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(Photos by Jeffrey Leeser)

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‘Hopping’ On Board

There’s something exciting happening in physical therapy. It started in Oregon and is now starting to go viral. The first “PT Pub Night” started off innocently enough, guided by a long-held desire to better explore personal connection as a benefit of Oregon Physical Therapy Association membership. Eight therapists with no relationship but their common profession gathered in March 2012 to discuss one simple question: What brought you here?

Every person shared a unique story about why they came. The discussion moved to imagining the possibilities that could emerge from regular interactions among professionals. A date for the next conversation was set and the monthly event was born.

Professional relationships are now being taken to new levels at each PT Pub Night. Networking has been described as the top reason individuals are attracted to attend. The ears of Pub Night leaders have also picked up on new business opportunities, conversation about career advancement, and planning for individual follow-up meetings.

So, is this working? Something sure seems right, with highlights including:

- One site in Oregon has grown to nine – Portland, Eugene, Hillsboro, Salem, Medford, Corvallis, Astoria, Bend and La Grande – all occurring at the same date and time each month.
- More than 300 individuals have connected at Pub Night.
- New PT Pub Night events have started in Massachusetts, California, New York and New Jersey. Others are starting to consider new events in Oklahoma, Ohio and Georgia. There was even a special Pub Night in San Diego at the Combined Sections Meeting last winter.

As PT Pub Night continues to grow and spread across the nation, one fact has become very clear: We can do more together than any of us could ever do alone.

You can learn much more about PT Pub Night at bit.ly/PTPubNight. Join the conversation on Twitter! @OregonPTs #PTPubNight #ThirdThursday

— Derek Fenwick, PT, MBA, GCS

Derek Fenwick is vice president of the Oregon Physical Therapy Association and lead organizer of PT Pub Night. Follow him on Twitter @DerekFenwickPT
any clinicians feel that MS is a “hopeless” disease; that due to its progressive nature, physical therapy is meaningless. This has led to therapists performing minimally effective “maintenance” programs, or sometimes refraining from treating this population at all.

This constitutes a clinical tragedy, as a large amount of recent literature clearly indicates that there are several interventions clearly effective in treating MS. Although there is insufficient space here to describe all available evidence-based interventions, we aim to provide a short introductory list.

MS is a disease with a widely varying presentation. Any region of the CNS can be demyelinated, so almost any neurologic symptom is possible. There are, however, some characteristics that are fairly ubiquitous.

Fatigue. Fatigue is the most common symptom in MS, affecting at least 90% of all patients. It is multifactorial in nature, with both primary and secondary components.

Despite this, fatigue is poorly understood by most therapists. It can present fairly subtly as a mild worsening of symptoms during exercise (such as worsening of paraesthesiae during sustained walking), or severely, such as the inability to exercise continuously for more than a few minutes at a time without risk of falls.

Therefore, persons with MS are unable to exercise for long enough periods or at a sufficient volume to lead to meaningful changes. This “volume problem” can be one of the principal reasons that persons with MS have difficulty benefiting from physical therapy.

Taking breaks, referred to as intermittent training, can allow persons with MS to exercise for longer periods. The amount of rest given can vary, but a good rule is to give recoveries before significant fatigue has occurred. By giving rests, greater volumes of work can be performed in all aspects of rehab, including gait training, strength training and balance training. Patients can work harder with less fatigue.

Thermosensitivity. Thermosensitivity refers to the fact that nerve conduction slows through demyelinated nerves. It’s common in MS; up to 80% of people with the disorder experience worsening of symptoms following even relatively brief exposure to heat.

An increase of 0.5°C may slow or even block nerve impulse conduction in demyelinated fibers. This phenomenon, also called Uhthoff’s, manifests as a temporary worsening of neurological function with increased body temperature. This usually subsides within minutes to hours, and leaves no lasting neurologic deficits, but may leave the person unable to exercise or even move during this period.

The rise in temperature can be due to increased environmental temperature, such as a warm day or an overheated room, or due to an internal rise in temperature, such as that resulting from an infection or — more important for physical therapists — sustained exercise.

Similar to the fatigue problem, persons with MS need to exercise to improve function, but thermosensitivity prevents them from doing so. As the thermosensitive person with MS continues to exercise, nerve conduction slows and mobility deteriorates. Intermittent training is one method by which rehab professionals can intervene; by giving breaks, core temperature will not rise to a level that will interfere with nerve conduction, and heat-related mobility impairments are less likely.

Another relatively straightforward intervention is cooling — either by having the patient wear cooling garments, keeping the room cool by air-conditioning or fans, ingesting cooling beverages, or some combination of the three.

Cooling vests, caps, and neck wraps can be introduced before, during, and after exercise, and can result in increased time and quality of exercise. If not available, an ice pack is effective. Take care, however, as a small number of MS patients may paradoxically worsen with cold, resulting in increasing spasticity.

Foot drop. Although MS is known as a neurologic disease, secondary orthopedic deficits can be relatively common. Foot drop can refer to some combination of tightening of the plantiflexors due to spasticity or prolonged positioning, and weakening of the dorsiflexors due to motor tract involvement or disuse.

Foot drop in MS is a process, presenting with relatively mild weakness and loss of ROM early in the course of the disease, and progressing to frank contracture and resulting falls as the disease advances. If you note even relatively mild diminishment of dorsiflexion range or strength, intervention should immediately start.

Foot drop that seems mild on one exam may present as far more severe if the individual performs a test in which there’s a need for prolonged continued dorsiflexion, such as the 6-minute walk test. Although the first 1-2 minutes may seem normal, by the end of the walk, foot slap, foot drag, and compensations such as circumduction, contralateral vaulting, and lateral lean may all be observed.

Intervention must involve stretching of the shortened plantiflexors and strengthening of the dorsiflexors. Stretching must be of sufficient volume, performed for several minutes a day. Night splints, in which the ankle is held in a mildly dorsiflexed position, is an option as the person can wear it for hours with little of the fatigue associated with more active stretching.

AFOs may actually worsen the problem, as the rigid positioning and resulting immobility of the foot can actually further shorten contracted plantiflexors and weaken dorsiflexors.

Multiple sclerosis can be a challenging disease for clinicians. However, with diagnosis occurring earlier and more frequently, more patients are going to experience mobility deficits specific to this disease, and be referred to physical therapy. Rehab clinicians must familiarize themselves with the basic treatment techniques for this population.
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Three Critical Questions

Before expanding into a new location, grow your practice from the inside

By Brandon J. Buehler, PT, DPT, OCS

If you’re like me, you’re bombarded by ways to grow or expand your practice on a weekly basis. Unfortunately, I see many of our colleagues grasping at these straws in hopes of growing their business. We go from dining doctors, to purchasing fancy treadmills, to launching Facebook ad campaigns and settling into new satellite offices.

It sometimes seems that as private practice owners, we will try everything just short of putting on a costume and spinning a sign outside our clinic.

Regrettably, after trying many of these expensive options, we are often left frustrated after investing a lot of money with very little return.

Importance of Growing Your Practice

Don’t get me wrong — we need to grow. Especially now, in order to survive in an environment with declining reimbursements and uncertainty in our profession, private practices must endeavor to grow and expand.

Not only is growing and expanding important for each of our individual practices, but crucial for our profession. Just as Princess Leia called out to Obi-Wan Kenobi, “Help me Obi-Wan, you’re my only hope,” our profession is calling out to us as its only hope. The future of physical therapy depends on us as private practice owners to elevate our profession by being successful, practicing autonomously, and setting the standards by providing the highest level of care.

The reality is that there are very effective ways to grow and expand your practice without trying the latest fad and spending lots of money. Growing your practice does not mean you need to open a new office or spend lots of money on marketing. There are effective steps you can take inside your organization that will take less time, money, energy, and effort to grow your business.

By answering the following three questions, you will unlock what I consider the three secrets of success in physical therapy private practice.

Who Are You?

It’s vital that you determine who you are. What is your company about? What defines you? Where are you going? What do you want to be known for?

Unfortunately, many business owners, especially private practice physical therapists, operate like they’re teenagers. They don’t really know who they are. They haven’t figured out what they’re about. Without any grounding, they go after the latest fad, try to be everything to all people, and don’t have the maturity or the footing to help carry them forward.

Your purpose and values are the foundation of your practice, from which you will grow and expand. Your purpose is the framework upon which everything else rests. You could have the coolest social media campaign, a slick website, and every letter after your name, but if you don’t know your purpose and values, you will not have a stable foundation. This will lead to you trying every method that comes your way to grow your practice, without success.

Your purpose defines who you are and why you exist. Your values will act as a guiding light and provide an agreement on how you will act and operate; they will provide your practice with depth and maturity. Once you have determined your purpose and values, make sure your team knows them and operates with them in view.

So how does this contribute to your growth? Without having this stable and solid foundation, you have no way to grow. It’s like trying to jump with your feet in mud — you won’t go very high, if anywhere at all.

Once your purpose and values are set, your whole company will be on the same page, you will know who you are, you’ll know where you are going, and you will be able to move in the same direction. You will have a stable foundation and platform to launch from, and then there will be the opportunity for growth to happen.

How Good are You?

The mistake many private practice owners make is that we don’t define what “good care” really is. Most practices try to relieve a patient’s pain or injury by providing good care, and eventually discharge them as a satisfied patient.

The typical scenario is that a patient who has an injury or pain comes to our office for treatment. They expect to give up some of their time and finances in order to receive that treatment. If all goes well, the patient is satisfied and goes back to the doctor to report their positive results.

“Good and satisfied” are no longer the standard that we in private practice should be aiming for. With changes in health care, increased patient financial responsibility, and hospitals, doctors, and corporations trying to take over our profession, good and satisfied is no longer good enough.

We need to deliver such over-the-top care and service that good and satisfied are considered a failure. Patients must go back to their doctor and those they know, and not stop talking about us.

Give your patients more than they pay for. Provide a clear explanation of their benefits;
Does an existing patient with a new complaint need a new evaluation?

By Pauline M. Franko, PT, CEEAA

QUESTION: If a patient on my caseload brings me a new referral for a problem in another area, do I perform a new evaluation and open a new chart, or do I do a re-evaluation?

ANSWER: You have several factors to consider. I will answer with the presumption that you are talking about a Medicare Part B patient — not one with a Medicare Advantage Plan or other type of insurer.

You must always consider your practice act and Medicare requirements, and go with the most stringent regulation. If your practice act requires you to perform a new evaluation and keep a totally separate record, then you must follow that requirement for your license. If they do not have guidance, then you would go with what CMS indicates. The benefit coverage manual is very clear in that it will not pay for re-evaluations if required periodically as part of your state practice act, and this would probably be extended to a new evaluation while the patient is still being treated. In the guidelines CMS also covers the situation in which you receive a referral from a different physician for a different problem.

The guidelines are found in the IOM Manual, Pub. 100-02, Chapter 15 §220.1.2 — Plans of Care for Outpatient Physical Therapy, Occupational Therapy, or Speech-Language Pathology Services.

A. Establishing the plan (See §220.1.3 for certifying the plan.)

“Two Plans. It is acceptable to treat under two separate plans of care when different physicians/NPPs refer a patient for different conditions. It is also acceptable to combine the plans of care into one plan covering both conditions if one or the other referring physician/NPP is willing to certify the plan for both conditions. The treatment notes continue to require coded treatment minutes and total treatment time and need not be separated by plan. Progress reports should be combined if it is possible to make clear that the goals for each plan are addressed. Separate progress reports referencing each plan of care may also be written, at the discretion of the treating clinician, or at the request of the certifying physician/NPP, but shall not be required by contractors.”

Re-evaluations are covered in the definition section as follows: “Re-evaluation provides additional objective information not included in other documentation. Re-evaluation is separately payable and is periodically indicated during an episode of care when the professional assessment of a clinician indicates a significant improvement, or decline, or change in the patient’s condition or functional status that was not anticipated in the plan of care. Although some state regulations and state practice acts require re-evaluation at specific times, for Medicare payment, re-evaluations must also meet Medicare coverage guidelines. The decision to provide a re-evaluation shall be made by a clinician.”

So in your situation you would complete a re-evaluation and combine both problems under one plan of care. The new certification interval starts from that re-evaluation date. The manual is at www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs.html

Disclaimer: Answers are based on Medicare guidelines for what is payable under the Medicare Part A and Part B benefit. As always, the provider should be aware of regulations that might supersede Medicare payment guidelines such as the state practice act and state administrative code. In any scenario, the practitioner must go with the most stringent requirement to be compliant. Information is current as of the time of publication.

Pauline M. Franko is owner of Encompass Consulting & Education LLC based in Tamarac, Fla. Visit www.encompassmedicare.com
Athletic injury can range from turf toe, to a fracture, to a torn ACL. Athletes who are injured typically have pain, swelling, and loss of function. Each clinician has to design a program geared toward the optimal outcome — returning pain free to life and sport.

Today, in the clinic, the therapist and other professionals have many options to choose from as to what kind of “healing” modality to choose. One of those options is electrical stimulation.

Electrical stimulation has been around since 1791, when scientist Luigi Galvani first discovered muscle activation through electrical stimulation. By the 1960s, the Soviets were utilizing electrical stimulation to strengthen the muscles of their elite athletes. More recently, medical physiology research pinpointed that electrical stimulation has an effect on the cells, vessels, muscles, bones, and nerves. It ultimately assists in the restoration of function.

**Tissues with Issues**
The best way to choose whether electrical stimulation should be administered is to first examine the athlete, and to explore the tissues with the issues, coupled with the mechanism of injury. Therapists may also put the tissue in a category of acute (hours to days), subacute (1-2 weeks), or chronic (4-6 weeks) from date of injury. This may assist in choosing the parameters to use when applying electrical stimulation.

After any type of injury, the body’s cells go through a cascade of “healing and protecting” events. Typically, this causes pain, swelling, and loss of function; all are good indicators to use electrical stimulation.

During the acute phase of tissue healing, local active rest (pain-free movement) is key. “Passive” therapeutic modalities are appropriate, such as electrical stimulation.

The added benefit of electrical stimulation for the athlete is that it has a psychological effect in that the athlete feels that he is “getting” something, and that something is helping to promote healing when the pulses of electrical stimulation are felt.

**Pain Inhibition**
Electrical stimulation is also good for pain inhibition. When the body experiences pain, the function of the muscles typically shuts down. Swelling occurs from disuse, followed by atrophy. These are all indicators that electrical stimulation would be appropriate at this time, for this person.

The “brain-pain cycle” is a pathway from an injured site to the brain, and back to the site, carrying a message of “ouch.” This cycle can be interrupted by placing electrical stimulation across the injured region while performing range of motion, soft tissue techniques, and manual resistive exercises.

The electrical stimulation acts as a “pain interrupter” while other necessary therapeutic manual techniques can be administered by the clinician.

Athletes can easily feel depressed from not being able to play due to injury. The injury has threatened their identity, caused isolation from friends, and taken away their usual opportunity for success and achieving goals.

**Back to the Field**
Electrical stimulation can assist in getting back to sport, depending upon how it’s used. An example of this occurred recently in my clinic. A high-level high school quarterback separated his shoulder at the acromioclavicular joint. Applying electrical stimulation through the joint not only felt soothing, but also inhibited pain and increased circulation to the joint and ligaments for healing.

I also treated a wrestler who dislocated his shoulder three times during one match. Electrical stimulation was placed on the shoulder, while gentle range of motion, isometrics, and neuromuscular manual reactive training were administered.

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Early in the new year is an excellent time to re-examine the nature of our business and what we do as rehab professionals. It’s not enough to say that, as treating clinicians or business owners, we simply provide physical therapy services to our patients. We can add value to our patients’ lives in a multitude of ways. Yet, there are many key challenges that physical therapists and rehab practice owners are faced with. More demanding documentation requirements; declining reimbursements; increasing levels of third party audits. Let’s not forget that newly licensed clinicians may have increased student loan burdens that may require them to seek salaries that are not compatible with what the marketplace has to offer.

Herein lies the opportunity to add value to the complex nature of the healthcare system in which we operate. As traditional business models are met with increasing obstacles, the enterprising business owner or clinician can consider offering wellness and preventive services that are uncorrelated to trends in insurer reimbursement. Programs that aim to prevent and manage diabetes, vestibular rehab and fall prevention programs are other potential revenue streams that should be strongly considered. It’s important to recognize that we’re not simply in the business of physical therapy. Rather, we’re in the business of health.1 Hospitals and doctors may concentrate on providing health care; I suggest that we want to provide our customers and patients health. If we can add enough value while providing a solution to that equation, there aren’t many obstacles that will matter.

As you consider how you and your organization can enhance strategies for delivering “health,” it’s critical to also re-examine how you can add value for yourself and your family. For many clinicians and business owners, that can mean taking a proactive stance toward personal financial security.
17

Your Leadership Toolbox

Not all managers are leaders, and not all leaders are created equal. Though healthcare is often lagging in leadership, a few managers stand out from the crowd.

Prioritize. Yes, there’s not enough time in the day to take care all of your “stuff,” and all of it is very important, but you must assign high-to-low priority to your tasks. Most people will defer taking care of harder items. Doing this will only make your “to do” list longer, and you’ll feel that you have accomplished nothing in your day. Take care of your high-priority tasks first!

Know your employees. Though some managers prefer to think about their subordinates as such, many of us do not. We prefer to view them as human beings. If you’ve read about Dale Carnegie or Warren Buffett, our country’s top businessmen and leaders, you know that they personalized their relationships with their employees. Surprise your employee by signing a funny birthday card and involve the rest of the team.

Stand up for your employees. Have you ever heard an employee say about their manager, “don’t waste your time talking to him — it won’t do you any good”? Stand up for your team. Yes, it’s hard to be the middleman between administration and your staff, but that’s the assumed role of a manager. Step up!

Delay your e-mails, and don’t work your life away. Don’t think that just because your e-mail goes out at 11 p.m. on Sunday, that everyone will think you’re a better manager. Spreading a workaholic culture or expectation is wrong. Based on many studies, if you shoot for the “work smarter, not harder” culture, your employees will respect you more.

Decide on your style of management. Indecisiveness is bad for employees. Not knowing what to expect from their manager is even worse. Decide whether you must micromanage (not advised) or whether you like the “open door” policy. Whatever you decide, make sure your employees understand your expectations.

Most clinical managers have grown into the position, and did not obtain it merely after completing an MBA program. We should strive to be leaders. As healthcare is evolving, so should the management component of healthcare.

As productivity and efficiency measures infiltrate the humanistic nature of the rehabilitation field, it’s important to set aside time to evaluate the efficiency of your own financial situation. Often, treating clinicians and business owners can be so busy caring for the health of others that they may need to be reminded to take care of themselves and those closest to them.

As 2014 begins to unfold, there are numerous reasons that this could be a very good year, as more improvement may be in store for the economy and asset markets.

2014 May Be a Very Good Year

On both Wall Street and Main Street, 2013 turned out better than many analysts expected. Perhaps the recovery will gain additional momentum in 2014, and asset markets may climb even higher. Can you remember how pessimistic things were at the end of 2012? Fear about imminent economic damage from the fiscal cliff and sequester cuts were pervasive, and people were fearful of another significant downturn in the domestic economy.

However, the economy and the stock market withstood these anxieties, and others. Last month, only hours after the Federal Reserve announced it would scale back its asset purchases this year, the Dow Jones Industrial Average closed at an all-time high.

Weren’t investors supposed to be disappointed when the taper occurred? Let’s just say that the timing was right. In August, just the hint of an oncoming taper resulted in a 5.6% pullback for the Dow. Months ago, some investors were still questioning the strength of the recovery.

Today, there is less to question. As Wells Capital Management chief investment strategist James Paulsen commented in USA Today, the Fed’s move amounted to a “vote of confidence in the future,” mirroring the confidence in the stock market.

The taper to Quantitative Easing 3 was relatively small ($10 billion) and came with a pledge to hold interest rates down “well past the time” unemployment declines to 6.5%. So the Federal Reserve likely intends to maintain its accommodative stance for some time, which is just fine by investors. (In fact, the Wall Street Journal says that only two of ten Fed officials believe the central bank will raise interest rates this year.)

The Fed’s monetary policy has been instrumental to the stock market’s record-setting performance, and it isn’t going away — which is good news for this year.

Let’s also recognize that quantitative easing isn’t the only thing powering this bull market. The unemployment rate fell to 7.0% in November, a 5-year low. It was 7.9% one year ago. Last year was the fourth straight year with a gain in annual job creation.

The Fed sees Gross Domestic Product improving more than half a percentage point to 2.8-3.2% in this year, and growth of 3.0-3.4% for 2015. Housing starts have doubled in the past four years, and rose 22.7% in November to a 5.5 year peak.

Recently released Case-Shiller Home Price Index data showed a 13.3% overall annual gain in home values, and even though year-over-year existing home sales declined in November for the first time in 29 months, the National Association of Realtors said existing...
home prices had improved 0.4% in a year.3-8
The global outlook may also improve. Economists at China’s National Academy of Economic Strategy feel that the People’s Republic of China maintained GDP of approximately 7.5% in 2013 and may see as much as 7.8% growth this year. Citing Eurostat and Bloomberg research, Money reports that the Eurozone economy is projected to grow about 1.4% per year for the next 3-5 years — notably better than the annual 0.2% pace of expansion recorded so far this decade.5,9
No one is saying that there won’t be challenges or surprises this year, and stock market gains may not approach what we’ve just witnessed in 2013. That said, many indicators are signaling that this year could hold considerable promise for both Wall Street and Main Street.

Your Annual Financial Check-Up
As virtually all businesses in every industry look to continually enhance productivity and improve efficiencies, part of the solution for yourself, your family and your business could be to review in what direction your finances are headed.

Life circumstances often change as time goes by. You may have changed jobs or started a new business, bought or sold a residence, decided upon new goals. These developments can change your financial objectives.

Also, it’s just sensible to measure your financial progress. If you’re not making progress in accumulating assets, or if you are assuming too much risk as a result of your current portfolio or financial decisions, it may be time for a change. An annual re-evaluation can be like a “deep, cleansing breath” where you can get away from daily distractions and think clearly about your financial plans.

The beginning of a new year is an ideal time to take a look under the hood — financially speaking. While reviewing your finances with an investment professional, you can estimate your net worth, and possibly learn about any tax changes that might affect your investments — business or estate. It’s also a good time to make voluntary IRA contributions and review your college funding goals for dependents.

Imagine letting your investments go for five or ten years, assuming that they’re doing OK, while you wonder what the quarterly statements mean. Imagine being a few years away from retirement, only to find you have less than
a year’s salary in savings. Imagine passing away and leaving unresolved money issues for your loved ones, or subjecting them to a contentious probate process.

These scenarios are all too real. If you make the resolution to improve the efficiency of your personal finances and review what’s happening in your life financially, you can plan to avoid these issues in advance. Putting things off can be dangerous.

As you consider how you can add value to the patients that you treat, or the physical therapy business you own or operate, reflect on how your own financial checkup may provide a sense of security for yourself and your loved ones. Improved productivity and efficiency of personal and business finances can help provide solutions to many situations.

We wouldn’t tell our patients to consider their physical health once in a lifetime, and then forget about it. Physical health is an ongoing priority. The same can be said for personal financial planning.

References are available at www.advanceweb.com/pt under the Toolbox tab.

Christopher M. Pandolfi is a New York State licensed physical therapist, chartered market technician (CMT) and investment professional advising clients through Cetera Advisor Networks LLC. The views in this article are not necessarily the opinion of Cetera Advisor Networks. Contact: cpandolfi@stefans-associates.com or 516-692-2744.

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A New Dimension

Thinking about starting a laser therapy service?

A

fter a car accident several years ago, I suffered a herniated disc in my lower back. I experienced numbness, tingling and burning in both my feet that would get worse when I sat for greater than 20 minutes.

Sound familiar? This is the typical presentation of a patient with a lumbar herniated disc that outpatient physical therapists treat daily.

While sitting at a conference several months after my accident, I noticed a gentleman in the corner with something that resembled a flashlight. I watched other physical therapists walk over and use this device on themselves, and talk about how much better their particular pain felt after using it.

As I sat there with back pain and both my feet feeling like they were on fire, I remember saying to myself, “Yeah right — ever heard of the placebo effect?” By the second day, I could not sit anymore — I was actually standing and trying to listen. The back pain and burning sensation in my feet became too intense for me to stay, so I planned on leaving the conference at the end of the day, two days early.

Nearing that point, I thought to myself, why not go try that laser that physical therapists have been raving about? The vendor showed me how to properly use it and explained to me how it works.

It sounded too good to be true, like most new gadgets marketed for pain relief. However, within five minutes I could feel my feet again, and the burning subsided. I stood there and thought — ultrasound, electrical stimulation, iontophoresis, phonophoresis, and shortwave diathermy all do not work this fast. As I read the studies, I saw that not only does the laser decrease swelling, spasm, and pain, it truly speeds up the body’s own healing rate. I was sold.

As owner of Sport and Spine Physical Therapy and Wellness Center LLC in Tampa, Fla., and a licensed DPT for eight years, I’ve had the opportunity to use some of the best equipment and innovations money can buy.

Working in the NFL for the New England Patriots for four years, I was privileged to be part of the medical staff for the Super Bowl XXXVIII championship team in Houston, Texas. I’ve also had the opportunity to work in the NBA with the Boston Celtics, and train and rehabilitate athletes preparing for the NFL combine and draft in New Orleans.

After moving to Tampa, I had the honor of working with our nation’s veterans and active-duty soldiers returning from war. Looking back, I’m positive that low-level laser therapy, or LLLT, would have expedited healing and facilitated the return of my patients to their respective activities.

How Can LLLT Help Patients?

The main goal of a physical therapist is to get patients moving safely and efficiently, ultimately returning them to their prior level of function, or better. We have an array of modalities to choose from that act as an adjunct to our treatments. So why should we use a modality like LLLT?

In physical therapy, many patients take two steps forward and one step back over the course of their rehabilitation; they start to feel better and stress themselves too much, causing an exacerbation. That one step back can be several days, a week, or more.

What if you could cause the body to heal itself 50-60% faster, and reduce inflammation immediately, painlessly and with no side effects? For the past four years, I’ve used LLLT as an adjunct to physical therapy, with dramatic results.

The greatest part about LLLT is the patient feels immediate relief nine times out of ten. 

Unlike cryotherapy, electrical stimulation, therapeutic ultrasound, iontophoresis, and shortwave diathermy, laser therapy works as a true healing device. In my experience, other modalities merely mitigate a patient’s pain for a short time.

LLLT works at the cellular level to increase the body’s own healing rate by approximately 50-60%, depending on the laser employed. Most of the body’s healing occurs during REM sleep, and laser expedites this process.

Laser wavelengths between 820 and 840 nanometers have very little absorption as they pass through our skin, thus allowing penetration much deeper than other modalities such as therapeutic ultrasound. On average, laser will penetrate 2-3 inches. Essentially, laser therapy works in two ways: it decreases edema and increases angiogenesis, or the creation of new capillaries, at the micro-capillary bed.

Cost Concerns

As I was personally skeptical about the efficacy of LLLT, I carry that skepticism over to introducing laser therapy to patients. Therefore, I always offer the first laser treatment for free. This gives the patient a feel for how well it works.

LLLT is not covered by any insurance carrier, and to my knowledge will not be covered in the future, since Medicare is taking billing laser continued on page 24

Conditions Treated

At Sport and Spine Physical Therapy and Wellness Center, I perform laser therapy daily in my clinic on these conditions, and more:

- Arthritis (rheumatoid arthritis and osteoarthritis)
- Back pain
- Degenerative disc disease
- Herniated discs
- Muscle spasms or stiffness
- Post-surgical pain
- Post-trauma acute pain
- Facet syndrome
- Sciatica
- Wounds (including decubitis ulcers)
- Carpal tunnel syndrome
- Temporomandibular dysfunction
- Migraine/tension headaches
- Muscle and joint strains/sprains
- Fibromyalgia
- Bursitis
- Tendonitis/tendinosis

—Ryan Whelton
Aiming Higher

Advanced technology, techniques keep injured athletes in the game

By Melissa Lichtenheld

To help athletes stay at the top of their game after a serious injury, sports doctors and physical therapists are pushing the edge to find the right balance between healing and maintaining strength and motion.

Marion Walker, a high school defensive back who injured his ankle during a football game, was up and running three months later. Under the watch of an orthopedic physical therapist, Walker has been performing sports-specific drills to be eligible for track season, when he will compete in the 800-meter race and relay events.

The 19-year-old Miami athlete, recruited to play collegiate football in California, was diagnosed with a torn deltoid ligament, dislocated ankle, and separation of the syndesmosis, a sheet of ligament connecting the leg’s fibula to the tibia.

“With the treatment plan we used, at three months it’s very realistic for an athlete to return to competition after suffering these injuries. We are so used to treating athletes that we are comfortable in knowing it won’t result in a failure of the surgery,” said Christopher Hodgkins, MD, the orthopedic surgeon who repaired Walker’s ankle at Doctors Hospital’s Center for Orthopedics & Sports Medicine in Miami.

Walker was injured when another player slammed into him as he was getting up from a tackle during a game for Coral Gables Senior High School, a four-time national champion that’s the alma mater of San Francisco 49ers’ running back Frank Gore and Houston Texans linebacker Darryl Sharpton.

“I wanted to stay in the game so I kept playing, but the pain got so bad I finally had to leave the field,” Walker said.

Surgery and Early Rehab

During surgery on Walker at the end of October, Hodgkins used an advanced device called a suture button to fix the syndesmosis tear, necessary to return stability to the ankle. Without treatment, athletes most likely would be unable to return to sports and could develop ankle arthritis if the injury is neglected, Hodgkins said.

With the suture button, athletes are able to move their ankle much earlier than usual, allowing them to work on gaining motion and strength as soon as possible without interfering with the healing process, he said.

Traditional stainless steel screws are still used by some physicians to repair the ligament, yet the screws sometimes break and have to be removed, causing further surgery for the athlete and time out of play, said Hodgkins, who specializes in conditions of the foot and ankle.

After surgery Walker wasn’t allowed to put weight on the foot for six weeks. He complied with doctors’ orders, but felt dejected at keeping the foot elevated and using crutches to get around. His spirits improved, he said, when he convinced friends to push him down the school hall in a wheelchair.

Two weeks after surgery, Walker started rehabilitation when the rigid half-cast came off. Placed in a boot, Walker was ready for range and motion exercises.

“If the foot is kept in a cast the entire first six weeks, the patient can’t move the ankle and muscles begin to atrophy. With the suture button device, we are comfortable with the athlete beginning to move the ankle at a very early stage,” Hodgkins said.

“Our goal in physical therapy is to make the transition from the first rehabilitation range-of-motion exercises to those more specific to sports, including jumping, hopping and running backwards. With the button device, athletes tend to make the comeback quicker because the range of motion isn’t lost,” said Jorge Giral, DPT, one of more than a dozen orthopedic physical therapists in the rehabilitation department at Doctors Hospital. Three physical therapists are certified in rehabilitation techniques with Pilates equipment and stretching. Giral has additional certification in orthopedic manual therapy and strength and conditioning.

During the second six weeks, Walker was walking and undergoing intensive physical therapy with aggressive strengthening, motion and balance exercises.

“The average time to start walking is at six to twelve weeks. We at Doctors Hospital have a lot of experience treating athletes, from professionals to the weekend warrior, and are more confident with them bearing weight. The sooner they can walk, the sooner they can get back to playing,” Hodgkins said.

Anti-gravity Training

Walker began walking on an anti-gravity treadmill, a machine developed by NASA that makes the body buoyant, reducing impact on joints and ligaments. Giral zipped him into the harness of the anti-gravity treadmill, a high-priced machine used in the sports world for about seven years for training and rehabilitation.

“I had been afraid to put weight on my foot and to walk on the regular treadmill,” Walker said. “With this other treadmill, I didn’t have any pain so I gained confidence.”

Giral said the anti-gravity treadmill allowed Walker to begin walking correctly while keeping up cardiovascular conditioning.

Once only accessible to professional and college sports teams and specialized hospitals, the anti-gravity treadmill has become a standard tool for physical therapy. The machine pumps air into a chamber wrapped around the body from the waist down. The increased air pressure on the body lifts it up, reducing the impact when feet touch the ground. It can be calibrated to change the body weight from 100 percent down to 20 percent.

“Physicians have taken a liking to the machine. The anti-gravity treadmill has become a standard tool for physical therapy,” said Hodgkins.

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machine, because the patient is able to return to weight-bearing and high-impact activities quicker,” Giral said.

Aquatic therapy remains popular, but its limitations include access, movements that are less natural, infection, and fear of water. People with incisions from surgeries such as ACL repairs are susceptible to reopening the wound.

“Most patients who fit in the harness are good candidates for the anti-gravity treadmill,” Giral said. “The use of the technology was initially for athletes, but we are now treating people with knee replacements, osteoarthritis and car accident injuries. Patients are happy. They feel like they are progressing because they are doing functional movements earlier in their recovery. It returns them to a sense of normalcy.”

Progressing from surgery to running is a slow transition period and the speed of doing the exercises depends on the athlete. The healing process is monitored with a series of X-rays, physical exams by the doctor, and subjective patient reports on the level of pain.

“The less pain, the more progress he or she is making,” Hodgkins said.

“Dr. Hodgkins says I’m where I should be,” Walker said. “The therapy is really helping me get into shape for track season.” ■

Melissa Lichtenheld is a freelance writer affiliated with Baptist Health South Florida, the parent company of Doctors Hospital.

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**Laser continued from page 20**

codes away, not adding them. At Sport and Spine Physical Therapy and Wellness Center, we offer “laser packages.” We sell laser treatments by the number of sessions. If a patient only wants to buy one treatment, we charge $49. However, the savings increase as the sessions purchased increase.

Patients see the benefit and usually purchase packages of 10-15 sessions. We tell patients that if, for some reason, they don’t use all the treatments for the particular condition they’re presenting with, they have the opportunity to utilize the rest of the unused package over the course of one year, or may share their laser package between immediate family members.

**How Do I Advertise It?**

There are a number of great ways to advertise LLLT. I recommend marketing your laser therapy service to the public instead of to physicians. In my experience, physicians have never heard of laser therapy, or don’t have much experience with lasers, and therefore are skeptical about it.

I’m still surprised to talk to orthopedic surgeons, neurologists and neurosurgeons who have never heard of laser therapy for pain relief. On the contrary, the public will try just about anything to relieve their pain.

I use a combination of mediums that specifically advertise “pain relief.” The treatment of pain is a $60-billion industry and growing with our aging population. If you want to tap into the patient population with pain, you need to advertise pain relief.

Advertising “physical therapy” just doesn’t work. Unfortunately, the public doesn’t associate physical therapy with relieving pain. From my experience, asking the general public (and I urge others to randomly ask people) what physical therapists do resulted in answers that shocked me. The common conception was a physical therapist is a cross between a fitness trainer and a massage therapist. The last thing a person suffering in pain wants to do is exercise. That’s why it is imperative you advertise “pain relief” for success with a laser therapy service.

Marketing doesn’t have to be costly. I’ve had great success using brochures, window graphics, banners, signs and flyers. Google, Bing, Yahoo Adwords, and pay-per-click advertising tend to be expensive and may not be worth your money.

Providing a complementary consultation along with a free laser treatment is crucial. The consultation provides you the opportunity to assess the underlying reason for a patient’s pain. Use this opportunity to impart your expertise on how to best treat the root cause of his pain in conjunction with laser therapy so the problem doesn’t return.

**Adding Another Dimension**

Low-level laser therapy is one of the fastest-growing modalities used by physical therapists across the country, and its effectiveness speaks for itself. By implementing the correct advertising methods, your practice will add another dimension. The ability to decrease pain immediately, safely, and without the use of injections or oral medications allows you to tap into a massive industry where pharmaceutical companies spend billions of dollars in advertising.

LLLIT is here to stay, so if you haven’t implemented it into your practice, I highly recommend you do. ■

Ryan Whelton is owner of Sport and Spine Physical Therapy and Wellness Center in Tampa, Fla. Contact: info@ptandpainrelief.com

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The Developmental Integration of Play and Pre-Literacy Apps for Early Childhood Service Providers...Which Apps to use when? Presented by Penina Ryback, MA/CCC-SLP and CEO of Socially Speaking, Inc. This program will provide a "hands-on" tutorial on implementing Apps in the iPad for a positive educational experience for young children with special needs and challenging behaviors. It provides tips on best practices for the busy service provider, developmental prerequisite skills when planning goals/lesson plans with the iPad and suggested strategies to foster self-regulation, fine motor and challenging behaviors. It provides tips on best practices for Early Childhood Service Providers...Which Apps to use when?

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Postural Restoration Institute, Contact: Postural Restoration Institute, Phone 888-691-4583 (toll-free); www.posturalrestoration.com

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Instructor: Suzanne Davis-Bombria; Kate Bain. Location: Texas Children’s Hospital, Houston, Texas 77030. Contact: Mitzi Wiggin, 832-826-6107 for more information; e-mail: mmwiggin@texaschildrens.org; or register online: www.texaschildrens.org/prmr and click on continuing education.

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Falls risk has been identified as a key factor in hospital admission and re-admission. Learn to use evidence based interventions for improving balance, preventing falls, promoting strength and function in geriatric and neurologic patients. A key focus is learning to select and use the most appropriate tools for assessing balance/risk of falls and evaluating function.
Participants will examine the relationship between cognition, the sensory system and balance control problems and will apply motor control interventions and motor learning concepts to specific conditions. Focus is on effective evidence-based treatment strategies to prevent falls and re-admission, improve functional balance and optimize the environment for patients with balance problems, including the elderly, those with stroke, Parkinson’s disease, and medically complex conditions across the continuum of care.
Instructor: Carole Burnett
Contact: Education Resources, Inc., 508-359-6533; 800-487-6530 (outside MA); www.educationresourcesinc.com

Electrical Stimulation: Enhancing Pediatric Outcomes
This two-day course with intensive hands-on lab format allows pediatric therapists the opportunity to learn about the use of electric stimulation modalities for functional rehabilitation in the pediatric population. Learn and practice how to select parameters for using TENS and FES to enhance treatment protocols specifically for the pediatric population with neurological and orthopedic diagnoses. Review TENS and FES parameter selection for chronic pain, muscle strengthening, neuromuscular rehabilitation, and the use of sensory level stimulation to enhance feedback and motor learning. Gait lab will review options for electrode placement, available devices, and use of sensory input rather than or before attempting motor response. Learn and practice specific treatment protocols for shoulder subluxation, rhomboid stabilization, and brachial plexus injuries. Facial paralysis from surgical or virus-based issues will be discussed. Recent research will be reviewed for electrical modalities, with contraindications specifically referring to Pediatrics. Prior knowledge of modalities & anatomy is helpful to maximize learning experience.

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June 20–21
Denver, CO

Lymphatic Correction Using Elastic Taping Method
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June 22–23
Denver, CO

Advanced Lymphedema Management I (Refresher)
May 15–18
Sacramento, CA
October 16–19
Charlotte, NC

Wound Management Strategies / Advanced Wound
March 22–23
Palm Beach Gardens, FL (WOUND)
March 24–25
Palm Beach Gardens, FL (ADV)

LANA® Exam Preparation Course
March 29–30
Houston, TX
July 19–20
Sacramento, CA

Contact:
Joachim E. Zuther, PT, MT, CDTI – Founder of the Academy of Lymphatic Studies and Author of Lymphedema Management: A Comprehensive Guide for Practitioners

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Advance for Physical Therapy & Rehab Medicine
This two day course is designed to provide participants with an introduction to the Neuro-IFRAH® principles of management and a practical application of these principles to increase function in adults with hemiplegia from a stroke or brain injury. Participants will be able to apply the information and handling techniques learned in a variety of treatment settings including acute care, inpatient and outpatient rehabilitation, home care, and skilled nursing facilities. Hosting opportunities available for 2014-2015. Contact: Rehab Education, LLC, 845-368-2458 for questions; info@RehabEd.com or www.RehabEd.com for details and registration.

The Norton School of Lymphatic Therapy's Advantage Optimal Access Format is a blended live & web-based certification program producing LANA-eligible lymphedema therapists in only 9 continuous days. Only 5 workdays and 2 weekendends make this course the most sensible, cost-effective, unmatched choice. Save large expenses on staff coverage, travel, hotel and meals. Take our online Virtual Tour and compare to other schools! This course teaches: Manual Lymph Drainage (MLD) & Complete Decongestive Therapy (Vodder/ Foeldi Tech) covering 135 hours, basic and advanced MLD, bandaging & Tx protocols, Tx of primary & secondary lymphedema, extremity & non-extremity lymphedema. All Norton School instructors are recognized national experts and are available via e-mail & phone consultation for Tx of complex patients. We offer Advanced Training Programs, Reviews, Bi-Annual Conferences, Specialized Training Videos & free lifetime listing in our Therapist Referral Database. Multiple courses offered per month nationally. Inquire about hosting a course! MD, RN, PT, OT, PT Assistants, Nurses & MTs qualified. The Norton School is recognized by FPTA, NJ, SBPTE, TPTA, AOTA & NBCTMB for CEUs. Senior Faculty: Steve Norton, MLD/CD, CLT-LANA; Andrea Cheville, MD, Medical Director. Contact: 866-445-9674 (toll-free); 866-854-7800 (fax); info@NortonSchool.com or www.NortonSchool.com

Learn about conservative and surgical management of Obstetrical Brachial Plexus Injury over the course of infancy, childhood, and teen years through a detailed overview of the anatomy of the initial nerve injury and the muscular and bony sequelae that often results in lifelong neuromuscular and orthopedic challenges. Learn comprehensive examination and intervention strategies for each stage of recovery throughout infancy, childhood, and teen years, and how to develop an on-going treatment plan to assist the child to achieve their fullest potential. Hosting opportunities available for 2014-2015. Contact: Rehab Education, LLC, 845-368-2458 for questions; info@RehabEd.com or www.RehabEd.com for details and registration.

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Brandon J. Buehler is co-owner and co-founder of Coury & Buehler Physical Therapy, a 4-location practice in Orange County, Calif. Coury & Buehler Physical Therapy was named ADVANCE Magazine Practice of the Year for 2013. Visit www.cbphysicaltherapy.com

The Wisconsin Physical Therapy Association (WPTA) will host its Spring Conference 4/10-11, 2014 at the Kalahari Resort & Convention Center, Wisconsin Dells. The conference will feature hands-on labs, lectures, discussions, expert panels and a professional issues forum. Attendees will receive contact hours qualified as continuing education by the Wisconsin DSPS for courses attended in their entirety. Registration includes continental breakfasts, morning & afternoon breaks, luncheons, Welcome Reception, Business Meeting, Awards Dinner and conference materials. All classes are held on a first-come, first-served basis. Sign up early! Contact: WPTA office at 608-221-9191; wpta@wpta.org for more information; www.wpta.org to download a registration form or register online.

Finally, look for us at the APTA CSM Conference in Las Vegas April 26-27, 2014.

If you have any questions, please contact us at 208-704-9606 or info@rnlawgroup.com.
For any athlete, loss of function and atrophy are the most devastating of all. Most athletes have played with pain and swelling, but loss of function is the most common reason to be sidelined, and to also undergo rehabilitation.

Whether the athlete has a simple sprain or strain, or a more complex injury such as torn ligaments, all will need neuromuscular recruitment intervention. Electrical stimulation can be utilized with or without exercise. It can either be applied weight-bearing or nonweight-bearing, depending on the phase of tissue healing or patient position tolerance. Both are functional, especially when weight bearing.

The added electrical stimulation gives more influence to the neuromuscular reactive intervention. Patients seem to enjoy the muscle assistance with the stimulation, giving them a “wow” effect when the electricity makes their muscles twitch. This not only adds function to the session, but it’s fun.

Take Precautions

As with the administration of any modality, there is a risk of injury with electrical stimulation. One athlete had nerve damage with a loss of sensation from his injury. The therapist at a previous facility used electrical stimulation at such a high intensity that the patient became burned and is permanently scarred where the electrodes were placed.

Thorough examination and assessment before, during and after the application of electrical stimulation is a must to assure that no skin irritation has occurred. Also, during the session, it is vitally important to inform the patient what will be felt and what to expect from the modality. During any part of the session, if there is any increased pain or discomfort, it must be reported to the therapist immediately.

As the field of physical therapy has become a doctoring profession, more evidence-based research is providing rationale to what clinicians prescribe. Good judgment is necessary when deciding whether to use electrical stimulation.

As with any part of a rehabilitation program, progression is expected, and electrical stimulation is not exempt from this. The athlete cannot play “wired up” with electrical stimulation and therefore must be able to progress to the point where he has gone from acute to chronic tissue healing. At this point, the therapist needs to think less about using modalities and more about using more functional sport activities to achieve return to sport.

Athletes can get injured from movement, and they need to return to sport with optimal movement. Electrical stimulation is not the cure-all or heal-all, it just helps. In the end, it is always best not to depend solely on modalities. They must be looked at as a part of a comprehensive, complete treatment regimen used to enhance tissue healing and promote safe return to sport.

Vincent M. Burke is president and owner of Infinity Rehabilitation and Sports Medicine LLC in Rochelle Park, N.J.
New Jersey, New York, Pennsylvania

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• Management experience required.
• Teaching experience required.
• Involvement in the academic community beyond physical therapy education required.
• Experience in instructional design and methodology required.
• Experience in student evaluation and outcomes assessment required.

We offer:
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Minimum Qualifications:
• Master’s degree required.
• One of the following: Physical Therapy Licensure (if a Physical Therapist) or Physical Therapy Licensure, Certification or Registration (if a Physical Therapy Assistant).
• 5 years clinical experience required.
• Management experience required.
• Teaching experience required.
• Involvement in the academic community beyond physical therapy education required.
• Experience in instructional design and methodology required.
• Experience in student evaluation and outcomes assessment required.

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Hand Washing

A new study by Michigan State University researchers found that only 5% of people who used the bathroom washed their hands long enough to kill the germs that can cause infections. The study appears in the Journal of Environmental Health. While 33% didn’t use soap, 10% didn’t wash their hands at all. Men were less likely to wash than women.

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