www.apta.org/CSM/Registration)

- **PHONE:**
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- **EMAIL:**
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*Per person, minimum 3 employees from the same location, registering together.
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APTA’s exclusive and official housing bureau for CSM is Spargo Inc. APTA does not endorse booking hotel reservations via any other sources. Book by January 2 to take advantage of the special APTA rates offered to all attendees.

CSM 2019 attendees can view rates, locations, and availability and make secure housing reservations in one of the following ways:

- **Email:** aptahousing@spargoinc.com
- **Online:** [www.apta.org/CSM/HousingTravel/](http://www.apta.org/CSM/HousingTravel/)
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All suite requests must receive APTA approval before the reservation is confirmed. Contact Housing Account Manager Candace Homer at candace.homer@spargoinc.com.

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Good news: discounted rates are available for CSM 2019 attendees! Please reference the codes below when making your reservations.

- **American Airlines**
  By phone: 800/433-1790 use **authorization number:** A4619BH
  Valid dates: January 19-29, 2019
  Not available for air travel confirmed online

- **Delta Airlines**
  By phone: 800/328-1111 use **file number:** NMS6Z
  Online: [www.delta.com](http://www.delta.com) and select the Meeting Event Code field (no ticketing charge)
  Valid dates: January 18-29, 2019

- **United Airlines**
  By phone: 800/426-1122 use **Z Code ZFKU** and **agreement code** 204756
  Valid dates: January 18-29, 2019

For rail, taxi, car rental discounts, and other travel resources visit [www.apta.org/CSM/HousingTravel](http://www.apta.org/CSM/HousingTravel).

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8 must-see monuments: Visit the National Mall and experience 8 moving and motivating monuments, including Vietnam Veterans, Jefferson, Lincoln, and Martin Luther King memorials.

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All preconference courses will start at 8:00 am on Tuesday, January 22, and/or Wednesday, January 23. Visit www.apta.org/CSM for complete course descriptions, times, and CEU information.
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S2 - Advanced Evaluation & Manipulation of Pelvis, Lumbar & Thoracic Spine Including Thurst
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Atlanta, GA Irwin Nov 3-4
Washington, DC Yack Nov 17-18
Denver, CO Yack Dec 1-2
2019 Birmingham, AL Irwin Feb 23-24

S3 - Advanced Evaluation & Manipulation of the Cranio Facial, Cervical & Upper Thoracic Spine
25 Hours, 2.5 CEUs (Prerequisite: S1; Intro S3 Webinar Included)
2019 New York, NY Smith Feb 15-17

S4 - Functional Analysis & Management of Lumbo-Pelvic-Hip Complex 16 Hours, 1.6 CEUs (Prerequisite: S1; Intro S4 Webinar Included)
St. Augustine, FL Nyberg Nov 3-4
Chicago, IL Nyberg Dec 1-2
2019 San Marcos, CA Grant May 4-5

MF1 - Myofascial Manipulation
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Boston, MA Cantu Nov 3-4
New York, NY Stanborough Nov 3-4
Denver, CO Stanborough Dec 1-2
Austin, TX Cantu Dec 1-2
2019 Philadelphia, PA Stanborough Feb 2-3

E1 - Lower Extremity Evaluation & Manipulation
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Louisville, KY Naas Oct 20-21
Raleigh, NC Busby Oct 20-21
Charleston, SC Naas Dec 1-2
Phoenix, AZ Tumer Dec 1-2
Philadelphia, PA Naas Dec 8-9
2019 St. Augustine, FL Busby Jan 12-13

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Also Available to OTs
Chicago, IL Busby Nov 3-4
Tulsa, OK Turner Nov 3-4
2019 Austin, TX Turner Feb 16-17
Miami, FL Busby May 11-12

E2 - Extremity Integration
21 Hours, 2.1 CEUs (Prerequisite: E1)
St. Augustine, FL Patla Oct 26-28
Chicago, IL Patla Nov 2-4
Miami, FL Mandel Nov 30-Dec 2
2019 Little Rock, AR Patla Mar 1-3

Thrust - Advanced Manipulation of the Spine & Extremities
15 Hours, 1.5 CEUs (Prerequisite: Any Earned Manual Therapy Certification and S1 USASHI seminar attendance or Fellow of AAMPT)
Austin, TX Irwin Oct 27-28

Cranio Facial Certification Preparation and Examination
23 Hours, 2.3 CEUs (Prerequisites: MF1, MF2, MF3, MF4)
St. Augustine, FL Jan 17-19

Manual Therapy Certification Preparation and Examination
24 Hours, 2.4 CEUs (Prerequisites: S1, S2, S3, S4; E1 Lower Extremity, E2, MF1)
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Spinal Boot Camp
15 Hours, 1.5 CEUs (Prerequisites: S1, S2, S3, S4)
St. Augustine, FL Oct 6-7

Exercise Strategies and Progression for Musculoskeletal Dysfunction
15 Hours, 1.5 CEUs (No Prerequisite)
Honolulu, HI Daugherty Oct 13-14
Denver, CO Daugherty Oct 20-21

Animals As Motivators: Dolphin-Assisted Therapy
14 Hours, 1.4 CEUs (No Prerequisite)
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Key Largo, FL McIntosh Oct 20-21

ADDITIONAL SEMINAR OFFERINGS

Dry Needling I
Intramuscular Dry Needling of the Cervical, Scalpula-thoracic, Craniofacial Region and Upper Extremity
25 Hours, 2.5 CEUs (Prerequisite: None)
Milwaukee, WI Krell
2019
Charleston, SC Krell
Apr 5-7

Dry Needling II
Intramuscular Dry Needling of the Lumbo-Pelvic and Lower Extremity
25 Hours, 2.5 CEUs (Prerequisite: DN I)
Atlanta, GA Krell
Nov 2-4

Running Rehabilitation: An Integrative Approach to the Examination and Treatment of the At Risk Runner
14 Hours, 1.4 CEUs (No Prerequisite)
St. Augustine, FL Vighetti
Oct 27-28
2019
St. Augustine, FL Vighetti
Apr 6-7

CF2 - Intermediate Cranio Facial
15 Hours, 1.5 CEUs (Prerequisite: Basic CF1 Online)
2019
Milwaukee, WI Hobson
Feb 16-17

CF3 - Advanced Cranio Facial
15 Hours, 1.5 CEUs (Prerequisite: CF2)
Denver, CO Strickland
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I earned a bachelor’s degree in chemistry in May 2000 and got the opportunity to move from my native Oklahoma to Massachusetts for a research internship with the Massachusetts Institute of Technology’s Biomechatronics Group. My first week there, I watched my new boss, Hugh Herr, run a bionic knee trial at Spaulding Rehabilitation Hospital for people with amputations. As I observed physical therapists (PTs) teaching recipients to use the technology, I knew I’d found my passion.

A couple years later, I moved back to Oklahoma and went back to school to become a PT. Upon graduation, I was hired by Norman Regional Health System to work in the acute and outpatient settings—a dream job for a new graduate who liked both areas of practice and didn’t want to have to choose between them. During my first year I was named physical therapy clinic coordinator at the Norman Regional location in Moore, Oklahoma. It had an outpatient clinic and a small inpatient hospital. I grew in my professional skills as the facility itself expanded, and I worked beside staff who I count among my best friends to this day.

Over the years, a few of my coworkers moved on, but their successors became my new friends. I found my work to be exciting and challenging. The patients gave me energy and purpose. I loved watching how even the slightest physical gains often resulted in huge functional improvements. My coworkers and patients felt like family, which made my professional life all the happier and more satisfying.

In fact, I honestly didn’t want anything to change. On May 20, 2013, however, my professional life got turned upside down. Literally! If you’ve heard of Moore, Oklahoma, it’s probably because 5 years ago the national news media was all over the story of how an F5 tornado with peak winds estimated at 210 miles per hour tore through the town. It tore through our Moore facility, as well.

In Oklahoma, tracking severe weather is common.
The air pressure was so intense that I felt as if an elephant was sitting on me. Others tell me that there were incredibly loud noises as the tornado bore down, but I don’t remember that. It had to have been loud, though, because it wasn’t just that the tornado created debris the size of cars. Actual cars were lifted off the ground and thrown into our building.

When the siege finally ended, we arose and discovered, to our great and relieved surprise, that the cafeteria had been left relatively unscathed, and that none of us sheltered there had sustained a serious injury.

Beyond the cafeteria itself, though, was utter destruction. Our planned exit route was completely blocked by overturned cars and rubble. We worked as a team to determine the best and safest way out of the building. The thing I most remember is all the former patients who rushed to the hospital to dig us out to safety. We had helped them in a time of need in their lives, and they’d come to us to return the favor. Their faces were so welcome! Their presence meant the world to us.

The next day, the hospital leadership called a debriefing to give us a chance to share our stories and emotions. They immediately assured us that we still had jobs, even though we no longer had a place to work. They followed through, too—quickly absorbing us into other health system locations. That made me prouder than ever to work where I do.

Within 3 days of the tornado, my immediate coworkers and I were seeing patients at Norman Regional’s Physical Performance Center in Norman. Our patients drove over from Moore—which touched us, as it wasn’t an easy drive given all the destruction the tornado had wrought. Twenty-four people had been killed on May 20, and property damage was estimated at $2 billion.

I still work for Norman Regional Health System. Its core values align with my own, and I enjoy serving a community that is as dedicated to us as we are to them. I manage Norman Regional Moore Physical Rehabilitation—which has been rebuilt and is thriving—as well as the health care system’s Physical Performance Center and physical rehabilitation at the Norman Regional HealthPlex specialty hospital.

I continue to provide direct patient care on occasion, which is important to me. Being in management, however, lets me ensure that staff feel the same level of caring, and feel as reassured about their job security, as I did 5 years ago, when I was at my most vulnerable. As job motivation, that’s as powerful as any force of nature.
By the Numbers

Special Edition on Opioids
(see related cover story on page 32)

Steps identified in the National Quality Partners Playbook: Opioid Stewardship to support high-quality, sustainable opioid stewardship programs. Actions include promoting leadership commitment and culture; implementing organizational policies; advancing clinical knowledge, expertise, and practice; enhancing patient and family caregiver education and engagement; tracking, monitoring, and reporting performance data; establishing accountability; and supporting collaboration with community leaders and stakeholders.

SOURCE

Civil penalty for opioid manufacturers that violate reporting requirements under the Controlled Substances Act. The US Senate is considering legislation (S. 2456) that would increase the penalty to $100,000 for failure to report “suspicious orders for opioids” or for “failing to maintain effective controls against diversion of opioids.”

SOURCE

Portion of all deaths in the United States in 2016 attributed to opioids. Young adults aged 24-35 were hardest hit: 1 in 5 deaths were opioid-related.

SOURCE

Year that opioid prescription volumes peaked in the United States. Between 2011 and 2017 opioid prescriptions dropped 29%—from about 72 pills per adult to 52 pills.

SOURCE

Illegal doses of opioids involved in the largest health care fraud enforcement action in Department of Justice history—most fraud, most defendants, and most doctors charged in a single operation.

SOURCE

ICD-10-CM diagnosis code for “opioid related disorders.” There are 117 different opioid-related ICD-10 codes, including “opioid abuse, uncomplicated” (F11.10), “opioid dependence with withdrawal” (F11.23) “opioid use, unspecified with opioid-induced sleep disorder” (F11.982), “poisoning by heroin, accidental” (T40.1X1A-S), and “poisoning by analgetics and opioid receptor antagonists, intentional self-harm” (T50.7X2A-S).

SOURCE
www.icd10data.com/ICD10CM/Codes.
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