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PTs HELPING TO HEAL SURVIVORS OF TORTURE
Their numbers in the United States are higher than you might think. Here’s what to look for and how best to meet their needs.

STRENGTH IN NUMBERS: THE POWER AND POTENTIAL OF CLINICAL DATA REGISTRIES
More than 110 qualified clinical data registries are helping improve health care outcomes while demonstrating the value of specific interventions. Here’s a look at some of them, and the benefits that APTA’s Physical Therapy Outcomes Registry can offer the profession.

COMPLIANCE MATTERS
Here’s what PTs need to know about the difference between habilitative and rehabilitative services.

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www.usclimatedata.com/climate/new-orleans/louisiana/united-states/usla0338

54
Selfies per 1,000 people taken in New Orleans—placing The Big Easy 36th of 459 cities worldwide, as ranked by Time magazine in 2014.
http://time.com/selfies-cities-world-rankings/

2,136
New clinical specialists to be recognized at the American Board of Physical Therapy Specialties ceremony at the start of CSM 2018.
www.abpts.org/About/Statistics/

100MILLION
Goal of the CSM 2018 “Step to the Beat” challenge; if attendees collectively take this many steps during the conference, APTA will donate $10,000 to Shoes4Kids.
www.apta.org/CSM

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Ask Questions. Remember Wellness.

In July 2013, APTA’s House of Delegates adopted a new vision for the profession of physical therapy: “Transforming society by optimizing movement to improve the human experience.” This vision is at the forefront of our growing autonomy as doctors of physical therapy. It is important to our identity and is helping raise awareness of #ChoosePT. Movement science is our expertise! We also are experts on the human body. We study how our bodies work at cellular, neurological, musculoskeletal, cardiovascular, and psychological levels.

This leads me to pose the question: Are we working to transform society by optimizing the human body not only through movement but also through wellness?

The 2017 Combined Sections Meeting (CSM) was one of my favorites. It is amazing to see how our community grows. The programming seemed to address more wellness issues than had previous CSMs. Some sessions dedicated to wellness were: “Sleepless in San Antonio—Guiding Patients to Better Sleep and Wellbeing,” “We Stink at Loading: Dosing Exercise, Proprioception, and Nutrition,” “Evolving Paradigms in Psychosocial Management of Debilitating Chronic Conditions,” and “Physical Therapy in the Community: Prevention Where We Live, Learn, Work, and Play.”

Typically, intake may focus solely on asking about pain, functional movements that previously could be performed but now can’t, and goals for physical mobility. We may ask about medications, but very seldom do we ask additional wellness questions. I suggest that we are remiss to think we can address our patients’ goals without also asking about sleep, nutrition, bowel and bladder function, and psychological state.

One may pose the question: How are sleep, nutrition, continence, and psychology within our scope of practice?

Research shows that sleep affects our immune function, tissue healing, pain modulation, cardiovascular health, cognitive function, learning, and memory. Thus, prognosis of the success of an intervention will be affected by our patients’ sleep habits. If we are trying to restore movement in individuals with chronic sleep problems, we can anticipate that they will not progress or heal as quickly as will individuals who are getting adequate sleep.

If an individual is eating a diet high in inflammatory foods, we can anticipate the person will have increased pain and comorbidities that will, in turn, affect care. Examples of inflammatory diets include those involving high daily intake of sugar, dairy, and processed food, and low vegetable and fruit intake.

If individuals are getting up throughout the night, rushing to the bathroom, or staying home because they are embarrassed by their bowel or bladder dysfunctions, we can anticipate they will have impaired sleep, increased risk of falls, increased deconditioning, and depression affecting their physical therapy care.

If our patients and clients are dealing with anxiety, depression, or negative stressors, their prognosis will be poorer, as they also may have increased inflammation, pain sensitivity, potential for dizziness, and/or potential for decreased adherence.

How can we incorporate a wellness model into our practices and improve the care of our patients? Along with our routine questions, we might consider asking, “Are you sleeping through the night?” and “If not, why?”
These simple questions may help us identify insomnia or urge incontinence that is causing that individual to awaken frequently. Let’s ask, “How often are you getting up to use the bathroom each night?” and “How many fruits and vegetables do you eat each day?” Also, don’t be afraid to ask, “Are you depressed?”

Asking these questions can help us treat physical issues with which we feel we can help, or refer out to specialists. We have the opportunity to optimize the movement system of our patients and make long-lasting changes toward a healthier lifestyle and improved quality of life. We can be a key profession in addressing not only chronic pain and movement but also neuroprevention and wellness. I encourage us all to begin by asking a few more questions.

Jamie Nesbit, PT, DPT  
Board-Certified Clinical Specialist in Neurologic and Geriatric Physical Therapy  
HonorHealth OP Therapy Services

[Editor’s note: The September 2017 issue of PT in Motion contains an article on the importance of PTs understanding issues related to nutrition (www.apta.org/PTinMotion/2017/9/). An article scheduled for 2018 will address the importance of sleep and the role of PTs. The September article includes myriad resources for PTs who want to further explore the topic of diet and food. The 2018 article similarly will provide resources on sleep education and management.]
Habilitation Versus Rehabilitative Services: What’s the Difference?

Here’s what PTs need to know, and why it’s important.

By Wanda K. Evans, PT, MHS, and Elise Latawiec, PT, MPH

The Affordable Care Act (ACA) established “essential health benefits”—a package of benefits designed to ensure that certain health plans offered in state health insurance exchanges provide enrollees with a baseline of coverage, benefits, and services. Although there are exceptions, most exchange plans must cover these benefits in order to be certified. Since 2014, receipt of these benefits by designated groups of newly eligible Medicaid beneficiaries also has been required.

Habilitative services—services that help a person keep, learn, or improve skills and functioning for daily living—and related devices are among the 10 essential health benefits that must be covered by designated health plans. ACA requires that non-grandfathered, fully insured health plans offered in the individual and small-group markets, both on and off the exchanges, provide coverage for these services and devices. Furthermore, health plans are not permitted to impose limits on coverage of habilitative services and devices that are less favorable than those imposed on coverage of rehabilitative services and devices. Also, for plan years beginning on or after January 1, 2017, health plans are prohibited from imposing combined limits on habilitative and rehabilitative services and devices.

Habilitation services differ from rehabilitative services in that the latter help a person keep, get back, or improve skills and functioning for daily living that have been lost or impaired because that individual was sick, hurt, or disabled.

The terms can apply to the same services, provided in the same setting, addressing the same functional deficits, and achieving the same outcomes. The difference is whether the services provided involve learning something new or relearning something that has been lost or impaired. Services that help the individual learn something new are habilitation services.

Use of the SZ modifier to indicate that services are habilitative is not new to
commercial payers. In 2014, it was introduced by several Blue Cross Blue Shield subsidiaries to allow for more accurate processing and payment of claims for rehabilitative and habilitative therapy services. If required by an insurer, the provider must add the modifier to therapy procedure codes when services are performed for habilitative purposes.

**Frequently Asked Questions**

*Does the separate-visit limit requirement apply to all health plans?*

No. The separate-visit limit for habilitative and rehabilitative services applies only to ACA-compliant individual and small-group health plans. It does not apply to self-funded small-group, large-group, or grandfathered health plans. Nor does it apply to Medicare or traditional Medicaid. It does, however, apply to Medicaid-managed care plans, and to people newly eligible for Medicaid through Medicaid expansion.

**What are some examples of habilitative and rehabilitative services?**

Habilitation describes services that are designed to establish skills that have not yet been acquired at an age-appropriate level. Treatment is provided to facilitate acquisition of those skills. Examples include therapy for a child who isn’t walking or talking at the expected age. These services may include physical therapy, occupational therapy, speech-language pathology, and other services for people with disabilities, provided in a variety of inpatient and/or outpatient settings.

Rehabilitation refers to reestablishing skills that were acquired at the appropriate age but have been lost or impaired because a person was sick, hurt, or disabled. Examples include recovery from a car accident or stroke. These services may include physical therapy, occupational therapy, speech-language pathology, and psychiatric rehabilitation, provided in a variety of inpatient and/or outpatient settings.

*Can I provide habilitation and rehabilitation using the same treatment goals?*

No. The treatments should have different goals. This will help clarify to payers that the nature of the services are different even if the same interventions are used. Habilitative goals must focus on providing a client with new skills, abilities, or functions. Rehabilitation must focus on restoration of previous functional abilities.

*Does every ACA-compliant plan use the SZ modifier to distinguish habilitative services?*

Not necessarily. Each plan may have its own system for implementing and tracking patient visits used under the habilitative benefit. Providers should check each ACA-compliant health plan for specific details—including which providers are required to report habilitative services, and if the plan uses the SZ modifier.
The ACA-compliant plan does not require the use of the SZ modifier. What should I do?

While the plan in question may not yet require the modifier’s use, it is reasonable to expect it eventually might do so. In the meantime, educate yourself and other staff clinicians on the differences between habilitative and rehabilitative services, and document each accordingly. Also, discuss with your billing service or staff the importance of using the SZ modifier to distinguish services. Look out for payer notification of any change in policy regarding the modifier’s use, and be prepared to comply with all requirements.

Why is required use of the SZ modifier happening?

This federal policy is intended to enforce the requirement that ACA-compliant health plans provide equal coverage for rehabilitative and habilitative services, and that rehabilitative and habilitative visits be counted separately.

What is APTA hearing from PTs around the country?

We’ve heard from several state chapters’ reimbursement committee chairs that some payers have announced that the modifier is available. However, its use does not appear to be widespread or problematic.

It Pays to Document

Documentation always has been an essential component of clinical practice in physical therapy. The added requirement to distinguish rehabilitative from habilitative services reflects increasing demand for specificity. It is critical that we understand these differences and articulate them to payers.

Be sure to check the patient’s evidence of benefit to determine whether he or she is eligible for habilitative services. Also, check your local payer policies for billing and documentation requirements.

APTA will continue to educate clinicians and advocate for proper reimbursement for services provided by physical therapists. Watch for future notices, and please let us and your state chapter know if you are aware of payers that require use of the SZ modifier that are not cited in the chart on APTA’s website at www.apta.org/Payment/PrivateInsurance/RehabVsHabSZModifier/.

If you have additional questions or concerns, contact your state chapter or APTA at advocacy@apta.org.

Additional Information

APTA Essential Health Benefits Page
- www.apta.org/EHB/
- “Determining an Essential Benefits Plan for Rehabilitation Services and Devices: A Value-Based Approach”
- “KHN Article: Private Insurers Could Dampen Access to Habilitative Services”
  - www.apta.org/PTinMotion/NewsNow/2014/1/15/HABServicesACA/
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While The PT’s Away
A star student must question his own hype.

Physical therapist (PT) students learn a great deal from the clinical instructors (CIs) who mentor them during their placements. But those lessons aren’t necessarily exclusive to clinical skills and treatment outcomes. Students also may gain instruction in what not to do, and may be challenged to heed their own ethical compass. Consider the following scenario.

A Confidence Game
Bob has completed the first year of his doctor of physical therapy program at Valleydale University and now is in his first clinical placement. Stephanie, Bob’s CI at Apex Physical Therapy, not only is a clinician but also manages the practice’s 3 locations, so Bob feels he’s getting strong grounding in both the clinical and business sides of physical therapy.

Stephanie’s announcement that she’ll be absent for the final 2 weeks of his placement in order to accompany a local dance troupe on its tour gives Bob pause, but when she sits him down the Friday before she leaves to discuss the arrangements, she reassures him that everything will be fine. She explains that the clinic at which he works won’t be admitting any new patients during her absence; that Gail, a veteran physical therapist assistant (PTA) Bob always has found extremely friendly and helpful, will be on hand; and that Tim, a “float” PT, will come in occasionally, depending on needs at the practice’s other locations.

“I’ve been very impressed with your abilities and instincts,” Stephanie says. “You ask great clinical questions,” she adds, “which is the mark of someone who’s going to be a fine PT.” Bob feels flattered by her confidence in him. He notes that, starting in week 5 of the rotation, Stephanie began sometimes excusing herself from the room to attend to matters elsewhere in the clinic. Bob reflects with pride on the fact that when his school’s director of clinical education (DCE) came by to visit him, Stephanie praised Bob’s confidence and what she called his “self-possession.”

Somehow, though, this looming situation makes Bob uncomfortable. He’s never been quite clear on exactly what “supervision” means in the context of the...
student-PT relationship. He has deferred to Stephanie on this and has assumed that proper procedures have been followed. For the next 2 weeks, however, Stephanie will be completely off-premises and unavailable for direction or consultation.

“You’re sure I’m up to this?” Bob asks, somewhat hoping that the uncharacteristic hesitation in his voice might prompt her to somehow expand his safety net.

“See what I mean about asking good questions?” she responds. “You’re right to ask, and I’m glad that you did. I’d expect nothing less of you. But yes, I’m completely confident that you’re up for this. You’re smart, you’re capable, you’ve worked with all these patients, and, like I said, you’ll have plenty of backup. I’ll leave you Tim’s phone number, just in case you feel you need a PT’s guidance when he’s working at 1 of the other clinics. Don’t sweat it—you’ll do great.”

Stephanie’s confidence is reassuring—so much so that Bob rethinks the idea of checking in with the DCE to double-check the propriety of these plans. “Okay, then. Let’s do this,” Bob responds.

The first 2 days of Stephanie’s absence go smoothly for Bob. He follows Stephanie’s plan of care with each patient and documents each visit, secure in the knowledge that Tim will countersign the documentation the next time he comes to the clinic—which he’s told will be Thursday. On Wednesday, however, a couple of things happen that rattle the student.

He’s completing a Medicare Part B billing form.

resources

At www.apta.org/EthicsProfessionalism/

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

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

- “Ethical Decision Making: Terminology and Context”
following Stephanie’s specific instructions, when he suddenly second-guesses himself. He tries to remember what he’d heard in class about billing, because he’s unsure, now that he thinks about it, whether it’s okay for him to use Stephanie’s billing number in her absence. In fact, he’s also unsure whether he’s allowed to bill services to Medicare Part B patients at all. Bob is tempted to use the phone number she’s been given to call Tim and double-check. He decides not to do so, however, telling himself, “Stephanie wouldn’t have told me to do anything that isn’t above-board.” Later that day, a patient named Dan arrives in considerable pain. “As Steph could tell you, I’ve had these flare-ups before,” he tells Bob. “I know from experience that all I need

Considerations and Ethical Decision-Making

If Stephanie hasn’t quite “created a monster” in Bob, she’s certainly encouraged him—through her supervisory, billing, and perhaps other practices—to play fast and loose with the rules of legal and ethical conduct. She’s fed his ego and praised his “instincts”—but those instincts now are at odds. To treat Dan, or to step back? To trust Stephanie on billing matters, or ask Tim for feedback, after all? What’s in the patient’s best interest?

Realm. Both the individual and institutional realms are at play. It’s individual in that these matters are between Bob and Stephanie, as well as between the student, the CI, and the patient. It’s institutional in that Stephanie is disregarding state and federal law regarding supervision and billing, respectively, and also in that the DCE at Bob’s school is being left out of the discussion.

Individual process. Stephanie lacks moral sensitivity in her actions toward patients and Bob. To the extent that Gail and other staff are aware of and haven’t challenged Stephanie’s illegal and unethical practices, they lack moral sensitivity, as well. Bob’s moral judgment is in question here—he must decide between right and wrong actions.

Ethical situation. This is a moral temptation for both Stephanie and Bob, in which each individual can benefit in some way from doing the wrong thing—Stephanie has fewer restraints on her actions, and Bob gets a smooth clinical experience and a strong recommendation from his CI.

Ethical principles. The following principles of the Code of Ethics for the Physical Therapist provide guidance to Stephanie, Bob, and Valleydale staff.

> 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 3D. Physical therapists shall not engage in conflicts of interest that interfere with professional judgment.

> Principle 3E. Physical therapists shall provide appropriate direction of and communication with physical therapist assistants and support personnel.

> Principle 4B. Physical therapists shall not exploit persons over whom they have supervisory, evaluative, or other authority (e.g., patients/clients, students, supervisees, research participants, or employees).

> Principle 5A. Physical therapists shall comply with applicable local, state, and federal laws and regulations.
is some stretching and a little time with that machine that makes my skin tingly. Then I should be good to go.” Bob knows that to do what Dan asks will require altering Dan’s plan of care. He excuses himself from the room and consults with Gail. She reminds him that, as a PTA, she can’t authorize such a change. “You need to call Tim,” she says.

Bob outlines the situation to Tim, who responds, “I’ve never treated the guy, and there’s no way I can get over there in time to see him today. Just tell him you’re sorry, but you can’t administer e-stim. Advise him to call his doctor.”

When Bob reenters the treatment room and turns down Dan’s request, the patient gets surprisingly angry. “Do you not get that I’m in pain here?” he asks, pleadingly. “Look, I know what works in these situations. You’re a smart kid. Steph raves about you. What’s the harm?”

The harm, Bob worries, not only is that he isn’t authorized to implement an alteration in Dan’s plan of care, but also is that Bob is being asked to treat symptoms without knowing the underlying pathology. The situation makes him uneasy. On the other hand, though, Dan is quite adamant about his needs, and Bob certainly would like to relieve his pain.

Stephanie has praised Bob’s confidence and self-possession, and she has, after all, entrusted him with a significant degree of autonomy. Bob replays Dan’s words: “She raves about you.” Will he somehow be letting his CI down if he doesn’t grant Dan’s request?

For Reflection
Stephanie has boosted the student’s ego in ways that have emboldened him. But to what end? What’s her motivation? To repeat the patient’s question, what’s the harm here—to Bob, to Valleydale, and, most important, to the patient?

For Followup
I encourage you to share your thoughts about the issues raised in this scenario by emailing me at kirschna@shp.rutgers.edu or by posting a comment online.

If you are reading the print version of this column, go online to www.apta.org/PTinMotion/2017/11/EthicsinPractice/ for a selection of reader responses to the scenario and my thoughts on those responses. Scroll down to the heading “Author Afternote.”

Be aware, however, that it takes a few weeks after initial print and online publication for feedback to achieve sufficient volume to generate this online-only feature.
PTs HELPING TO Heal SURVIVORS OF TORTURE

BY ERIC RIES
Their numbers in the United States are higher than you might think. Here’s what to look for and how best to meet their needs.

Laura Pizer Gueron, PT, DPT, MPH, still thinks about a client she treated while she volunteered for the Center for Victims of Torture (CVT) in Minnesota. Though he was many years removed from his torture experience in an African nation—which had included suspension by his arms, confinement in a small cage, and beatings—the abuse’s deep physical and psychological toll remained.

“He had very limited shoulder active range of motion,” Gueron recalls, “and a lot of pain and guarding. I saw him 8 or 10 times. We did simple active and passive range of motion stretching, exercises for his arms, and progressed to use of resistive stretch bands. I administered gentle massage and shoulder mobilizations. I gave him a microwaveable heating pad for pain relief at home. I offered lots of reassurance to help decrease pain catastrophizing and fear-related avoidance.”

By the end of their time together, the man had full range of motion in his shoulders and was thrilled with his progress after years of pain and self-limited activity. He later exclaimed to Gueron, “I helped my friend paint all the rooms of his house!”

“With another Minnesota client,” Gueron relates, “I did a joint visit with a psychotherapist from CVT who had told me, ‘This gentleman won’t disclose anything to me, and, as a result, I feel that he’s not making the progress toward psychological healing that he could be making.’ I did some myofascial release and performed very gentle manual therapy while the psychologist engaged this man in conversation. He started disclosing all of these details related to his torture experience and the ways in which it had affected him.”

“He was very grateful,” Gueron recounts. “He told me, ‘I feel safe in my body now, and can be with my wife again in a sexual way. I’m sure,’ Gueron says, “that the psychotherapy he’d also received contributed to that transformation, but he specifically credited physical therapy administered by Kenyan physios. To me, it illustrated so beautifully the power of what physical therapy and PTs can do to promote healing.”

April Gamble, PT, DPT, cites the case of a young woman who sought help at an aid organization in the United States, trains and employs local people at locations in other parts of the world, partners with local organizations in the autonomous state of Kurdistan in Iraq, conducts research into how best to treat survivors of torture, and advocates for torture’s end.

Gueron, who volunteered for CVT with refugee clients at its “healing center” in the Twin Cities for 21 years, has worked since 2013 as the organization’s clinical advisor for physiotherapy. In that part-time paid position she works primarily with CVT operations in Nairobi, Kenya, where CVT-trained-and-employed local physiotherapists (as PTs are known there and in many parts of the world), treat clients in a city with a refugee population that the office of the United Nations High Commissioner for Refugees (UNHCR) estimates at more than 50,000. In addition to working remotely with Kenya-based staff, Gueron travels to Nairobi twice a year, for a week at a time, to lead trainings, field questions, and gain in-person insights.

For many survivors of torture, physical therapy’s value—beyond its rehabilitative and functional benefits—lies in “helping people come back into their body” as Gueron puts it. She recalls a client approaching her after a group session in Nairobi and saying, “I love my wife, but I didn’t desire her because I was not in my body”—meaning that he’d mentally and emotionally dissociated himself from his body because of the abuse it had endured. Just 4 sessions of sensitively administered physical therapy with CVT-trained Kenyan physiotherapists had worked wonders on him, the man said.
with which CVT partners in Kurdistan. She’d been held captive by a militia group for nearly 2 years and had experienced sexual violence and other forms of torture inflicted on her and others. As the site’s physiotherapist trainer for CVT, Gamble works full-time with local physiotherapists to develop their skills in what PTs with mental health training, like Gamble, term a “trauma-focused physiotherapy approach.”

“A psychotherapist had identified that the client had symptoms of PTSD [posttraumatic stress disorder], anxiety, and depression,” Gamble recounts. “She had severe headaches, pain in her lower legs, chest pain, shortness of breath, and difficulty sleeping. She wanted to be able to clean her house again, shop, and take care of her family.” Gamble provided direct clinical supervision to local physiotherapists, helping them devise an integrated care plan that included relaxation and mindfulness techniques, therapeutic exercise, gradual increases in physical activity, interceptive exposure (a cognitive behavioral therapy technique used in treating panic disorder), and an individualized home exercise program.

“We saw her once a week for about 10 weeks, and by the end of that time she’d met her goals,” Gamble reports. “She still has occasional headaches, but we’ve given her strategies to manage them. She no longer has shortness of breath, so she doesn’t avoid climbing stairs anymore. Fear and anxiety no longer cripple her movements and actions. She feels motivated for the future.”

MaryAnn Burke de Ruiter, PT, MS, like Gueron, was a long-time volunteer for CVT among its clients in Minneapolis-St Paul’s refugee community before becoming paid part-time to support an overseas arm of the organization—in her case, its operation in Jordan. Earlier, she had worked (not for CVT) in El Salvador for a few years in the 1990s, just after that nation’s 12-year civil war. She’s now employed full-time by the Minneapolis Public Schools.

Giving up her work with refugee populations at the end of last year was “a hard decision,” she says, but it was the right one for her—given an overloaded schedule, family demands, and, she suggests, the need for a break.

Looking back to her earliest experiences with survivors of torture in Central America, de Ruiter recalls that her “biggest learning curve” as an American PT wasn’t so much the practical matter of adapting her physical therapy skills to a new environment as it was the psychic challenge of acknowledging the dimension of suffering.

“When I first got to El Salvador I wondered if torture occurred to the extent that people were telling me it did,” de Ruiter says. “I came to discover just how cruel humans can be to other humans.”

AN UNDERUSED PROFESSION

“Practising physical therapists should understand the general and specific physical and psychological functional limitations, participation restrictions, and impairments that can result from torture, and the appropriate functional examinations/assessments and interventions/treatments for survivors.” So states the World Confederation for Physical Therapy (WCPT) policy statement on torture—which APTA endorses as “consistent” with the association’s “core values of altruism, compassion, and caring.”

The Copenhagen-based Dignity Danish Institute Against Torture (Dignity)—a world leader in the antitorture movement and in institutionalizing physical therapy’s role in treating survivors—put it this way in a journal article titled “Physiotherapy for Torture Victims”:

The immensely complex problems after torture require very special rehabilitation efforts. Almost all torture victims complain of chronic pain from the musculoskeletal system. Often with neurogenic pain, hyperalgesia, and allodynia. With this in mind, it is not the task of the physiotherapist to make the patient free from pain, but to guide him to a better understanding of the nature of the pain, and the pain influence on physical functions. Active training in order to improve physical ability, correction of inappropriate movement patterns in order to avoid disuse, and relaxation exercises in order to counteract muscular tension and stress, play a key role in physiotherapy treatment of torture victims.

Those words were written in the year 2000. When it comes to reality on the ground 17 years later, WCPT’s use of the word “should” in its policy statement on torture is instructive. PTs interviewed for this article laud Dignity’s
leadership and note that CVT counterparts around the world—particularly in Europe—recognize physical therapy’s importance to survivors of torture and include PTs in their programs. They emphasize, however, that there are many gaps, and that much work remains to be done.

Karen Fondacaro, PhD, a psychologist who directs Burlington, Vermont-based New England Survivors of Torture and Trauma (NESTT), goes so far as to characterize this integration as “in the infancy stage.” Often, she says, “the medical community doesn’t know what to do with forms of trauma such as torture. They may call in a psychologist, but I don’t think calling in a physical therapist necessarily is on their radar.”

Gamble suggests the disconnect has at least as much to do with physical therapy’s evolution as with its under-appreciation by other medical fields. But she’s excited by the changes she’s seeing.

“In recent years the physical therapy profession increasingly has been recognizing and developing its role in mental health—in the biopsychosocial model of care delivery and in modern pain science,” she says, citing treatment approaches that recognize the complexity of disease processes, pain response, and the varied ingredients needed for recovery and healing. “We’re just starting to advocate for the role of physical therapy in mental health and chronic pain,” Gamble says. “We’re beginning to tell people, ‘We have the skills to contribute here. We are part of the solution.’”

Word gradually is getting out, she adds, citing as an example the World Health Organization’s inclusion in 2013 of physical therapy as “1 of the key professions” among medical teams responding to traumatizing sudden-onset disasters.4

Gamble concedes, however, that US-based PTs may take professional pride in this trend without quite knowing what it has to do with them. Yes, the UNHCR estimates the worldwide number of refugees—defined by the organization as people who have been forced to flee their country because of persecution, war, or violence—at 22.5 million. But, are the US numbers of refugee survivors of torture really significant enough that PTs in Dubuque, Fresno, or Raleigh need seriously to consider this population’s trauma experiences and therapy needs?

Yes, Gamble emphatically responds—citing a research analysis released by CVT in 2015.5 The press release announcing its publication bore the headline “US Home to Far More Refugee Torture Survivors Than Previously Believed.”

CVT’s meta-analysis of previous studies concluded that the oft-cited figure of 400,000 to 500,000 refugee survivors of torture residing in the United States—a statistic that’s been in vogue for 20 years, and that might in and of itself be sobering to any PT familiar with it—is in fact off by a sizable 44%. “We conclude,” the CVT author wrote, “that the number of refugee torture survivors in the US could be 3 times the previous estimate—perhaps as high as 1.3 million.” And that estimate doesn’t include, the analysis added, the number of torture survivors who have been granted protection through the US asylum system.
What this means, as de Ruiter puts it, is that “a lot of PTs in the United States likely are seeing survivors of torture in their practice settings, whether they know it or not.”

“Chances are good that you’re seeing them, or that you will see them, among your patients and clients,” Gamble agrees. “We know that survivors of torture experience high rates of chronic pain, cardiovascular disease, and chronic disease. Those all are reasons that people see physical therapists.”

The need for physical therapy among survivors of torture, meanwhile, is illustrated by a pair of studies. One determined that “prevalent musculoskeletal pain” was a “correlate” to torture in 80% of 221 individuals examined at Dignity. Another identified significant pain issues in traumatized refugees as long as 20 years after their torture experience.

FOCUSING ON TRAUMA

When she talks about a “trauma-focused physiotherapy approach,” what Gamble means, she explains, is “the physiotherapist is working on improving both physical and mental health functioning.” The approach, she says, “takes into account the effects that psychological trauma has on the mind, the body, social interactions, and even the person’s greater community. It requires understanding the stages of trauma recovery through which individuals progress, and pacing treatment to where the client is in that process.

“A trauma-focused approach,” Gamble continues, “incorporates aspects of modern pain science—identifying the type of pain with which the client presents and tailoring your interventions to it; providing pain education; and offering relaxation, sleep hygiene, self-regulation, and exposure techniques. You then integrate these approaches with what PTs do best—exercise for strengthening, flexibility, and endurance, which contribute to improved physical and mental health functioning.”

An important skill Gamble learned from the physiotherapists and psychotherapists with whom she’s worked for CVT—first in Jordan, now in Iraq—is “when it’s appropriate to gradually expose clients to their ‘triggers’ in order to improve function.”

She gives an example. “One client was triggered back to her torture experience anytime something touched her low back, because she’d held that part of her body against a door to try to keep perpetrators from entering the room in which she was holed up. So,” Gamble continues, “we initially avoided this type of stimuli and worked on increasing the client’s sense of safety and control of her body. Gradually, however, it was important to abolish avoidance behaviors in order to work on restoring back movement. We taught the client strategies to manage her body reactions, then gradually introduced those triggering stimuli until they no longer elicited a physical and emotional response. During my work with this client,” she adds, “I was in close collaboration with psychotherapist trainers to ensure appropriate progression.”

“Because pain catastrophization and fear avoidance are so high among survivors of torture, it’s important,” Gueron says, “for the physical therapist to communicate that some pain can be okay—that not all pain must be avoided. The torturer may have planted the message in the person’s mind that he or she always will feel pain and that it never will heal. So, a big part of the physical therapist’s role is decreasing clients’ fears, assuring them that they can get back to doing the things they loved, and very gently guiding them through increased activity levels.”

Group activities often provide a safe space for survivors of torture to literally work out their physical and psychological issues.

“Many of our clients in Nairobi haven’t been touched in a kind and gentle way since before they were tortured,” Gueron notes. “Our Kenyan physiotherapists will direct clients to massage themselves with tennis balls, because touching themselves directly may feel threatening to them. Clients will start to feel some pleasure in areas of their bodies that are tight or painful. Then, after a couple of sessions, the physios will have clients partner up and massage each other with the tennis ball. It’s a trust-building and communication exercise. Clients gradually start communicating instructions like, ‘Upper shoulders, please.’ ‘You can do my back a bit harder.’ ‘A little more here.’

“It’s hard to describe why it’s so valuable,” Gueron says, “but I think it’s that the client has been granted choice and control, and that the exercise involves being touched in a kind way. It’s a big part of their healing process.”

When she worked in El Salvador, de Ruiter relates, “we’d have groups bat balloons back and forth, kick beach balls, and massage each other’s shoulders and necks. These were hands-on ways of getting people to feel their bodies—to recognize that they do have shoulders, that they do have necks and backs, that they can move and can have fun doing so. Together, they learned that movement needn’t always be painful.”
SEENING HER CLINIC THROUGH NEW EYES

Justine Dee, PT, and Karen Fondacaro, PhD, were friends but not yet professional collaborators when, in 2012, the Burlington, Vermont-based physical therapist and psychologist got to talking about the array of physical and emotional pain issues facing a client population that both women had treated—refugees.

They agreed that Dee, a private practitioner, and Fondacaro, cofounder and director of New England Survivors of Torture and Trauma [NESTT]—which at that time encompassed psychology, social work, and legal services but not physical therapy—should work together to better meet the needs of local refugees. (Since 1980, more than 7,000 refugees from more than 30 countries have arrived in the Green Mountain State through the Vermont Refugee Resettlement Program, that organization reports.)

Fondacaro visited her friend’s clinic for better insight into what PTs do and how they do it. That seemingly mundane field trip was a major eye-opener for both women.

“I went into Justine’s office and asked if I could take pictures of the tools she used in her work,” Fondacaro recounts. “I was shocked! I said, ‘Justine, these tools could be extremely frightening for torture survivors, and possibly could provoke or trigger traumatic responses. These items need to be described to this population before they are introduced.’”

Asked to confirm that her friend had effectively described her clinic as a latent torture chamber for survivors of torture, Dee recalls that day with a laugh born of education. “To a client with a torture history, it’s true—a physical therapy clinic can be a scary place if the PT doesn’t provide education and context. We physical therapists,” Dee notes, “tend to think that the tools we use to help patients feel better—things like instrument-assisted soft-tissue mobilization, dry needling, TENS [transcutaneous electrical nerve stimulation] and other forms of e-stim, and traction—are benign. It wouldn’t occur to most of us that these interventions could trigger a flashback or adverse response in a patient or client. In fact, though, some of these tools figure in common methods of torture in home countries of refugees.”

Dee has learned a lot about avoiding re-traumatization of her refugee patients and clients by working with the clinical psychologists at NESTT. It isn’t, she says, that it’s incumbent on PTs to hide the tools of their trade—although, she notes, a woman from Bhutan once searched her clinic for needles, certain that Dee was a police officer bent on tormenting her with injections. Rather, the key to preventing re-traumatization lies in “having a forthcoming discussion” with the patient or client.

PTs “should be aware that a standard physical therapy intervention meant to relieve pain and discomfort may not have the effect that they are anticipating, and they should be alert to the importance of avoiding any technique that may have been used inappropriately on that person,” Dee says. “How you do that,” she continues, “is by talking with that individual—by thoroughly explaining why a certain intervention is recommended in that situation, describing the anticipated benefit, and asking if the patient is okay with going ahead with it. These all are aspects of informed consent that we should be practicing, anyway,” she notes, “but they’re particularly important in refugee populations.”

It is “critical,” Fondacaro agrees, “for the PT to take the individual through each step: ‘Let’s look at this machinery. Let me tell you about it, and why it’s safe.’ ‘Does this instrument make you feel unsafe? We don’t have to use it.’” A primary issue with survivors of torture, she says, is “trust. The PT must foster it.”

Dee and Fondacaro shared their message of physical therapy do’s and don’ts, and what Fondacaro calls the profession’s “essential role in healing” this patient population, at APTA’s Combined Sections Meeting (CSM) in 2015, in a presentation titled “Trauma-Informed Physical Therapy for Survivors of Torture.” Dee also presented on torture-related issues at CSM earlier this year, along with April Gamble, PT, DPT, physiotherapy trainer for the Minnesota-based Center for Victims of Torture’s partnering operations in Iraq.

Dee now serves as NESTT’s director of physical therapy services, seeing NESTT clients in her clinical practice and sharing her insights with clients and staff at the organization’s facility.

“Justine has spoken with our refugee groups about the value of getting up and moving—even though they often don’t want to because they are depressed, or because movement feels unsafe to them,” Fondacaro says. “Over time, the participants see the importance of movement to their recovery and healing, both emotionally and physically.”

JUSTINE DEE
RESOURCES

Dignity Danish Institute Against Torture
https://dignityinstitute.org/
Human rights institute involved in treatment, research, international development work, and advocacy. Represented in more than 20 countries. Provides free access to “world’s largest library on torture.”

HealTorture.org
www.healtorture.org/
Resource center of the Center for Victims of Torture. Provides an array of documents and links to providers, survivors, students, and the public. Offers access (email lgueron@cvt.org) to a protected, PT-created Facebook group designed to “facilitate communication, share ideas, and offer support.”

“Torture Survivors: What To Ask, How To Document”
Article from the Journal of Family Practice.

“Compassionate Considerations”
www.apta.org/PTinMotion/2010/10/EthicsinPractice/
From PT in Motion magazine, an ethical look at the complexities of serving patients who have experienced torture.

CLINICAL TIPS

If any patient or client self-reports pain that’s lasted more than 6 months, “that should start to raise some alarms and flags for the PT,” says Justine Dee, PT, MS, a private practitioner in Vermont who also serves as director of physical therapy services at the aforementioned NESTT. “There are a lot of scales and tools you can use,” she advises, “such as the TSK and FABQ [Tampa Bay Scale for Kinesiophobia and Fear-Avoidance Beliefs Questionnaire], to help you identify if a person is avoiding activities and may be fearful of them.”

Referral to a psychologist may be a valid option, de Ruiter says, “if a client reports persistent chronic pain and his or her story doesn’t make good clinical sense as to why that would manifest,” which could suggest that psychological factors are involved. “But don’t discount the significant role that you, as a PT, may be able to play,” she adds. “Listen to your clients. What are they telling you? Just because it doesn’t fit what makes sense to you doesn’t mean they’re not telling you the truth—their truth. They’re not necessarily symptom-magnifying. There’s such an overlay of body-mind interaction.”

“Be authentic, interested, and sensitive to the whole person in front of you,” de Ruiter continues. “That’s important with all clients. But people with a torture history, in particular, need to know, by the way you ask your questions, that you’re open to talking about their past trauma but won’t force the issue. Convey that the door is open if and when they’re ready to disclose more. Believe what your clients tell you.”

Gueron advises, “Always be careful with touch with this population. Touch can be wonderful and healing,” she says, “but it’s got to feel safe for the client. The position that he or she is in can be very important. The client may tolerate touch when he’s sitting and facing the door, but being in a prone or supine position might be triggering. If you feel the client’s body getting tight, or if he or she suddenly seems to be holding in breath or showing other signs of anxiety, be sensitive to that. Say, ‘Let’s stop for a second.’ Ask questions: ‘Can I check in with you?’ ‘Is this going okay?’ ‘Do you want me to do something different?’”

As a psychologist, Fondacaro is professionally trained in how best to respond should a client “dissociate”—become uncommunicative, perhaps stare blankly, and seem to “not be there” even while he or she physically is in the room. “It can be frightening when people dissociate,” she says, “but physical therapists need to be able to [recognize and manage] it.”
There are tools PTs can deploy when a client dissociates, Gamble advises. “Grounding techniques can help the client better manage overwhelming emotions, anxieties, and/or flashbacks,” she says. “I recall a client who experienced frequent dissociative episodes, particularly during psychotherapy sessions. In that instance, the Jordanian physiotherapist and I worked together to develop a series of discrete physical tasks that the physiotherapist could lead the client through while the psychotherapist worked on getting him to better explore his emotions and express his thoughts. This enhanced the psychotherapy’s success,” Gamble says, “and helped the client feel in better control of his body and mind.”

Survivors of torture also may express “suicidal ideation”—sharing suicidal thoughts and/or desire to hurt themselves. “In that situation, it’s important for physical therapists to know their boundaries,” Fondacaro says. “Listen. Convey that ‘such feelings aren’t uncommon for someone who’s been through your experiences.’ But also, make sure the person has a safety plan. Physical therapists should establish relationships with mental health professionals to whom they can refer these clients.”

Gamble expands on that. “As the physical therapy profession continues to develop, and as PTs increase our responsibilities within a direct access environment, we should have the skills to screen...”
for and support individuals who are in a mental health crisis—which can involve having suicidal or homicidal thoughts, and can stem from domestic violence, as well.”

– APRIL GAMBLE

MEETING THE CHALLENGE

In fact, WCPT calls on its member organizations and PTs to include torture education in DPT programs and postprofessional instruction.

“The curriculum for physical therapist entry-level and continuing professional development programmes,” the world body’s policy statement on torture reads, “should include the prevention and prohibition of torture, as well as the examination/assessment, evaluation, and intervention/treatment of victims of torture.”

“These topics could and should appear as themes throughout the DPT curriculum,” Gamble says. “For example, case scenarios could be woven into teaching on musculoskeletal and cardiovascular issues. Competency measurements during clinical experiences could integrate application of trauma-informed principles.”

Gamble also would like to see all PTs screen patients and clients for depression and PTSD.

“As consumers get more direct access to our services in the States, we have a responsibility, I believe, to identify whether psychological symptoms are present,” Gamble says. “Two simple questions,” she adds, “have been validated as an effective method of screening for depression: ‘During the past month, how often have you been bothered by feeling down, depressed, or hopeless?’ and ‘How often in that time period have you been bothered by having little interest or taking little pleasure in things’?”

On the subject of mental health, Gamble is the only PT interviewed for this article who works full-time in the treatment of survivors of torture. She’s seen a lot—the physical and psychological damage inflicted on patients and clients by beatings, electrical torture (often applied to male genitals), water torture, sexual torture, forced physical exhaustion, forced positioning for extended periods, and prolonged exposure to bright lights.

“One skill I’ve learned from this work is the concept of self-care—tending to my own physical, emotional, and psychological well-being so that I can continue working with this population,” Gamble says. “I’ve picked up a lot from my psychologist colleagues.”

Gamble’s self-care includes regular exercise and physical activity, cultivating friendships in Iraq and staying connected through technology to family and friends in the United States, and fully appreciating the mundane, reassuring commonalities that transcend international borders.

“I don’t want to minimize the conflicts and poverty, or the fact that people in Iraq are struggling and vulnerable,” Gamble says. “But people also are living their lives here, just like they do everywhere else in the world. And my life in Iraq involves things like going on hikes in the mountains, witnessing beautiful sunsets, going out for ice cream with friends, and playing a weekly basketball game.”

The rewards of her work are many, she says. She’s challenging herself and learning new things. She enjoys
facilitating Iraqi physiotherapists’ “journey of learning.” She savors her role in improving the lives of patients and clients who have lost so much.

“It’s a special thing for a PT,” MaryAnn de Ruiter observes, “to have the opportunity to help clients understand the relationship between how their body feels and their mind thinks, and to help them see that movement improves not only their physical function, but also their energy level, mood, and ability to socialize.”

Guided by health care teams that include PTs, survivors of torture discover that “touch, movement, and being active can be healing and comforting. They find,” de Ruiter says, that “although not all injuries and memories can be healed, there can be increasing moments of joy in their lives.”

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

REFERENCES


Getting Around: Community Mobility

By Danielle Bullen Love

APTA’s Strategic Plan envisions transforming society by reducing barriers to movement. Enhancing community mobility is a key element. Many PTs already are helping to achieve the vision.
Community mobility has been defined as “planning and moving around the community and using public or private transportation, such as driving, walking, bicycling, or accessing and riding in buses, taxi cabs, or other transportation systems.” Yet, as a report by the US Census Bureau observes, “Much of the developed landscape in the United States was designed to accommodate automobile travel, complicating travel by walking or bicycling in many areas.” Further, traffic congestion and poor road design is hampering even auto travel in many cities.

But community mobility is more than getting from Point A to Point B. It also involves opportunities for exercise, relaxation, and transport alternatives to the automobile.

Thus, the Centers for Disease Control and Prevention, in “Overcoming Barriers to Physical Activity,” cites a “lack of parks, sidewalks, bicycle trails, or safe and pleasant walking paths convenient to homes or offices” as a deterrent to community mobility.

Other research has shown that when communities are designed with movement in mind, there are more opportunities for physical activity. In “Tracking Physical Activity Around the World,” the National Institutes of Health analyzes a study of steps data captured by smartphone apps. “Data from 69 US cities showed that higher walkability scores were associated with lower activity inequality,” the document notes. “Nor do enough people in the profession realize the extent to which the planned environment can encourage people to be active. Those are areas in which the profession’s expertise would be valuable, Hinze says.

“As a profession, we should push our communities to be ready for our patients and clients—citizens at large—to walk, roll, or ride the sidewalks, streets, and trails,” says Sarah Greenhagen, PT, DPT. Greenhagen, a board-certified clinical specialist in geriatric physical therapy, is co-founder of Catalyst Physiotherapy, Performance and Wellness in Sandwich, Illinois.

In 2015, APTA’s Michigan delegation, led by Hinze, advanced motions to amend the association’s position statements on the roles of the profession and APTA in advocating for prevention, wellness, fitness, health promotion, and management of disease and disability. The delegation proposed adding language supporting APTA and its members in advocating for “appropriate efforts that enhance community design to promote safe physical activity and active forms of transportation for individuals and populations of all ages and abilities.” The motions passed APTA’s House of Delegates in June 2016.

“From the association’s perspective, when we talk about advocacy, we talk about any opportunity to better position PTs and PTAs so they can have an effective role,” says Justin Elliott, APTA’s vice president of government affairs. Those opportunities can arise at the individual, organizational, community, chapter, and national levels.

APTA’s Strategic Plan for 2017 includes the society-facing goal that “Barriers to movement will be reduced at population, community, workplace, home, and individual levels.” Anita Bemis-Dougherty, PT, DPT, MAS, APTA’s vice president of practice, says, “Our focus always has been on reducing barriers, to allow people to...”

“So, figuratively if not literally, how do communities get from Point A to Point B? The physical therapy profession needs to be more involved in making sure people of all ages and abilities have places to be active, says Chris Hinze, PT, DPT, a physical therapist (PT) at Grand Traverse Pavilions in Traverse City, Michigan. After all, he points out, APTA’s vision for the profession is “Transforming society by optimizing movement to improve the human experience.”

“We do a good job of encouraging 1 patient at a time to be physically active,” Hinze says, “but PTs and physical therapist assistants (PTAs) could do better. PTs need to provide more support from a community-design standpoint.” PTs and PTAs traditionally aren’t active in urban planning, he notes. Nor do enough people in the profession realize the extent to which the planned environment can encourage people to be active. Those are areas in which the profession’s expertise would be valuable, Hinze says.

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Chris Hinze
continue to function and participate within their community, whether they are going to school, work, or recreation.” Traditionally, PTs and PTAs have focused on individualized care for their patients. A shift is needed to include an emphasis on influencing the health behaviors of entire communities.

What’s Hindering Community Mobility?

Advocating for community mobility begins by acknowledging the barriers that separate people from activity. Perceived lack of safety is a primary reason people choose not to venture outside their homes. That feeling can come from the physical environment, such as cracked sidewalks, or even a lack of sidewalks that makes walking hazardous. Lack of curbs that are level with the road and absence of pedestrian-friendly crosswalks also make mobility hazardous.

Cycling frequently is cited as another means of community mobility. While some cities have taken the initiative and installed bike lanes, such lanes can be dangerous if they aren’t properly separated from traffic.

Lack of safety also can arise from psychosocial factors. When Nicole Stotts, PT, DPT, prepares her patients for the end of their plan of care, she encourages them to walk. But often they won’t, she reports, because they fear for their personal safety. Stotts, a board-certified clinical specialist in geriatric physical therapy, practices at Ingalls Memorial Hospital in Harvey, Illinois. “In the community my hospital serves, there are areas of poverty and crime. At times, people are afraid to go outside,” she says—explaining that, with some residential areas affected by vacancy and disrepair, the environment is not always safe. Additionally, some public areas lack accommodations for people with limited mobility to maneuver safely.

With patients who are geriatric, cognitive issues can be an additional barrier to community mobility, Stotts says. Getting around in the community can require the help of another person, and that isn’t always a possibility. Some patients aren’t able to drive or call a taxi. If their surrounding environment doesn’t support safe walking as a mode of transportation, they simply don’t leave their homes.

Community mobility also is hindered by a lack of awareness and resources. “There’s definitely an equity issue when it comes to safe places to be active,” Hinze says. He observes that designated walking and biking trails are not as common in rural areas and in areas with lower socioeconomic populations.

Models of Community Mobility

Zachary Rethorn, PT, DPT, of BenchMark Physical Therapy in Chattanooga, Tennessee, asks, “What is a person’s social and cultural environment? What is being modeled?”

When Rethorn has traveled to Europe, he’s seen bike lanes “everywhere.” Those communities are built around walking and biking as safe, environmentally friendly modes of transit—in contrast to the car-centric culture of most of America. It can take patients without cars 2 to 3 hours to get to Rethorn’s clinic. The surrounding environment was not built to support alternative means of transportation.

In Global Age-Friendly Cities: A Guide, the World Health Organization (WHO) writes, “The outside environment and public buildings have a major impact on the mobility, independence, and quality of life of older people.”

The report cites public green spaces, walkways, and cycle paths as factors that encourage safe and healthy aging. Walkways and sidewalks should be designed or modified to serve the mobility needs of as many people as possible, WHO says. That includes widening them so people in wheelchairs can maneuver, creating a smooth, level surface that makes walking or rolling easy, and lowering curbs to become more even with roads.

Accessible and affordable transit, including free or low-cost services for seniors, also is a factor that determines age-friendly cities. “Being able to move about the city determines social and civic participation, and access to community and health services,” the report says.

Hinze agrees. “We need to shift design principles away from designing for automobiles and toward designing for people.”

What can PTs and PTAs do to promote these types of change?

“Every PT has a potential role to play,” Elliott says. “It’s up to individuals to determine where they think they can be
most effective, based on their expertise, their interests, and the needs of their community, town, or city.”

Education and encouragement are the first steps in getting around those barriers. “As a profession, we strive to increase a person’s ability to engage in their surroundings and meaningful activities,” Greenhagen says.

That can be as simple as advising people to walk if their trip is under a certain distance, suggests Jennifer Ryan, PT, DPT, MS, program coordinator in critical care at University of Chicago Medicine and education chair of the Cardiovascular and Pulmonary Section of APTA. In Ryan’s home town of Chicago, the city’s Safe Passage program stations adult volunteers at corners along the route to school. Kids then can feel safe as they walk and get in some physical activity for the day. Rethorn’s Chattanooga had success incorporating a river walk—a car-free walking and biking path.

With patients who are older, “Exercise can alleviate symptoms of depression,” says Stotts, noting that staying inside the home all day can cause people to be lonely and depressed. According to a recent study, the more times community-dwelling elders leave their home, the more positive correlations there are to health status. Regardless of age, as Ryan puts it, “Your body and brain need you to move.”

Community centers offer a wide range of recreation opportunities, including exercise classes for senior citizens. “It’s a huge benefit, especially for those without social support. They look forward to meeting with each other,” notes Stotts. Since not everyone can afford expensive gym memberships, community facilities should be accessible, both physically and financially, she says. That includes the availability of affordable community transportation options.

PTs and PTAs also can speak for populations that have a more difficult time moving, including those who rely on mobility aids such as wheelchairs and walkers. “People with disabilities often are underserved,” Stotts observes. Her main focuses are on quality of life and independence—giving people the tools they need to get out of their homes and have something to look forward to.

What Is the Value of Inclusive Community Design?

Community planners should design buildings and neighborhoods that are safe and accessible for everyone, according to both research and the PTs interviewed for this article. “Appropriate community planning and design can open up the availability of a town’s businesses, parks, schools, and churches to all of the members of the community,” says Greenhagen.

Getting involved at the planning stages of projects is a way PTs and PTAs can advocate for community mobility resources. Ryan shares the experience of a fellow PT who saw flaws in her church’s plans to build a new, round building in which attendees would have to walk downhill to approach the altar. The PT saw that the proposed church floor would be too steep for those who use assistive devices. She used her disability awareness to collaborate with those with construction knowledge to develop a better option.

PTs and PTAs also can use their knowledge of human movement to speak up and become involved on a civic and community level. Ryan suggests PTs and PTAs attend public hearings on potential modifications to public buildings. They can help ensure that such changes meet the criteria for people who use assistive devices. Bemis-Dougherty notes that “APTA encourages its members to help engineers figure out how to make cities more accessible places for people with disabilities.”

Rethorn has spoken before his city’s department of transportation about the relationship between lowered speed limits and leisure and fitness walking. He offers his services as an advocate and has spoken to city council members on the topic.

Ryan gives the example of a town debating whether to repave bike paths. “A PT should be the person who brings
Making Communities More Livable

AARP and the Walkable and Livable Communities Institute have published a collection of 11 “Livability Fact Sheets” for use in helping make communities safer, healthier, more walkable, and more livable for people of all ages. There are many areas in which PTs and PTAs are, or could become, involved.

Within the fact sheets are these suggested strategies:

Bicycling. Half of all trips taken in the United States are 3 miles or less, but only 3% of commuting trips are by bicycle. Surveys indicate that 60% of Americans would ride a bike if they felt safe doing so, and 8 out of 10 agree that bicycling is a healthy, positive activity.

According to the fact sheet on bicycling, “Bicycle-friendly features increase safety for all road users, including motor vehicles.” It points to action by New York City in 2010 to remove a traffic lane and paint a 2-way bicycle path with a 3-foot parking lane buffer next to Brooklyn’s Prospect Park. Weekday bicycling traffic tripled, speeding by all vehicles dropped from 74% to 20%, crashes for all road users dropped 16%, and injuries fell by 21%—all without a change in corridor travel time.

The fact sheet suggests that bicycle advocates build support for a public process that develops a pilot project, provides adequate bicycle parking, creates routes and wayfaring signs, and establishes a bike share program.

Density. The larger the number of housing units per acre, the higher the density. The AARP fact sheet on density supports dense, mixed-use developments—which, it explains, “come in a variety of forms, from small-lot detached homes to condo buildings and townhouses in a suburban town center, to apartments atop downtown retail shops.”

The document cites studies that found that when the housing market declined in 2007, the neighborhoods that held their property values best were high-density communities that featured a mix of uses. The reason, it explains, “is that many baby boomers and young adults are choosing to settle in walkable neighborhoods that offer a mix of house and transportation options and are in close proximity to jobs, schools, shopping, entertainment, and parks.” Further, it adds, “The nation’s decreasing birthrate and aging population will continue to boost the demand for smaller homes in more compact neighborhoods.”

The fact sheet urges: Build support for a public process; inspire the public with new model projects; ensure that any new development complements a neighborhood’s existing homes and streetscape; develop the right design for the area (which may include smaller single-family homes on small lots, with rear-access garages or street parking); and use form-based codes (not conventional zoning) that consider the relationship between buildings and the street, pedestrians and vehicles, public and private spaces, and the size and types of streets and blocks.

Modern roundabouts. Every day in the United States, more than 20 people are killed at traffic intersections, and many more are seriously injured. The fact sheet on modern roundabouts says that these circular intersections that move traffic counterclockwise around a central island can help reduce deaths and injuries. Roundabouts can handle 30% to 50% more traffic than conventional intersections. Roughly the size of a baseball infield, modern roundabouts differ from rotaries or traffic circles, which can be as big as an entire outfield. The US Department of Transportation has called modern roundabouts a “proven safety countermeasure.”

In particular, they can improve safety for bicyclists, pedestrians, and older adults, the fact sheet says. For example, after installing a string of 5 roundabouts, San Diego, California, was able to reduce the number of vehicle lanes in the road from 5 to 2 while reducing travel time, adding on-street parking, and attracting new businesses. The number of people walking rose, noise pollution fell, and the increase in walking, bicycling, and street life brought new business to retailers.

Tips for advocating for roundabouts include: Adopt a roundabout-first (rather than intersections) policy, build support for a public process, design for speeds lower than 20 miles per hour, keep dimensions tight, and make it beautiful.

Revitalization without displacement. The AARP fact sheet on revitalization cautions: “Mixed-use revitalization—and its potential to restore health and prosperity to a community—also carries with it the potential to increase property values and, therefore, real estate prices. While many in the community will profit from the improvements and rising values, others may not.” It continues: “It behooves all redeveloping communities to ensure that revitalization increases community health and stability by providing such features as affordable housing, robust transit services and access to transit, as well as a range of needed services and shops within walking and bicycling distance.”

Addressing walkability, the AARP Public Policy Institute issues a caution regarding the mobility impact on older residents who are displaced into areas that are not as livable or walkable: “In areas far from transit, areas with few community features and services nearby, and areas with poor transit service, losing mobility can mean losing independence.” Further, it notes that low-income families spend 55% of their household budget on transportation...
costs. “Revitalized places made walkable and accessible to transit can reduce these expenses, which makes the community more supportive of all people.”

For advocates of mixed-use revitalization, the fact sheet says the goal “is best achieved when a municipality plans for and financially supports affordable housing for all income levels in the community.” Steps may include encouraging employer-assisted housing, creating home ownership programs, and adopting inclusionary zoning—requiring developers to build affordable units, usually in exchange for increased development rights or subsidies.

Sidewalks. People who live in neighborhoods with sidewalks are 47% more likely than are residents of areas without sidewalks to be active at least 30 minutes a day, according to a study cited in the fact sheet on sidewalks. Another study concluded that safe, accessible, well-maintained sidewalks are a fundamental community investment that enhances public health and maximizes social capital. A third study found that 8 in 10 Americans prefer being in a community that offers sidewalks and good places to walk.

The fact sheet also offers success stories, such as the experience of Austin, Texas. The city has built almost 100 miles of new sidewalks since 2005 to encourage walking as a viable mode of transportation, and to improve safety, accessibility, and pedestrian mobility. Austin prioritizes compliance with the Americans with Disabilities Act; sidewalks that allow children to walk safely to school; a connected network of sidewalks, trails, and bikeways; and sidewalks that serve bus stops.

Among the tips for those advocating for sidewalks are: Engage neighbors and the community, make the sidewalk wide enough, use a site-appropriate design, and prioritize high-use areas and connectivity.
awarded a grant to further our goal of improving the accessibility to our town, regardless of method of transportation (ie, walking, biking, cane/walker, wheelchair, or stroller). We will complete this analysis by the end of 2017.”

Hinze is on the board of the nonprofit Norte! in Traverse City, Michigan, founded by a husband and wife who are both PTs. Norte! focuses on cycling and hosts “bike trains,” where kids meet before and after school to ride together. It also teaches bike safety in urban settings. And it has an advocacy program—for instance, it supports dedicated and separate bike lanes. “My role is to ramp up advocacy efforts,” Hinze says. “We saw a need for the organization to be a stronger voice in the community for a safe place for kids to bike.”

The program started as a grassroots movement and is growing. Elected leaders listen to large numbers of voters, Hinze explains, so mobilizing support is crucial. “We’ve become a voice in city hall on why these issues are important.” Other cities have similar organizations that promote safe biking or safe walking. Hinze points to these as good opportunities for PT and PTA involvement.

Ryan agrees that cycling is a great opportunity for exercise and for environmentally friendly transportation. PTs and PTAs can educate consumers on proper bike fitting, and on making safe choices such as wearing helmets.

**APTA’s Role**

On an association level, APTA’s volunteer group pool offers members the chance to volunteer to serve on national panels, work groups, and task forces on different mobility and wellness topics when such opportunities arise.

“APTA is doing a good job at looking at opportunities for other groups with

**Resources**

**AARP Livable Communities**
www.aarp.org/livable-communities/?cmp=RDRCT-LIVABL_SEPT09_012

**AARP**
Enhancing Mobility Options for Older Americans
www.apta.com/resources/reportsandpublications/Documents/enhancing_options.pdf

**The Alzheimer Association Public Policy Division and The National Highway Traffic Safety Administration**
Community Mobility and Dementia
https://one.nhtsa.gov/people/injury/olddrive/CommMobilityDementia/CommMobileandDementia.pdf

**American Federation for the Blind**
www.afb.org/default.aspx

**Community Transportation Association of America**
Resources

**Magee Rehabilitation Hospital**
Day in the Life: Community Mobility
http://mageerehab.org/video/day-life-community-mobility/

**National Aging and Transportation and Disability Center**
Checklist for Assessing the Accessibility of Transportation and Mobility

**World Health Organization**
Global Age-friendly Cities: A Guide
whom to collaborate,” Hinze says.

One example is the National Physical Activity Plan Alliance (NPAPA), of which APTA is a member. NPAPA oversees the National Physical Activity Plan, a series of policies and programs that support the organizations’ vision: “One day, all Americans will be physically active, and they will live, work and play in environments that encourage and support regular physical activity.”

The plan includes a section on transportation, land use, and community design. It calls for designs that support safe biking and walking, and affordable public transit.

“Physical activity and public health organizations should advocate for funding and policies that increase active transportation and physical activity through greater investment in bicycle and pedestrian infrastructure and transit,” the plan states.

“Every PT should advocate for safe places to engage in physical activity,” Rethorn says. “Community resources should be available to everyone.” Whether those resources are walking trails, bike paths, or community centers, PTs and PTAs can be voices for stronger community mobility.

Danielle Bullen Love is a freelance writer.

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STRENGTH IN NUMBERS:

The Power and Potential of Clinical Data Registries

More than 110 qualified clinical data registries are helping improve health care outcomes while demonstrating the value of specific interventions. Here’s a look at some of them, and the benefits that APTA’s Physical Therapy Outcomes Registry can offer the profession. By Michelle Vanderhoff
The transition to value-based care may seem daunting to some physical therapy practices. It requires accountability for patient outcomes, evaluating the effectiveness of interventions, and making technical and organizational changes—all within an evolving and sometimes complicated payment system. The ability to demonstrate and quantify the value of physical therapist (PT) interventions is powerful leverage, however, when it comes to fair payment for physical therapist services currently covered under insurance plans, as well as for some services not covered, such as prevention.

Data analytics tools—and particularly clinical data registries—can help providers meet these challenges in their own clinics and position the profession for success within the health care ecosystem, say PTs and others interviewed for this article. This includes APTA’s Physical Therapy Outcomes Registry, which collects and aggregates electronic health record (EHR) data to help PTs make well-informed clinical decisions and track and benchmark clinical outcomes.

Since payers don’t have consistent outcomes data to review, explains Heather Smith, PT, MPH, they control physical therapy expenditures “through blunt cost-reduction measures” such as multiple procedure payment reduction (MPPR) and the therapy cap on the Medicare side, and utilization review on the private payer side. And even if payers did look at outcomes, she observes, they would find it difficult to evaluate them because “we don’t have a set of uniform measures that are applied across all therapists.” Smith is APTA’s director of quality.

Private payers, she notes, are “definitely interested” in outcomes data. Understandably, part of the reason is to enhance their own bottom line. Additionally, though, pressure is coming from the group coverage market as employers attempt to curb costs. Almost 40% of large employers are starting to incorporate value-based care into their health benefit plans, according to the National Business Group on Health.1

Clinical registries can help immensely with quality improvement, although clinicians must balance the benefits of participation with the burden. More than a decade ago, some physician specialty societies began to use clinical registries to measure the effectiveness of care. Back then, the registries were manual-entry databases. Today’s technology enables many registries to pull clinical data directly from EHRs.

This has been a boon for the American Academy of Ophthalmology (AAO) IRIS® Registry (for Intelligent Research in Sight). IRIS launched in 2014 and already includes 16,700 participants and more than 148 million patient visits. AAO Medical Director of Health Policy William Rich, MD, who oversees the IRIS Registry, previously was part of a private practice. Rich reports that his colleagues’ hesitations dissipated when they realized how little additional work the registry would require.

### Producing “Revolutionary” Findings

While it’s taken some time to build up a sufficiently robust amount of data to draw deep insights, the IRIS Registry already has yielded some surprising findings. For one eye condition, 90% of ophthalmologists had shifted from an older procedure to a newer one Rich calls “high tech” and “elegant.” But an analysis of more than 100,000 patient cases revealed that the 90-day re-operation rate for the newer procedure was 2.5 times greater than the older one. The discovery amazed Rich, who also is past president of AAO. “That’s revolutionary,” he says. “It’s going to change the way we practice.”

“[REGISTRY DATA IS] REVOLUTIONARY. IT’S GOING TO CHANGE THE WAY WE PRACTICE.”

— WILLIAM RICH, MD

This reaction is echoed by Frederick Masoudi, MD, MSPH, chief science officer of the American College of Cardiology’s (ACC) National Clinical Data Registries (NCDR). After he and his colleagues assessed registry data, they found that many patients receiving an implantable cardioverter defibrillator (ICD) for primary prevention, and without a clinical indication for pacemaker function, were receiving dual-lead defibrillators, when a less-expensive, less-risky single-lead defibrillator would suffice.

NCDR consists of 10 clinical registries focused on cardiovascular procedures and conditions. Masoudi’s team introduced a quality metric into the registries to prompt health systems and physicians to “think more about which device is best for their patients.” Researchers have published hundreds of papers based on registry data, and their findings have changed clinical practice guidelines, according to Masoudi. In total, NCDR includes more than 100 million patient records from 15,000 cardiovascular specialists, with approximately 3,000 facilities participating.2

**A Range of Registries**

There are several different kinds of registries. Some, such as NCDR’s LAAO Registry (for Left Atrial Appendage Occlusion), support both Food and Drug Administration
(FDA) post-market surveillance studies and CMS coverage-with-evidence decisions (in which CMS requires contribution of data to generate clinical evidence in exchange for reimbursement).

Some are outpatient registries focused on treatment of a specific condition or disease. Others are specialty-specific registries, such as IRIS and the Physical Therapy Outcomes Registry. Many society-sponsored registries, including APTA’s, are Qualified Clinical Data Registries approved to submit Merit-based Incentive Payment System (MIPS) quality data to the Centers for Medicare and Medicaid Services (CMS), which can be helpful for practices whose EHRs are not equipped to submit quality measures.

While some EHR vendors are beginning to create their own “registries,” they are “hampered by lack of data standardization,” Masoudi explains. Others provide “quality feedback” based on claims data, but don’t offer the granular clinical detail that registries from specialty societies do.

Two things distinguish specialty society registries from EHRs, according to Masoudi: (1) the ability to provide true national benchmarks, and (2) the expertise that underlies the programs from the development of guidelines and performance measures, and the integration of those measures using a standardized, clinical lexicon that has been developed by NCDR.

“WHEN YOU PAY ATTENTION TO THE DATA...IT HELPS IMPROVE YOUR TREATMENT AND YOUR DOCUMENTATION.”

– NICHOLAS A. VAGANOS, MD

“Trying to generate clinical insights out of [claims data] occasionally works well. But most of the time,” Masoudi says, “it obscures numerous clinical nuances that are highly relevant to the patients we take care of.”

Such nuanced data can yield valuable—and sometimes surprising—benefits to individual practices as well. “When you pay attention to the data...it helps improve your treatment and your documentation, and then you have a better quality score,” says Nicholas A. Vaganos, MD, a cardiologist at Cardiology Consultants of Philadelphia, which participates in NCDR’s PINNACLE Registry. His colleague, Christine Coyne, RN, director of quality and compliance, concurs: “Sometimes, as a large practice, we have this feeling that we are doing things very well...But then we get the numbers, and we realize, ‘Oh, not quite as good in this particular area as we thought.’”

Being in a registry is necessary, Vaganos says, “because there’s no other way to keep track of all these parameters, measures, things like that. I honestly don’t know how someone could do without this.”

Registry analytics also can help practitioners validate what they are doing right, Smith suggests, and better understand patient populations such as individuals with low back pain, Parkinson disease, stroke, or joint replacement. “If PTs are seeing great trends with great outcomes with a patient population,” she says, “what are they doing differently from their colleagues, and how can their clinic and others adopt those interventions? How can they change the patient care pathway to achieve the best outcomes?”

Identifying Flaws in Documentation

Sometimes less-than-optimal outcomes data may reflect incomplete documentation rather than poor care, says Nathan Glusenkamp, newly appointed director of orthopedic registries at the American Academy of Orthopaedic Surgeons (AAOS). He had been president of provider solutions at FIGmd, the software vendor that powers APTA’s registry and several others.

Glusenkamp describes a client that was shocked that its performance measure for smoking cessation was at 0% even though the providers were sharing pamphlets and resources with every patient who was a smoker. As it turned out, smoking cessation was not being documented in the client’s EHR system—a fact illuminated by its registry. Making that small change in documentation wasn’t a huge burden, yet it improved providers’ scores in the registry and, Glusenkamp says, had “other benefits for the patients, and for other providers who were seeing those patients,” because other providers in the system could see that counseling already had been provided to a patient.

Presenting a Complete Picture?

Some PTs may have valid concerns about how their data might look to others, because they suspect the outcomes might be influenced by “social determinants of health” such as a patient’s socioeconomic status or education level. While registries contacted by PT in Motion aren’t yet measuring these factors, Coyne believes providers will “begin to see changes in what is being measured” under the Medicare Access and CHIP Reauthorization Act of 2015’s [MACRA] Quality Payment Program (QPP), and “these kinds of things will begin to play into our [outcome] measures.”
How Does the Physical Therapy Outcomes Registry Work?

If you are considering participating in the Physical Therapy Outcomes Registry, you might be asking, “Will we have to change our workflow?” and “Will it be a huge time commitment for staff?” The answer to both questions is “no.” It doesn’t require you to hire new staff, either.

In the past, clinical registries relied on manual entry of patient data into an online portal, which—most providers agree—is impractical due to time commitment and staffing concerns. Interoperability between EHRs and registries has been challenging, too. FIGmd, the company behind the Physical Therapy Outcomes Registry, sidesteps the technological obstacles by using keywords, machine learning, and natural language processing to extract data. It includes narrative data and coded data such as billing codes, lab results, and prescriptions to give the most detailed picture of a patient episode.

“The only potential change [to workflow] may come in the information providers gather on a patient so that we can capture as much clinical information as possible,” says Kellin Lawler, client account manager at FIGmd. She cites 1 new client that had just implemented an EHR and needed guidance on adding certain data elements, such as ICF codes, that were not included in the EHR.

After a practice completes the enrollment process, it works with a FIGmd representative to install “Registry Practice Connector” software either on the practice’s EHR database server or on a computer that can access the database. This software acts as a go-between by querying the EHR, then securely pushing that data to the registry servers. For practices unable to install the software, the registry can accept data files from the practice, or its EHR vendor can push the data to the registry.

During the integration process, the registry software will learn how to accurately “map” your data—essentially, where you keep the plates and the forks in your EHR’s kitchen. Cheryl Dimapasoc, PT, DPT, director of implementation and compliance at OptimisPT, explains, “We take the measures and data in OptimisPT and match them up with the data that the registry is collecting. Once the names of those data points are mapped on both sides, there is a seamless flow of information from OptimisPT to the registry that allows that data to be analyzed.”

Nightly, the software uploads the encrypted data to the registry, separated into de-identified clinical data and public health information data, which is secured in compliance with Health Insurance Portability and Accountability Act laws and regulations. For practices that voluntarily participate in the Merit-based Incentive Payment System, that data will be re-identified before submission to the Centers for Medicare and Medicaid Services.

After integration is complete, you may look at your registry dashboard, see a metric that appears inaccurate, and find that your documentation processes need to be fine-tuned, or that your mapping needs to be refined.

Clients will be able to access site- and provider-level performance metrics to monitor quality measures and make adjustments where necessary. Practices will be able to track patients across multiple episodes of care and view aggregate outcomes data over time. Many of the provider reports will allow users to filter the data on demographics/characteristics in order to get a more accurate picture of their influence. Multisite practices can compare outcomes metrics and patient demographics among individual facilities.

The registry takes security seriously. FIGmd maintains accreditation with the Data Registry Accreditation Program of the Electronic Healthcare Network Accreditation Commission (EHNAC), and is certified by the Office of the National Coordinator (ONC) for calculation and transmission of electronic clinical quality measures.
The Physical Therapy Outcomes Registry intends to include risk adjustment in the calculation of outcome measures, Smith says. But, she continues, while “capturing the entire picture is incredibly important,” the registry’s first responsibility is helping PTs “understand their own practice before they even begin to compare themselves with similar practices.” That, she says, will ensure that documentation and billing processes are “fine-tuned” to guarantee complete data.

To help PTs dig deeper into their data, the APTA registry—which officially launched in February—will include “modules”: condition- or disease-specific sets of data elements designed to describe and risk-adjust process-of-care and clinical outcomes for a defined patient population. The first such module, a collaboration with APTA’s Academy of Pediatric Physical Therapy, will focus on congenital muscular torticollis. It will include neck movement and functional limitations, torticollis severity, and prognostic factors.

Analyzing a large amount of such data will help describe typical practice patterns, variations in them, and associated outcomes. “Modules provide a continuous feedback loop not only for PTs, but also for guideline developers,” says James Irrgang, PT, PhD, ATC, FAPTA, scientific director of the APTA registry’s Scientific Advisory Panel.

Meeting the Challenges

Despite the promise of registries to improve quality of care and patient outcomes, there can be challenges when onboarding. Coyne emphasizes thinking twice “if you think you are going to join a registry and they are going to do everything for you.”

“I didn’t have anyone to guide us, because [registries were] so new,” she says. “But as somebody who’s done this for several years, I would say the most important thing [as a registry user] is to keep in touch with your representative, question any data you think doesn’t look right, and explore your data,” Coyne says. “It’s not just 1-sided.” For example, she says, a registry will not gather all your data if you haven’t directed them to where the specific data resides in your EHR. Providers always should check data output after an EHR update, as well, she adds, to make sure nothing has been lost in translation.

EHR interoperability has been enough of a challenge to be a continuing priority of the Office of the National Coordinator for Health Information Technology (ONC). In the past, EHR vendors have been accused of “data-blocking”—hiding data, or keeping it from being shared with third-party software systems. This practice now is illegal under the 21st Century Cures Act. Rich, who recently served on an interoperability panel convened by the National Quality Forum, said the ONC likes the idea of “starting from the bottom up” and asking “What does your profession need to measure?”

FIGmd—the registry software used by APTA, AAO, and ACC—has a very large clinical vocabulary. It uses machine learning and natural language processing to extract data—including narrative data—to the registry itself. (See “How Does the Physical Therapy Outcomes Registry Work?” on page 37) Glusenkamp describes this artificial intelligence as “a matter of repetition.”

He explains, “When we work with a given specialty area for a length of time, a lot of that initial data mapping starts to be automated, and we can train our mapping software to do a lot of that matching up...as opposed to doing that manually. It reduces a lot of the burden on our team, and on the PT.”

As technology makes it easier to measure and monitor quality of care, those interviewed for this article say, there is less reason to shy away from registries. In the case of the first ACC registries, Masoudi describes 2 early responses to what he calls the “nascent movement to improve quality”: to “stick one’s head in the sand” or “accept one’s professional responsibility and take a leadership position.”

He acknowledges it was a “tough road,” but he adds, “as times have changed and the culture has changed...it’s not enough just to say we’re doctors and assume we deliver high-quality care. We must embrace accountability based upon data for the care we deliver.”

Michelle Vanderhoff is manager, editorial services, at APTA.

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Health Care Employment Rose 20,200 in August, But Sites Are Shifting

Health care added 20,200 jobs in August, following an increase of 39,400 in July, according to the US Bureau of Labor Statistics (BLS), for a total of 15,798,700 people nationwide employed in that field. Ambulatory services added 11,000 jobs. Home health care services, however, lost 200 jobs and now stands at 1,413,100. Nursing and residential care facilities gained 2,800 jobs in August. That sector’s employment stood at 3,337,900 jobs. Over the past 12 months, health care overall has added 328,400 jobs.

In a well-publicized analysis conducted by the BLS in 2015, 2 of the fastest-growing occupations during the period 2014-2024 are projected to be physical therapist assistants—up 40.6%—and physical therapists—up 34%. However, a review of the full BLS report on health care employment provides a somewhat broader perspective.

That review—conducted by the Center for Health Workforce Studies at the University at Albany, State University of New York—found, “While job growth in the health care sector continues to outpace growth in other employment sectors, that growth has slowed in recent years. From a high of nearly 29% growth between 1992 and 2002, jobs in health care grew by only 20% between 2004 and 2014.

“Between 2004 and 2014, jobs in health care increased by just over 2.5 million (20%),” the review continued. “Employment in offices of health practitioners grew by more than 800,000 (24%) over that same time period. Hospitals added 475,000 jobs (9%), home health care increased by 489,000 jobs (63%), and nursing and residential care facilities added 335,000 jobs (16%) between 2004 and 2014. These trends may be in part attributed to an increasing focus on outpatient care, as well as efforts to maintain patients in their homes.”

The bottom line? While job growth will continue, it may occur unevenly. “By 2024, nearly 30% of all employment in health care will be in offices of health practitioners, and hospitals will account for a smaller percentage of health care sector employment than in earlier years,” the report concluded.


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Professional Pulse

Report Looks at Assistive Technologies in the Workplace

Assistive technologies to help individuals in the workplace are developing rapidly. If their promise is to be fully realized, however, thinking around access, user training, reimbursement, and other barriers needs to catch up. That conclusion is found in a recent report from the National Academies of Science, Medicine, and Engineering. Authors of the study include Physical Therapy (PTJ) Editor-in-Chief Alan Jette, PT, PhD, MPH, FAPTA, and Linda Resnik, PT, PhD, FAPTA, executive director of the Center on Health Services Training and Research (CoHSTAR). Funded by the Foundation for Physical Therapy, CoHSTAR is a multi-institutional, multi-disciplinary center dedicated to advancing health services and health policy research capacity in physical therapy.

The report, “The Promise of Assistive Technology to Enhance Activity and Work Participation,” is the result of an extensive review of the literature pertaining to assistive products and technologies, a series of public meetings on the topic, and a public teleconference that invited expert comment. The purpose: to develop an analysis of the adult use of assistive technologies—including wheeled mobility devices, upper-extremity prostheses, and technologies designed to assist with hearing, speech, and communication.

The report also examines the challenges of putting these technologies to their most widespread and effective use. “Appropriate-quality assistive products and technologies …may mitigate the impact of impairments sufficiently to allow people with disabilities to work,” the authors write. “In some cases, however, environmental and personal factors create barriers to employment despite the impairment-mitigating effects of these products and technologies. In addition, maximal user performance requires that individuals receive the appropriate devices for their needs, proper fitting of and training in the use of the devices, and appropriate follow-up care.”

The concept of barriers and training needs affected most of the committee’s conclusions, which include recommendations that point to the importance of proper fit, ongoing follow-up, better training for providers, and understanding among employers and others that a device that may be useful to an employee today may become less useful over time.

www.nap.edu/catalog/24740/the-promise-of-assistive-technology-to-enhance-activity-and-work-participation
www.bu.edu/cohstar/

CMS MAC Claims Review Process Moves to More Targeted System

The US Centers for Medicare and Medicaid Services (CMS) is moving away from its current practice of randomly selecting claims for audit in favor of a more targeted approach that it hopes will streamline the process and result in fewer appeals.

The new program, dubbed “Targeted Probe and Educate,” directs Medicare administrative contractors (MACs) to select claims for items or services that “pose the greatest financial risk to the Medicare trust fund and/or those that have a high national error rate”—focusing only on “providers/suppliers who have the highest claim error rates or billing practices that vary significantly out from their peers.”

The program was piloted in 1 MAC jurisdiction in 2016 and expanded to 3 more in July of this year. All MAC jurisdictions were expected to follow the procedure “later in 2017,” according to an August CMS fact sheet.

Once a claim and provider have been targeted, MACs will begin a multiphase process by probing 20 to 40 claims per provider. If the provider is found to be noncompliant, it must participate in education on meeting requirements. After the education phase, the MAC must wait 45 days or more before reviewing another batch of 20 to 40 claims. At that point, the MAC either can determine that the provider is in compliance or can submit the provider to another round of education and later review. If a third review round doesn’t improve compliance, the provider will be referred to CMS for possible further action.

The new process moves away from the “Probe and Educate” program, a less-targeted process that resulted in more reviews.

www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Medical-Review/Targeted-Probe-and-EducateTPE.html
HEALTH CARE HEADLINES

**CDC: Rates of Cardiac Rehab Use Among Heart Attack Survivors ‘Suboptimal’**

Although cardiac rehabilitation (CR) significantly reduces the likelihood that a heart attack survivor will die of a later cardiac-related cause, only about 1 in 3 heart attack survivors in the US receive CR, according to a new analysis from the US Centers of Disease Control and Prevention (CDC). That “suboptimal” rate represents “missed opportunities to access an evidence-based intervention that has been documented to improve patient survival, quality of life, functional status, and cardiovascular risk,” the CDC writes.

Using results of the Behavioral Risk Surveillance System, a telephone survey conducted annually, the CDC analyzed rates of CR use in 2013 and 2015. Average use was estimated at 33.7% in 2013 and 35.5% in 2015. The report breaks down CR use by demographic and other variables. Among the findings:

- Based on 2013 data, men received CR more often than did women (36.4%, compared with 28.8%), and whites more often than non-Hispanic blacks (35.4%, compared with 25.3%).
- An estimated 46.6% of college graduates received CR—2 times the rate among individuals with less than a high school degree (23.3%) in 2013.
- Individuals with some form of insurance in 2013 received CR at a rate of 34.4%, compared with 25.2% of individuals with no insurance.

Authors of the analysis acknowledge several limitations to their study. Still, they argue, those weaknesses don’t overshadow the core conclusion: CR is being underused.

“Health system interventions to promote [CR] referral and use, supported by access to affordable rehab programs within the community, should be prioritized to improve outcomes and prevent recurrent events,” the authors write. “Some strategies that might improve use of [CR] include higher payments for rehab by insurers, eliminating or reducing copays for patients, and extending [CR] clinical hours to improve access, as well as providing standardized referrals coupled with linkage to [CR] staff member liaisons at hospital discharge or by primary care providers and cardiologists.”

www.cdc.gov/mmwr/volumes/66/wr/mm6633a1.htm

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CMS: Start Preparing for New Medicare Beneficiary ID Numbers

Although the official rollout won’t occur until next year, it’s not too soon for health care providers to prepare their practice management systems for a new Medicare beneficiary ID system that will not use Social Security numbers (SSNs).

Details on the change are available in a guidance resource from the Centers for Medicare and Medicaid Services (CMS). The shift will move the Medicare system away from Health Insurance Claim Numbers (HICNs) that contain the beneficiary’s SSN and toward a CMS-generated Medicare Beneficiary Identifier (MBI). The change, intended to thwart fraud, was required by provisions in the Affordable Care Act and the Small Business Jobs Act.

According to CMS, new cards with MBIs will be mailed to beneficiaries beginning in April 2018, with official startup of the use of MBIs in claims beginning in October 2018. Providers can start using the MBI as soon as their patients receive the new cards and should have systems in place to accept the new number by April.

The changeover includes a transition period from October 2018 through December 2019, during which time CMS will accept claims using either the HICN or MBI.

www.cms.gov/Medicare/SSNRI/Providers/Providers.html

Survey Reveals Differences In Readiness for Payment Reform Among Large Health Care Organizations

The march toward value-based payment models may be on, but that doesn’t mean everyone’s moving.

A new report from the accounting and management consulting firm EY (formerly Ernst and Young) highlights some significant differences in the ways larger health care providers are preparing—or not preparing—for value-driven care. According to the results of a survey of 700 health care executives, 67% of organizations with annual revenue between $100 million and $499 million have not implemented any value-based initiatives. Nearly the reverse is true, however, among the highest-earning organizations. About 62% of surveyed companies earning $5 billion or more a year have implemented value-based payment models, and 47% have initiated bundled care models.

“With market forces pushing for a new care delivery model, many organizations will undoubtedly be dragged into the realm of value,” write the report’s authors. “Relying on a series of disjointed initiatives to get there is not an effective strategy.”


APTA is working to ensure that physical therapists (PTs) have a solid understanding of what payment reform means by offering resources on its Payment Reform webpage. The latest addition is a short online quiz that can help members assess their readiness for payment reform.

www.apta.org/PaymentReform/
www.apta.org/PaymentReform/StatusQuiz/
Thanks to our generous donors, the Foundation for Physical Therapy has awarded more than $17 million in scholarship, fellowship, and research grant funding to launch the careers of more than 500 physical therapist scientists, resulting in an estimated $753 million in funding from other sources.

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Happy holidays and thank you for your support!
Reports Show a Drop in Opioid Prescriptions and Dosage Strength, Rise in Prescription Duration and Opioid Hospitalizations

The latest news on the opioid crisis is mixed. Reports show some reduction in prescription rates and dosages, but an overall increase in prescription length, wide variation in prescribing across the United States, and prescription prevalence in 2015 that was 3 times as high as it was in 1999 and 4 times higher than it was in Europe in 2015. Centers for Disease Control (CDC) Acting Director Anne Schuchat told National Public Radio that the 2015 per capita prescription opioid rates are enough for “every American [to] be medicated around the clock for 3 weeks.”

The CDC analysis came on the heels of a report from the Agency for Healthcare Quality and Research (AHRQ) showing that opioid-related inpatient stays and emergency department (ED) visits more than doubled between 2005 and 2014.

The CDC report analyzed retail prescription data from 2006 to 2015, including rates, amounts, dosages, and durations prescribed. The analysis also included a county-by-county look at prescription data in 2010 and 2015. Here’s what researchers found:

The good news: overall prescribing rates have dropped by 13% since 2010 peak levels. From 2006 to 2010, opioid prescribing rates increased from 72.4 per 100 people to an all-time high of 81.2 per 100. By 2015, that rate had dropped to 70.6 per 100 people. The amount of opioids also dropped, from the 2010 peak of 782 morphine milligram equivalents (MMEs) per capita to the 2015 rate of 640 MMEs per capita—still more than 3 times higher than 1999’s rate of 180 MMEs per capita.

The drop includes a decrease in prescription of high-dose opioids. The number of high-dose prescriptions (daily dosages of 90 or more MMEs) mostly was stable between 2006 and 2010, at 11.4 per 100 people, then dropped to a rate of 6.7 per 100 by 2015.

The bad news: prescription duration times have increased since 2006. While fewer people may be prescribed opioids, and while those opioids may be at lower strength, the rate of prescription supplies of 30 days or more jumped by 58% between 2006 and 2015—rising from 17.6 per 100 people to about 28 per 100. The overall average days’ supply also rose during that time period—from 13.3 days in 2006 to 17.7 by 2015. That’s a 33% increase.

The highest-prescribing areas tended to share certain characteristics. Researchers found several common characteristics of the high-prescribing counties, including larger percentages of non-Hispanic whites, higher rates of uninsured or Medicaid enrollment, lower education levels, higher rates of unemployment, “micropolitan” (small cities and towns) status, more dentists and physicians per capita, higher suicide rates, and a higher prevalence of diagnosed diabetes, arthritis, and disability.

The CDC report was released not long after AHRQ published its analysis of opioid-related inpatient hospital stays and ED visits from 2005 to 2014. That report found that inpatient stays increased by 64% during the time period, with opioid-related ED visits doubling. The news was worse for women: between 2005 and 2014, inpatient rates that were historically lower than those for males caught up, so that by 2014, opioid-related inpatient rates for both sexes were roughly equal.

The report was produced by AHRQ’s Healthcare Cost and Utilization Project.

www.npr.org/sections/health-shots/2017/07/06/535656477/opioid-prescriptions-falling-but-remain-too-high-cdc-says
www.cdc.gov/mmwr/volumes/66/wr/mm6626a4.htm
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Infants born preterm may be less able to perform certain motor and exploratory behaviors, which could lead to future cognitive and developmental delays, suggests a study in the September issue of PTJ. According to the study’s authors, physical therapists in early-intervention programs should target behaviors such as head control and ability to make a fist. Non-object-oriented exploration, wrote the authors, “is not only critical for infants to learn how to engage in social interactions and to learn about objects; it is also key for infants to learn to control their own bodies so they can perform perceptual-motor behaviors like lifting their heads against gravity, reaching, or moving their hands into midline.”

Researchers followed the development of 24 healthy full-term infants (37-42 weeks gestational age), 24 infants born preterm, and 6 preterm infants who were born with brain injury. Some of the findings include:

**Holding up the head.** Through the age of 9 months, all infants improved their ability to hold up their heads while lying on their stomach, but those born preterm were less able to do so.

**Holding the head in midline.** In the prone position, all infants improved, but full-term infants showed the greatest ability. Preterm infants with brain injury showed the least. There was no significant difference among the groups in ability to hold the head in midline while sitting.

**Hand mouthing.** Preterm infants with brain injury showed more hand mouthing than the other groups while prone but less while supine. There was no difference while sitting.

**Touching the body or surfaces.** Touching the body decreased for all infants over 9 months, but preterm infants with brain injury did so much less frequently than did infants in the other groups.

**Bouts of exploration per minute.** At 6 months old, infants without brain injury performed 7% more bouts of exploration per minute while sitting than did preterm infants with brain injury. This difference increased to 74.6% by 18 months old.

The authors wrote that these non-object-oriented exploratory behaviors can “provide proprioceptive and haptic feedback, increase body awareness, and are believed to be the precursors of future reaching and grasping behaviors.” Impairments in this area, they concluded, “are likely to cascade into delays in reaching and object exploration, which in turn will result in future motor and cognitive delays”—something proper early intervention could address.

Providing Physical Therapy in the Home

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Chapters 1-14 each include a guideline, criteria, case scenario, practical applications, and references; Chapter 15 provides additional helpful resources.


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Professional Pulse

Study Links TV-Watching to Higher Risk of Later Mobility Disability in Older Adults

Older adults who choose to spend most of their time sitting and very little time being physically active risk sacrificing their mobility later on. That’s the conclusion of a new study that says adults 50 to 71 who spend more than 5 hours a day watching television and fewer than 3 hours a week being physically active triple their chance of later experiencing a mobility disability.

The study, published in the *Journals of Gerontology: Medical Sciences*, analyzed data from 134,269 participants in surveys jointly sponsored by the National Institutes of Health (NIH) and the American Association of Retired Persons (AARP) in 1995-1996 and again in 2004-2005. The authors analyzed respondents’ self-reported television viewing and other sedentary behaviors and average number of hours per week spent in light- and moderate-intensity physical activity (PA). Next, they matched up data sets with respondents’ mobility status as reported in the later survey. (All respondents used in the study reported no mobility disabilities in the first survey.)

Researchers were particularly interested in separating the impact of television viewing from that of other sedentary behaviors such as computer time, napping, and sitting without watching TV. On the PA side of the equation, they were interested in finding out to what degree PA offset the debilitating effects of sedentary behavior. Here’s what they found:

- After adjusting for PA, the relationship between total sedentary time and mobility disability was “almost negligible.” However, disability increased steadily with increased reported hours of TV time.

- Compared with the referent group who reported watching no more than 2 hours of TV per day, respondents reporting 3 to 4 hours per day of TV viewing experienced 25% higher odds of mobility disability. Respondents reporting watching TV for 5 or more hours a day were found to have 65% increased risk of mobility disability.

- The odds of mobility disability dropped progressively as frequency and intensity of PA increased, although hours spent watching TV consistently pushed odds higher.

- Respondents who reported 7 or more hours of PA a week and up to 6 hours a day of sitting did not see their risk of mobility disability rise appreciably.

“Our findings corroborate those of other studies reporting sedentary behavior to be a risk factor for loss of physical function that is distinct from level of moderate-to-vigorous-intensity [PA],” the authors wrote. As for the stronger association between TV time and mobility disability than for the more generic “sitting” time and mobility disability, researchers believe 2 issues could be at play: first, respondents may be reporting TV-watching time with greater accuracy; and second, sitting time may be broken up during the day by periods of PA, whereas TV watching tends to take place in long periods of sitting uninterrupted by PA.

“Sitting and watching TV for long periods, especially in the evening, has got to be one of the most dangerous things that older people can do,” lead author Loretta DiPietro, PhD, MPH, told National Public Radio. She speculated that binge-watching made possible by streaming video likely is making the problem worse.

“Our findings and those of others indicate that reductions in sedentary time, as well as increases in [PA], are necessary in order to maintain health and function in older age—particularly among those who are the least active,” the authors wrote. “Current US public health recommendations for [PA] have not addressed sedentary time, but our results suggest doing so may be useful for reducing mobility disability.”

The-Joint-Associations-of-Sedentary-Time-and

www.npr.org/sections/health-shots/2017/09/04/547580952/get-off-the-couch-baby-boomers-or-you-may-not-be-able-to-later
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Knee osteoarthritis (OA) has more than doubled among Americans since 1940, say researchers, and the increase can’t be explained by longer lifespans or a higher prevalence of obesity and overweight in recent decades. Instead, the real culprit could be physical inactivity, which the authors describe as “epidemic in the postindustrial era.”

The study, appearing in the Proceedings of the National Academy of Sciences, compared knee joints of 2,756 skeletons from 3 groups of individuals: those who lived in the 1800s and early 1900s (“early industrial,” N=1,581), those who lived during the late 1900s through the early 2000s (“postindustrial,” N=819), and prehistoric hunter-gatherers who lived between 6,000 and 300 BCE (“prehistoric,” N=176).

Researchers were looking for knee joint eburnation—the ivory-like result of bone-on-bone contact that occurs after cartilage erodes—as the indicator for moderate to severe OA.

Here’s what they found:

- The prevalence of knee OA in the postindustrial skeletons was about 16%, a rate 2.6 times higher than that in the early industrial group, which had a 6% incidence rate. Knee OA prevalence in the prehistoric sample was 8%.
- After controlling for body mass index (BMI) and age when that information was available (1,859 of the 2,756 skeletons), researchers were unable to establish a correlation between these factors and prevalence of knee OA. Instead, rates remained 2 times higher for the postindustrial group even when compared with early industrial skeletons with similar ages and BMIs. BMI for the prehistoric sample could not be estimated.
- In the postindustrial individuals with knee OA, 42% had the disease in both knees. Bilateral occurrence was 30% among the early industrial samples with knee OA, and 17% among the prehistoric group.

“Although knee OA prevalence has increased over time, today’s high level of the disease is not, as commonly assumed, simply an inevitable consequence of people living longer and more often having a high BMI,” the authors write. “Instead, our analyses indicate the presence of additional independent risk factors that seem to be either unique to or amplified in the postindustrial era.”

The researchers believe that risk factor could have to do with “environmental changes”—namely, the reduced levels of physical activity associated with the postindustrial era, despite the human body’s need for regular exercise. It’s a phenomenon known as a “mismatch disease,” when the human body can’t easily or rapidly adapt to changes in the lived environment.

The good news, according to the researchers, is that their findings point to the possibility that knee OA is a largely preventable condition—provided there’s a widespread “reappraisal of potential risk factors that have emerged or intensified only very recently.”

www.pnas.org/content/early/2017/08/08/1703856114.full
Nominations for the 2018 Honors and Awards Program are being accepted September 1–December 1, 2017

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Registry to Collect Torticollis Data Through Collaboration With Academy Of Pediatric Physical Therapy

APTA has signed an agreement with the Academy of Pediatric Physical Therapy to collaborate on the creation and integration of a congenital muscular torticollis module within the Physical Therapy Outcomes Registry. The module will be based on the academy’s clinical practice guideline on the topic.

A module is a set of data elements that describe and risk-adjust process-of-care and clinical outcomes for a defined patient population. These condition- or disease-specific data elements are based on evidence-based clinical practice guidelines and will help refine the way outcomes data is analyzed and interpreted for specific populations. Modules will build on the current functions of the registry, which collects a core set of patient and outcomes data from an electronic health record.

The torticollis module will include more granular information, such as description of the type of cranial deformity, right side or left side of the head, and torticollis severity, among other factors. Analyzing a large amount of this data will help describe typical physical therapist practice patterns, variations in care, and the effectiveness of physical therapy interventions in different types of patients—all key elements in the registry’s mission to amass outcomes data to inform practice and enhance research.

“This is the registry’s first module agreement with an APTA section, and we look forward to more such collaborations in the future,” said James Irrgang, PT, PhD, ATC, FAPTA, scientific director of the registry’s Scientific Advisory Panel. APTA is working with other sections to develop guideline-based modules in other areas.

For more information about participating in the Physical Therapy Outcomes Registry and how sections can play an integral role in module development, visit www.ptoutcomes.com.

ASSOCIATION RESOURCES

PTNow Expands Resources, Offers New Search Experience

PTNow, APTA’s online evidence-based practice resource, has been updated and expanded. Additions include:

- 92 new clinical practice guidelines (CPGs) and more than 80 updates to existing ones
- More than 50 new tests and measures, including new resources on pain and cognitive impairment
- 22 new clinical summaries
- 20 new Cochrane reviews

Finding those resources is now easier than ever, thanks to a retooled search function that’s both user-friendly and expansive—providing members with easy access to journals and other resources relevant to clinical practice. The PTNow site also has simplified access to its CPG+ collection, which provides expert appraisal of selected CPGs.

www.ptnow.org/Default.aspx

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<td></td>
<td>Denver, CO</td>
<td>Turner</td>
<td>May 19-20</td>
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### E2 | Extremity Integration | $595 | 21 Hours, 2.1 CEUs (Prerequisite: E1) | |
| | (Prerequisite: Intro S2 Seminar Included) | | | |
| | Austin, FL | Mandel | Nov 10-12 | |
| | New York, NY | Patel | Dec 1-3 | |
| | Philadelphia, PA | Patel | Mar 2-4 | |
| | Phoenix, AZ | Patel | May 11-13 | |

### S2 | Advanced Evaluation & Management of Pelvis, Lumbar & Thoracic Spine Involving Thoracic 15 Hours, 1.5 CEUs (Prerequisite: S1) | $495 | Nov 4-5 | Birmingham, AL |
| | (Intro S2 Seminar Included) | | | |
| | New York, NY | Yack | Dec 1-3 | |
| | Minneapolis, MN | Yack | Feb 3-4 | |
| | St. Augustine, FL | Yack | May 5-6 | |
| | Washington, DC | Yack | May 12-13 | |

### S3 | Advanced Evaluation & Management of the Cervico-Facial, Cervical & Upper Thoracic Spine 27 Hours, 2.7 CEUs (Prerequisites: S1) | $795 | Nov 9-12 | San Marcos, CA |
| | (Intro S4 Seminar Included) | | | |
| | Baltimore, MD | Smith | Mar 8-11 | |

### S4 | Functional Analysis & Management of Lumbo-Pelvic-Hip Complex 15 Hours, 1.5 CEUs (Prerequisites: S1, Intro S4 Seminar Included) | $495 | Nov 11-12 | Atlanta, GA |
| | (Intro MF Seminar Included) | | | |
| | Chicago, IL | Nyberg | Dec 2-3 | |
| | Miami, FL | Nyberg | Feb 10-11 | |
| | Boston, MA | Lomennan | Jul 28-29 | |

### MF1 | Myofascial Manipulation 15 Hours, 1.5 CEUs (Prerequisite: Intro MF Seminar Included) | $495 | Nov 4-5 | Ft. Myers, FL |
| | (Intro MF Seminar Included) | | | |
| | St. Louis, MO | Nails | Nov 4-5 | |
| | Las Vegas, NV | Turner | Dec 9-10 | |
| | Baton Rouge, LA | Nails | Jan 20-21 | |
| | Honolulu, HI | Turner | Jan 27-28 | |

### Spinal Boot Camp 15 Hours, 1.5 CEUs (Prerequisite: S1, S2, S3, S4) | $495 | Jan 15-14 | St. Louis, MO |
| | (Intro MF Seminar Included) | | | |
| | St. Louis, MO | Nails | Jan 15-14 | |

### CF2 | Intermediate Craniofacial 15 Hours, 1.5 CEUs (Prerequisite: Basic CF1 Seminar) | $495 | Feb 3-4 | Chicago, IL |
| | (Intro MF Seminar Included) | | | |
| | Chicago, IL | Holson | Feb 3-4 | |
| | Austin, TX | Strickland | Mar 12-13 | |

### CF3 | Advanced Craniofacial 15 Hours, 1.5 CEUs (Prerequisite: CF2) | $495 | Nov 4-5 | Little Rock, AR |
| | (Intro MF Seminar Included) | | | |
| | Little Rock, AR | Parks | Nov 4-5 | |
| | Indianapolis, IN | Strickland | Dec 9-10 | |
| | Boston, MA | Strickland | Feb 10-11 | |

### CF4 | State of the Art Craniofacial 15 Hours, 1.5 CEUs (Prerequisite: CF3) | $495 | Apr 6 | Milwaukee, WI |
| | (Intro MF Seminar Included) | | | |
| | Milwaukee, WI | Agustsson | Apr 6 | |

### Genetic Rehabilitation for Physical Therapist Assistants and Occupational Therapy Assistants 15 Hours, 1.5 CEUs (No Prerequisites) | $495 | Nov 11-12 | Atlanta, GA |
| | (Intro MF Seminar Included) | | | |
| | Atlanta, GA | Gray | Nov 11-12 | |

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By Chris Kolba, PT, PhD, MHS

Defining Moment

Chris Kolba, PT, PhD, MHS, is the tactical rehab and conditioning coordinator at The Ohio State University’s Wexler Medical Center. He also is a certified strength and conditioning specialist.

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

Life and Death in a Single Rep

Helping a warrior gain the strength to serve.

I’ve always been a big believer in the importance of physical strength in overall health. Time and research have shown that most people who physical therapists (PTs) see in the clinic need more strength than they have when they first arrive, if they’re to recover optimally from injury and if they’re to be best equipped to battle the aging process.

My background involves training for many years in various forms of karate and in Krav Maga—a self-defense system developed by the Israeli defense and security forces that combines techniques from boxing, wrestling, aikido, karate, and ground-fighting. The strength, coordination, balance, and discipline I’ve derived from these pursuits has been invaluable in all facets of my life. I’ve also lifted weights since high school. Therefore, being able to combine strength training and combat drills with education and training as a PT is, for me, a match made in heaven.

To be effective in their work, police officers and military personnel need both strength and the ability to fight—in defense of themselves and others. They are tasked with protecting the lives of all Americans, and they sometimes must put their own lives on the line to ensure the preservation of our safety and freedoms. If having the privilege to serve these valiant individuals as a PT didn’t light my fire, I’m not sure what would!

So, enter Larry. My experience with him defined why I do what I do.

Larry was a police officer in a demanding urban environment who also was in the Air Force Reserves. He had developed knee pain that was steadily progressing. It was starting to limit his job activities and his workouts, especially running. He had learned he was being deployed to Afghanistan and would be assisting a Navy SEAL team in its missions there. He knew he needed help if he was to be up to the task.

He saw his doctor, who found that Larry had a meniscal tear. Given the demands of his police work and the requirements of his upcoming deployment, he opted to have surgery immediately, then begin rehab. Larry’s wife had been
a colleague of mine. She was familiar with my experience and background, and she believed her husband would respond well to my style of rehab. She told Larry about me, and he agreed that we seemed like a good match. But I'd have only 4 months to help get him literally combat-ready.

Talk about a no-pressure situation, right? Actually, there wasn't as much pressure as you'd think. Larry and I quickly found that we shared a passion for strength training and hard work. We had a rapport and a common purpose. We didn't so much sweat the timeline as savor the challenge and feel excited to get to work.

I'd been fortunate up to that point in my career to have worked with a number of high-level athletes. Larry’s mental toughness and capacity for work, however, were as strong, if not stronger, than I’d ever seen in any patient or client. This got me excited, because it allowed me not only to push the limits of strengthening beyond the subacute phase but also to incorporate my love of martial arts into Larry’s rehab via various combat drills. This opportunity to bring it all together—my creativity, extensive background in strength training and combat-related techniques, and expertise as a PT—captured what most excites me about working in sports medicine.

Larry and I worked together in perfect synergy, and within 3 weeks he had regained full motion. All of his swelling was gone, and he was walking normally and without pain. We moved on to weights—with squats, deadlifts, and leg presses—in addition to various balance and stability exercises on level and unstable surfaces.

At about 7 weeks Larry was able to start jogging and jumping. We incorporated punching, kicking, and ground-fighting drills—ground-fighting is a form of wrestling that mimics hand-to-hand combat and takes place while the “combatants” are on the ground. We also did stair runs together, climbed over walls, and incorporated jumping and rolling drills. Larry’s rapid progression brought home to me everything that excites me about working with both sports and tactical athletes.

Larry’s hard work, coupled with my appreciation of his willingness to pay the ultimate price for our country, inspired me to coin a phrase that started out as a deliberately over-the-top statement—sort of an in-joke—but became a mantra as Larry and I trained together: “1 more rep may mean the difference between life and death!” Obviously, I didn’t mean that literally as we worked out in a gym. Still, I shouted it often to exhort Larry to push himself through an extra rep—mindful of the fact that every extra bit of strength might be meaningful in a real life-and-death situation in Afghanistan. I do a lot of “supersetting” with clients—following one exercise with an opposing one, such as following a series of pushups with a “pull”-type exercise. Larry fully embraced the challenge and always gave me that extra rep.

The effect was that our mentality, work ethic, and dedication to workout goals meshed, bringing out the best in both of us. By the conclusion of our time together, not only was Larry combat-ready, he actually was in better shape than he had been prior to his injury. We both felt confident that he would have no physical difficulties during his tour in Afghanistan.

And indeed he didn’t. Larry successfully fulfilled his duties overseas and returned home safely from deployment. It gave me a great sense of satisfaction to know I’d facilitated his ability to serve and defend our country, and I’d perhaps even helped keep him a little safer through his conditioning and readiness. My work with him encapsulated what I love about being a PT.
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College athletes annually injured in both practice and competition in women’s gymnastics, as reported by the National Collegiate Athletic Association. The injury rate is 10.4 per 1,000 athlete exposures.

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American adults who consider saturated fats in food to be healthful. Another 19% said saturated fats were neither healthful nor unhealthful.

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55%
Americans who think that increasing pain management training would be very effective in reducing prescription painkiller abuse. Other strategies rated as very effective: increasing access to treatment programs (51%), public education and awareness programs (44%), and increasing research about pain and pain management (43%).

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20.3%
Graduates of CAPTE-accredited physical therapist programs in 2016-2017 who are minorities. That’s an increase from 13% in 2014-2015. Minority student enrollment rose from 17% to 22.9% during the same period.

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3,405
Mean contact/clock hours in physical therapist education programs in 2016-2017. That’s an increase from 3,383 during 2015-2016.

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