SUMMER 2018

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Federal Physical Therapy

SECTION

Quality physical therapy care across federal medical facilities.

SERVICE REPRESENTATIVES

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United States Air Force
Brandon Wielert, PT, DPT

Save the Date!

APTA Combine Sections Meeting

WASHINGTON DC • JANUARY 23–26, 2019
President’s Message
Mark Havran, PT, DPT
President, Federal Physical Therapy Section, APTA

It just seems like yesterday that we were finishing up at CSM in New Orleans. We again had a successful lineup of courses that received rave reviews. We look forward to that tradition continuing at the next CSM in Washington D.C. January 23-26. We expect our Federal Physical Therapist Members to have a strong presence in our Nation’s capitol. I encourage you to plan for attendance a what expects to be another great turnout, great course offerings, and a chance to demonstrate our advanced skills and best practices within the Federal system for all to see.

NEXT 2018 has just finished and there was a lot of excitement and momentum built. APTA President, Sharon Dunn, was re-elected at NEXT 2018. Her inspirational address was part affirmation and part challenge, laying out a path for the future of a profession that is nonjudgmental, inclusive, and ready to take action to achieve APTA’s transformative vision for society.

Watch the video or read the entire address on APTA’s #PTTransforms blog.

Our movement to improve communication to membership, improve social media outreach, improve student affiliations, student scholarships, and expanded residencies all will impact and transform society. What a better way to learn about advanced practice within physical therapy than to be a member and advocate our best practices! It is an honor to work alongside our board and service representatives. We are planning not only continued support of National Student Conclave, an enhanced federal advocacy component, yet also a focused strategic plan that will guide the section for years to come. On behalf of the board, we look forward to working with you on increasing engagement among our members, increase awareness to non-members on what you do, and highlight the value of the services you provide each and every day.

This newsletter will give a sneak peek to some pre-con courses, some inspirational stories, and highlights of just a few best practices that are occurring. We are looking forward to the build up to CSM2019.

Section Delegate Report
Carrie W. Hoppes, PT, PhD

The 74th session of the APTA House of Delegates convened June 25-27, 2018 in Orlando, Florida. Three hundred and ninety-eight Delegates were in attendance. Dr. Sharon Dunn was reelected president and Dr. Matthew Hyland was elected vice president. The House adopted several important motions this year. Unanimously, the House strengthened APTA’s position on sexual harassment. The House also voted in favor of person-centered services, opposing policies that would permit a provider to deny physical therapy services based on a provider’s religious or personal objections to the patient that may be based on age, gender, nationality, religion, ethnicity, socioeconomic status, sexual orientation, health condition, or disability. The House also voted in favor of essential health benefits, believing that a specific set of comprehensive physical therapy services should be included in all insurance plans without limitations based on preexisting conditions. The association was also charged with developing a long-term plan to eliminate the improvement standard (that services are payable only if they improve the patient’s condition). Finally, the association was charged with defining the role of PTs and PTAs in disaster preparation, relief, and recovery. The necessary 2/3 vote to hear the motion for the section vote (adding two voting delegates for each specialty section to the House) was not reached. While this was disappointing to the sections, we are already planning to rally for the section vote again in 2020!
Federal Affairs Update
Amanda Simone, DPT, CLT-LANA

Federal Advocacy: The Common Link
What do VA telehealth crossing state lines, PTA treatment reimbursement by TRICARE, and the Qualification Standard revisions all have in common? The answer is Federal Advocacy by APTA. These are just a few examples of the issues APTA staff and members have been advocating for over the past year. APTA advocacy has had some significant wins over the past year to celebrate, including but not limited to:

1. VA Telehealth Final Regulations: The Department of Veterans Affairs released a final rule on May 10, 2018, effectuated June 11, 2018, which allows VA health care providers to administer care using telehealth or virtual technology regardless of where in the United States the provider or veteran is located. This will support the VA’s efforts to better serve our nation’s veterans. Full details of the rule can be found here.

2. TRICARE: The National Defense Authorization Act of 2017, signed into law on December 12, 2017, included a provision adding PTAs (and OTAs) as authorized providers under TRICARE. However, this change is not yet effective. The change to regulation will be implemented through the notice and comment rulemaking process. The proposed rule is expected in the fall of 2018 or spring of 2019. A 60-day comment period will follow the release of the proposed rule, after which the Department of Defense will review the comments and draft and publish the final rule. Until the rule is finalized and published, TRICARE does not consider a PTA as an authorized provider, and the rule will not be retroactive. APTA will keep members informed of the timeline for this changeover to the TRICARE system. For more information, see APTA’s TRICARE webpage.

3. Permanent Fix to the Therapy Cap: On February 9, 2018, a permanent fix to the decades-long efforts to end the hard Medicare Part B therapy cap represented a huge win for APTA Advocacy efforts. That said, APTA continues to work to ensure that the implementation of the new policy is favorable for the profession. Additional information can be found here.

The above outlined wins make abundantly clear the importance and value of federal advocacy. Unfortunately, there are several myths that exist concerning federal employees and federal advocacy engagement. Provided below is clarification on some of the ways federal employees can be fully engaged in federal advocacy efforts while ensuring the Hatch Act and Federal Employee Code of Conduct are not violated.

Some FAQs on Federal Employee Engagement in Advocacy
1. Can I sign a petition?
   • Yes. You are able to sign a petition on your own time and, if done electronically, using your personal email address. We do not recommend forwarding/soliciting additional signers using a government email address or to a government email list serve.

2. Can I be involved with APTA federal advocacy work?
   • Yes. You can be engaged in APTA federal advocacy work; however, it needs to be done during your personal time (off tour/AL) and not be completed using government funded equipment (GFE). During participation, you cannot give any impression that you are representing the agency for whom you work.
   • For regulatory advocacy, (i.e., writing comments, expressing their individual opinion on how a proposed regulation or policy will impact PTs and patients) APTA recently launched a regulatory advocacy webpage that outlines all of the available comment opportunities and provides, at minimum, a generic template letter or a more specific letter template for more significant action items.

3. Can I correspond with my state or national representatives?
   • Yes, on your own time using your personal address/email address

4. Can I attend state or national advocacy events including PT PACT events?
   • Yes, on your own time. You may attend but you cannot organize/advertise the event or collect/solicit for donations/payment to attend the event.

5. Can I serve on APTA advocacy related committees and work groups?
   • Yes, on your own time using your personal email address.
   • If you are interested in serving on federal committees or task forces, contact Kara Gainer at advocacy@apta.org to let her know of your interest and share a brief bio and your current CV. She maintains a volunteer pool to draw from when opportunities arise.

6. When speaking with my representatives, can I share stories of my work?
   • Yes, however, you must maintain HIPAA-compliance and cannot disclose any specific agency information.
relevant to share are likely more relevant to the nature of physical therapy practice/profession as opposed to the specifics of
the practice of physical therapy in the federal sector. You must also be clear that you are not representing the agency you
work for but are present on your own time in advocacy for your profession.

7. Is there a simple way to stay informed of what is happening on Capitol Hill and within the Executive branch?
   • Yes, simply join the PTeam

8. Can I serve as a Key Contact for my state or Federal Section
   • Yes! Of course!

The best part is that the Federal Section is currently in the process of expanding our engagement in federal advocacy efforts. This
creates some great opportunities for our members to get involved and even serve in leadership positions. We are currently seeking to
establish a list of Key Contacts for the first time for the Federal Section. This is a great way for both new professionals and experienced
clinicians alike to get more involved in both small and large ways depending on your availability. For those familiar with traditional
state Key Contact roles, please note that this will be slightly different and may or may not be independent of each other depending on
your interest. Federal Section Key Contacts will serve as points of contact on issues and opportunities related to the area you serve,
be sought out to provide feedback on what issues matter to you in your role, and be looked to for ideas of how to keep moving the PT
profession forward. If you are interested in getting more involved with federal advocacy and want to learn more about engagement
opportunities, please contact Federal Section FAL, Amanda Simone, at amandasimone28@gmail.com.
Outgoing Service Reps Recognized for their Service (L-R)
Joseph Kardouni & Renee Schroeder

Andrea Crunkhorn recognized for her service as Vice President

Students awarded CSM Scholarship

Presentation by FAL, Amanda Simone and APTA Director of Regulatory Affairs, Kara Gainer
Registration opens August 22!

Pre Cons:

1 Day
- Beyond Swings: Incorporating Kettlebells in the Rehabilitation Process
- Move to Health: Holistic Approach to Managing Patients With Musculoskeletal Pain
- Outcomes and Advances in Prosthetic Rehabilitation for People With Limb Loss

2 Day
- Bootcamp: Experience Military PT Education From Basic Training to Blast Injuries

Sessions:
- Osseointegration at a Military Medical Center
- Bone Stress Injuries: What's your Grade? Management, Rehabilitation, and Imaging
- CPG to Recognize Health Conditions That May Necessitate Referral to a Physician
- Returning to Running: From the Clinic to the Track
- Effect of Body Composition on Physical Performance and Injury Rates
- The Future Integration of Rehabilitation: A Roundtable Discussion
- Dual Tasking to Optimize Performance for the Tactical Athlete
- Sleep: The Impact of Sleep on Pain, Healing, and Wellness
- Functional Return-to-Duty Decision Making Post mTBI and Musculoskeletal Injury
- Rehabilitation in the Digital Age: Virtual Reality, Games for Health, and TeleRehab
- 2017 Rehabilitation for the Individual With Lower Limb Amputation CPG
- Get Out There! Advanced Wheelchair Skills Training Empowers Optimized Mobility
- Human Performance Optimization: Performance, Injury Resistance, and Rehab
- Blood Flow Restriction and Ischemic Preconditioning: State of the Science

We Hope You Can Join Us!
One of the 31 specialties making up the Medical Service Corps, Navy Physical Therapy has 105 active duty positions across the continental United States and abroad, with a diversity of assignments which include large medical centers, small community hospitals and clinics, aircraft carriers, and positions in special warfare communities. Application to become part of this team is a highly competitive process – we want the best for our warfighters and their families. In general we are looking for graduates from competitive programs with a history of academic excellence, who have developed strengths in neuromusculoskeletal medicine or are actively pursuing this expertise. Very important is a desire to serve your Country with flexibility and dedication to the Navy-Marine Corps team; being open to the adventure of multiple assignments and the challenge of adapting to the demands of different teams, missions, and patient populations. We are open to new graduates with leadership potential, and those who have started to hone their leadership skills with a few to several years of experience.

A testament to the professional commitment of our PT community is that more than 80% of our personnel have achieved a specialty Board Certification, and we are striving for 100%. The Navy also offers recognition for this achievement with additional board certified pay.

Applying can be a multi-year process or happen relatively quickly (a few months) based on timing and the needs of the Navy. Some successful career officers have had to exercise persistence in applying over successive years to be offered a position, while others were lucky with timing. If this rewarding career appeals to you it’s recommended that you pursue early and persevere!

Those interested in becoming an Active Duty Navy PT should contact their local medical recruiter. The recruiter will be able to provide the number of opportunities available for joining the Navy that year and guide you in the administrative processes for recruitment. Information about Navy PT can be found at HERE.

To qualify for Active Duty employment consideration as a Physical Therapist in the Navy Medical Service Corps, you must meet these basic requirements:

- Be a U.S. citizen currently practicing in the U.S.
- Master of Science or Doctoral degree in physical therapy (entry-level or advanced) from an institution accredited by the American Physical Therapy Association (APTA)
- GPA of 3.0 or higher on a 4.0 scale
- Be willing to serve a minimum of three years of Active Duty
- Be between the ages of 18 and 41
- Be in good physical condition and pass a full medical examination
- You may also be expected to meet certain preferred requirements:
  - Previous experience as a physical therapist (constructive credit for work experience now offered to physical therapists)
  - Letter of recommendation from a physical therapist currently serving in the military
  - Professional and personal recommendations (letter of reference from professor[s] for new graduates, or letter of reference from supervisors in physical therapy for workforce applicants)
  - Current licensure required for workforce applicants (newly graduated therapists have one year to become licensed)
  - Personal interview with an Active Duty Physical Therapist

Recent News from Navy PT

Rosenthal MD et al; Physical Therapists Forward Deployed on Aircraft Carriers: A Retrospective Look at a Decade of Service, Military Medicine, 2018

- This report quantifies a 10-yr period of physical therapy services (PT and PT Technician) in providing musculoskeletal care within the carrier strike group and adds to existing literature demonstrating a high demand for musculoskeletal care in operational platforms.
- Access to early PT intervention aboard aircraft carriers was associated with a better utilization ratio (lower average number of visits per condition) than has been reported in prior studies and suggests an effective utilization of medical personnel resources.
- The impact of Navy PTs serving afloat highlights the importance of sustaining these billets and indicates the potential benefit of additional billet establishment to support operational platforms with high volumes of musculoskeletal injury.


- Graduation of 2017 class to include LCDR Joshua Halfpap
- Program Mission: To train and educate specialized, advanced-practicing physical therapists who maximize military readiness and health outcomes through patient care, research, and teaching
- This specialized, rigorous, and advanced orthopaedic manual therapy training program is designed to progress the examination and treatment skills of experienced physical therapists to the level of clinical expert for orthopaedic conditions, with a particular focus on manual therapy assessment and intervention.
PT Roles in the Development of Clinical Communities in Navy Medicine

- As part of the Military Health System (MHS) effort to become a High Reliability Organization (HRO), Navy Medicine has established six (6) Clinical Communities which are networks of multidisciplinary stakeholders with a specialized focus, who collaborate to drive change at the deckplate and enhance patient safety, clinical quality, and Readiness.
- Navy PTs currently Chair the Neuromusculoskeletal Subcommunities of Back Pain/Spine, Equipment Safety and Standardization, and Human Performance.

Army Update

Submitted by:
LTC Ian Lee, PT, DSc, MHA, MBA

The Army is leaning forward to place more physical therapists in Army units in support of the Holistic Health and Fitness (H2F) system. The current plan is approved, both uniformed and civilian physical therapists will support 90 Army brigades across the Army. Physical therapists will be members of high functioning teams that include nutritional, cognitive, strength and conditioning, and other musculoskeletal specialists working in functional fitness facilities. Based on current support for H2F, plans are underway to increase both military and civilian recruiting over the next several years.
US Public Health Service Update

Use of Physical Therapy in Combating the Opioid Crisis

Submitted by:
CAPT Jeffrey Lawrence, PT, DPT, OCS
U.S. Public Health Service

Since the introduction of the 5th Vital (Pain) sign by Joint Commission in 2001 as well as the introduction of OxyContin and other opioids for treating pain, the alarming trend of opioid abuse continues to make national headlines. The yearly U.S. death rate from opioid overdoses now almost equals or surpasses the total number of American lives lost (58,220) during our 16 year involvement during Vietnam War from 1959-1975.1

Our current U.S. Surgeon General Vice Admiral Jerome Adams, MD - 20th U.S. Surgeon General notes “The deaths from opioid overdose increased almost 5 times from 2001-2013”. We are now in the middle of an opioid epidemic that claims 115 lives each day in the United States – or one person every 12.5 minutes. In 2014, 47,055 drug overdoses deaths occurred in the United States with 61% of these deaths involved prescription opioids and heroin. Heroin overdoses have more than tripled between 2010 to 2014”2. Admiral Brett Giroir, MD, Department of Health and Human Services (HHS) Assistant Secretary of Health also recently noted during an interview the latest data shows 3 out of 4 persons who use heroin started with prescription opioid misuse.3

These statics mentioned only reflect the lives we have lost and do not take into account all of those who are addicted and those lives, families, and careers that have been devastated from this epidemic. Defeating the opioid epidemic is a national priority for our President and his Administration including our HHS Secretary Alex Azar, Assistant HHS Secretary Admiral Brett Giroir, MD and our U.S. Surgeon General Vice Admiral Jerome Adams, MD, as well as the 6,500 Commissioned Officers serving in the U.S. Public Health Service.

Our HHS Secretary, Assistant HHS Secretary and Surgeon General all have “Opioids and Addiction” as one of their top priorities. The Office of the Surgeon General released the first ever Surgeon General’s report on Substance Use and Addiction in November 2016. Facing Addiction in America: The Surgeon General’s Report on Alcohol, Drugs, and Health” addresses alcohol, illicit drugs, and prescription drug misuse with chapters dedicated to neurobiology, prevention, treatment, recovery, health systems integration and recommendations for the future. It provides an in-depth look at the science of substance use, disorders and addiction, calls for a cultural shift in the way Americans talk about the issue, and recommendation actions we can take to prevent and treat these conditions and promote recovery”.4

While many of the alarming trends are now well known, one of the lesser known alarming trends is the decrease in the utilization of physical therapy to help combat this epidemic. As any battlefield commander recognizes you need to use all available assets to combat and defeat ones enemy and win the war. However, one of our best assets (physical therapy) in our country’s battle with opioids currently looks to be vastly underutilized.

In a recent study by Freburger et al, the authors found that from 2003-2014 the referral rate for all musculoskeletal related physical therapy visits dropped by 50% from 94.4 per 1,000 to just 42.9 per 1,000.4 Conversely, referrals to specialist physicians for musculoskeletal related conditions increased at close to the same rate.4 Interestingly, a 2005 study by Moore JH et al found that the clinical diagnostic accuracy by physical therapists (PTs) and orthopaedic surgeons on musculoskeletal injured patients referred for magnetic resonance imaging (MRI) was significantly greater than non-orthopaedic providers. Additionally, there were no difference in clinical diagnostic accuracy noted between PTs and orthopaedic surgeons.5

Further noted is the recent viewpoint published in the May 2018 Journal of Orthopedic and Sports Physical Therapy by Mintken et al titled “Physical Therapists Role in Solving the Opioid Epidemic”. The authors noted that “Physical Therapists need to expand their educational efforts not only to our patients and communities, but also to physicians and other referral sources who continue to overprescribe opioids and under prescribe physical therapy.”6 The authors cited a study by Zheng et al that estimated 170 million individuals were consulted for low back pain between 1997 and 2010. Only 10% of these patients received a referral for physical therapy, while up 45% received an opioid prescription”.6

Mintken et al also aptly noted that “appropriate management of acute pain as the key to preventing progression to persistent pain.6 The authors cited a recent Gallup poll of 6,200 Americans showing 78% would prefer drug-free intervention.6 Respondents felt physical therapy was the safest and most effective drug free pain management approach, yet those surveyed would seek care from a physician (53%), Chiropractor (28%), Massage Therapist (7%), Physical Therapy (6%) respectively. The authors commented the following statement: “Unfortunately, there is a lack of public awareness about what physical therapy has to offer”.6

Making matters more frustrating, this alarming drop in physical therapy referrals and usage occurred even with the increases in entry-level education to clinical Doctor of Physical Therapy (DPT) programs for entry level and transitional advanced DPTs, as well as clinical residencies and fellowships for recent and seasoned therapists since the late 1990s thru 2018. Currently, approximately 96% of accredited physical therapy programs now offer the entry-level DPT degree and the remaining programs are planning to convert to the doctoral level by year 2020. Further data from the
American Physical Therapy Association (APTA) shows an expansion of direct access for physical therapy in the past 10+ years.

There is "some form" of direct access, per American Physical Therapy Association (APTA), in all 50 states, the District of Columbia, and the U.S. Virgin Islands. Drilling down, there is "unrestricted" patient access in 18 states. That is defined by the APTA as "No restrictions or limitations whatsoever for treatment absent a referral." Another issue that has been observed is the stress placed on patients as well as the emergency medical system noted by LeBec, M. and Jogodka, C. in the article titled “The PT as a Musculoskeletal Specialist in the ER". The article noted the following:

- Forty-five percent (45%) of all patients visiting ER said problems accessing Primary care is why they went to ER.
- Thirty-eight percent (38%) said they would NOT have gone to ER if they could have a scheduled provider visit in a reasonable time.

We have entered into a “Perfect Storm”. This is due to a combination of the escalation of opioid prescriptions leading to misuse, addiction and further for some to heroin use coupled with the significantly measureable drop in the utilization and access to physical therapy (due to decreases in referrals and public misconception of what PT can do to alleviate musculoskeletal pain, especially for acute patients). Additionally, many physical therapists are working using a physician based referral model that is vastly outdated with the educational advancements of physical therapy programs throughout the United States.

At our own federally run health center, we service a patient catchment area of 14,000 in a very remote region of the Northern Arizona. We have 11 providers (MD/mid-level) on staff. We additionally employee three (3) full time physical therapist here at our location. The physical therapists also serve on the medical staff.

Our physical therapy department opened in 2006. We have recognized areas for improvement through ongoing patient tracking and surveys. We realized that we had a patient show rate and provider referral issue, especially with our acute patients. About 65% of our total patients were keeping their initial evaluation and about 70% would keep their follow up appointments due to a variety of issues. Some unique to the socio-economic and physical environment we work in. One of the biggest environmental factors is that almost 80% of the roads in our area are unpaved and barely maintained and many patients do not have adequate transportation.

We realized that the sooner we treat the acute patient the less likely they will become chronic and rely on medications for pain management. We surmised we would ultimately gain a better show rate. We conducted a series of five (5) major initiatives to improve patient care, improve our patient show rates and satisfaction ratings since opening.

These five (5) initiatives were improving Patient Care (IPC) Plan-Do-Study-Acts (PDSAs) which were conducted from 2012-2016 and are as follows:

1. Reminder Phone call PDSAs (2012): We had pre-appointment 24-hour reminder phone calls to see if this would improve evaluation show rates. Results demonstrated no significant improvement for initial evaluation visits especially with chronic conditions.
2. “You have to Show Up to Improve”: Acute vs. Chronic Scheduling (2013): PT department sent invitation letters to “chronic” patients that were referred by in house providers to actually have them schedule with PT versus just automatically scheduling the patient. This decreased our chronic no-show rate patients by 6% and afforded more scheduling slots for acute patients.
3. Does PT Work - Comparing acute vs. chronic Visits/Outcomes (2013): This was a 1-year retrospective chart review of acute versus chronic patients based on clinical outcome measures. We found 85% of acute patients demonstrated a statistically significant improvement in their outcomes measures. Patients who completed PT demonstrated a statistically significant improvement in their outcomes measures vs 50% of our Chronic Patients surveyed. These results were achieved with only 4.78 visits per patient.
4. Vestibular PT Outcomes Chart Reviews (May 2015): 95% of our treatable vestibular patients reported “getting better” in 1-4 visits.
5. Specialty Ortho Chart Reviews (June 2015 to June 2016): We reviewed all orthopaedic consults sent out of house by our providers and found 75% of these referrals were for chronic conditions and only 22% of all of these referrals sent out of house to orthopaedics were ever referred to physical therapy.

In 2013, our health center’s medical director recognized that the opioid issue was spiraling in the wrong direction. He then mobilized a chronic pain team to get ahead of this issue. The team consists of primary providers, pharmacists, counseling, physical therapists and complementary medicine. The team meets bi-monthly to review our chronic pain patients, their medications and other treatment options they may or may not have been receiving. Since the formation of the chronic pain team at our center, the results have been significantly trending positive helping reduce opioid reduction at our health center by over 60% in both prescription and use.

Based on our Health Center’s chronic pain initiative and our departments previous PDSAs, by late 2015 we began working on an improved model of care for our patient care delivery that we would start testing in January 2016. One article published in 2001 by Flynn et al and their clinical commentary on “Appropriate Use of Diagnostic Imaging in Low Back Pain: A Reminder That Unnecessary Imaging May do as Much harm as Good” really caught our attention. In this article, the authors mention the Virginia Mason example for a Pathway for Low Back Pain (LBP) management with old and new model/approaches.

The “Old model/Approach” of treating musculoskeletal LBP
typically flows as follows:
- Patient has their initial meeting with physician or mid-level (Note: this might take a month to occur and then there is no set procedure for treatment).
- Next, the patient may see a specialist then undergo diagnostics, such as MRI.
- Then additional follow up with the doctor or mid-level provider.
- Then maybe get a referral for physical therapy and/or possibly sent for additional specialist follow up.
- The health care costs for this “Old Model” at the time of this commentary’s publication in 2011 was between $2100-$2200 per patient.

In the “Direct Access New Model/Approach”:
- The patient with LBP immediately sees the physical therapist and bypasses the initial medical doctor or mid-level provider visit.\(^9\)
- The physical therapist decides to treat and/or refer patient to a specialist.\(^9\)
- The health care costs associated with the “New Model” at the time of this commentary’s publication in 2011 was between $900-$1,000 per patient.

Based on the “New Model” and in conjunction with our chronic pain team and our own previous improvement tests of change we moved forward to do a 6 month Pilot Test from 2016-17 on: “The Use of Physical Therapy with Urgent Care and Direct Access Patient Care for Acute Musculoskeletal Conditions”.

We used the various resources to help guide us.\(^8,12\) After reviewing these resources our department established seven (7) goals that we wanted to accomplish:

1. Evaluate acute patients at point of entry.
2. Improve same day access and follow ups.
3. Improve patient outcomes, education and satisfaction.
4. Help further screen patients prior to possible further specialist consultation or tests to reduce unnecessary medication, imaging/specialist referrals and reduce unnecessary extra health care costs.
5. Help decrease indirect expenditure, such as time off work.
6. Help prevent patients from becoming chronic pain patients.
7. Avoid provider burnout/overload.

We comprehensively educated our providers and nursing/triage staff and stakeholders on the benefits of physical therapy for acute musculoskeletal pain and presented the overview of our pilot program. We designed a schedule to have one of our therapists on a daily basis cover mornings or afternoon as the on call therapist with our Urgent Care and Out Patient Clinic. Therapist patient schedules were modified and we opened up predesignated “Direct Access” acute care slots in the mornings and afternoons.

The conclusion of this pilot test’s results were very positive:
- Our total monthly referrals for acute based musculoskeletal related conditions increased by 15%.
- Patient appointment show rates for these patients increased from 65% to 90%.
- Patient satisfaction surveys improved with these acute patients from 94 to 98% with our acute patients.
- Outcome driven data collection demonstrated 85% of our patients met their patient goals and outcomes.
- Our therapy staff all were very positive and satisfied 95% with this pilot study test of change, as were our medical providers.

Based on this data we immediately moved forward and implemented this program with our department. Our greatest struggle has been our medical/nursing provider turnover due to our very isolated and remote location. Because of this and we are now looking to further refine and advance this model for our patients and health center and go to full “Direct Access” for all of our patients not just acute. We are highly confident our patients and staff will happily embrace this change.

References:
We saw an opportunity to implement a new intervention to combat this decline and go beyond traditional rehabilitation after amputation. Of course, we weren’t looking for the next offensive tackle to take on linebackers like NFL Denver Broncos’ Von Miller. We did have veterans looking to get to the next level and be able to confidently navigate throughout the community, as well as improve balance and build endurance.

The ideal candidate for our agility clinic is a veteran who has undergone a lower extremity amputation, transtibial or transfemoral, unilateral or bilateral. They must have intact skin, or wounds that are progressively healing. They must be successfully ambulatory using their prosthetic leg at a K2 or low K3 level (see fig. 1). We chose to not include those that have wounds greater than four weeks old, are not ambulatory, or those that have not been medically cleared for vigorous activity.

We then looked for the ideal intervention for our participants. After a few iterations, we finally settled on an agility program included within the article “Agility and Perturbation Training for a Physically Active Individual with Knee Osteoarthritis” published by Fitzgerald, et al. She developed this program in a case study for one of her patients suffering from knee osteoarthritis. Not surprising, this program is not fast paced and would not be extreme enough for the NFL combine. However, it has been shown that adding agility and balance training techniques to general rehabilitation exercise programs can make them much more effective. This particular program was made up of ten sessions at a frequency of two 30-minute visits per week. We modified this for our clinic and combined visits to make one 60-minute session per week for five weeks and then repeated the program for a total of ten visits. We then added two sessions, one at the beginning of the clinic and one at the end, for pre- and post-outcome measures. The detailed protocol is found in fig. 2. It is made up of activities such as side stepping; crossover stepping; backward walking; sudden starts; stops, and changes in direction during walking; using multidirectional and translational perturbations of support surfaces during balance training. The veterans also perform these activities in variable order and at variable speeds. Fitzgerald proposes this wide variety of techniques incorporated in the program provide balance challenges to the patients and allow them to solve these “novel movement problems.”

Typical agility programs are running based and performed at high speed. Conversely, another attractive feature of Fitzgerald’s program is that activities are carried out at walking speed so as not to overload joint structures, leading to increased pain, swelling, and inflammation. The participants will continue to reap benefits from these activities by challenging knee stability in a controlled manner, developing motor skills adequate to protect the knee from potentially harmful loads during functional activities. We propose following amputation, our veterans will benefit from the same approach. Our participants are generally one to two years out from their amputations. Their residual limbs are continuing to mature and get used to the new socket pressures resulting from walking and navigating obstacles in their daily lives. They lack proprioception in their new prostheses and many times in their neuropathic “sound” limbs. Overall, these agility techniques similarly challenge our participants to solve movement problems.
and build confidence after prosthetic restoration. Our belief is that this will improve functional mobility and help with community reintegration.

We have been pleased with the initial outcomes, albeit we have had a small number of participants who have finished the protocol. Thus far, we have had fourteen veterans participate in the agility clinic, four following transfemoral amputation, nine following transtibial amputation and one with bilateral amputation (TFA/TTA). We do collect a slew of outcome measures before and after training. Namely, we collect the Amputation Mobility Predictor (AMP), Two-Minute Walk Test (2MWT), Timed Up-and-Go (TUG), Four Square Step Test (FSST), Dynamic Motion Analysis (DMA) from the Proprio 5000 balance platform, and the Stair Climbing Power Test. We also collect self-reported measures, specifically the WHO Disability Assessment Scale 2.0 (WHODAS 2.0), the Prosthetic Socket Fit Comfort Score (SCS), and finally the Prosthetic Evaluation Questionnaire (PEQ).

We have had a variety of results from our outcome measures. However, the seemingly most robust measure appears to be the Amputee Mobility Predictor (AMP). This test is easy to perform (with or without a prosthesis) and efficient for valuable clinic time (10-15 minutes). For the majority of our participants, the AMP seems to reflect functional improvements following the agility clinic protocol. Eleven out of our fourteen participants demonstrated an improved score on the AMP and remarkably, ten veterans improved by moving up a full K-level with one even moving two designations! Remember that the K-levels describe specific functional activity levels. It appears the agility clinic protocol has the desired effect of improving our veteran's balance and effectively improving their function and confidence.

We look forward to continuing to collect data in our ongoing clinic to determine if there truly is a statistically significant improvement in our veteran's balance and function resulting from the clinic. For the clinicians out there, keep this protocol in mind for your next patient that you think may benefit. Amputees, those with knee osteoarthritis, likely a variety of diagnoses fit the bill. Being creative, we can continue to improve our veteran's outcomes. Who knows... you may, in fact, identify the next NFL superstar!

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References:


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Fig. 1 K-Levels

| K-Level 0 | Does not have the ability or potential to ambulate or transfer safely with or without assistance, and a prosthesis does not enhance quality of life or mobility. |
| K-Level 1 | Has the ability or potential to use a prosthesis for transfers or ambulation in level surfaces at a fixed cadence. Typical of the limited and unlimited household ambulator. |
| K-Level 2 | Has the ability or potential for ambulation with the ability to transverse low-level environmental barriers such as curbs, stairs, or uneven surfaces. Typical of the limited community ambulator. |
| K-Level 3 | Has the ability or potential for ambulation with variable cadence. Typical of the community ambulator who has the ability to transverse most environmental barriers and may have vocational, therapeutic, or exercise activity that demands prosthetic use beyond simple locomotion. |
| K-Level 4 | Has the ability or potential for prosthetic ambulation that exceeds basic ambulation skills, exhibiting high impact, stress, or energy levels. Typical of the prosthetic demands of the child, active adult, or athlete. |
Fig. 2 Agility Clinic Protocol

Week 1 and 6
- Front crossover steps walking forward 20’ x 3
- Back crossover steps walking backwards 20’ x 3
- Side-Stepping 20’x 3 sets
- Single-leg standing on foam surface, no perturbations 10 sec x 3 sets
- Roller-board perturbation 10 sec x 3 sets

Week 2 and 7
- Front crossover steps walking forward 30’ x 3
- Back crossover steps walking backwards 30’ x 3
- Side-Stepping 30’x 3 sets
- Braiding 10’ x 3 sets
- Single-leg standing on foam surface, no perturbations 20 sec x 3 sets
- Roller-board perturbation 20 sec x 3 sets

Week 3 and 8
- Front crossover steps walking forward 30’ x 3
- Back crossover steps walking backwards 30’ x 3
- Side-Stepping 30’x 3 sets
- Braiding 20’ x 3 sets
- Shuttle Walking x 2 sets
- Multiple direction changes during walking 20 sec x 2
- Single-leg standing on foam surface, with perturbations 30 sec x 3 sets
- Roller-board perturbation 10 sec x 3 sets
- Tilt-board anteroposterior and mediolateral 10 sec x 2 sets

Week 4 and 9
- Front crossover steps walking forward 30’x3
- Back crossover steps walking backwards 30’x3
- Side-Stepping 30’x 3 sets
- Braiding 20’ x 3 sets
- Shuttle Walking x 2 sets
- Multiple direction changes during walking 20 sec x 2
- Obstacle course 1 set
- Single-leg standing on foam surface, with perturbations 30 sec x 3 sets
- Roller-board perturbation 30 sec x 3 sets
- Tilt-board anteroposterior and mediolateral 30 sec x 2 sets

Week 5 and 10
- Front crossover steps walking forward 50’ x 3
- Back crossover steps walking backwards 50’ x 3
- Side-Stepping 50’x 3 sets
- Braiding 50’ x 3 sets
- Shuttle Walking x 2 sets
- Multiple direction changes during walking 30 sec x 2
- Obstacle course 1 set
- Single-leg standing on foam surface, with perturbations 30 sec x 3 sets
- Roller-board perturbation 30 sec x 3 sets
- Tilt-board anteroposterior and mediolateral 30 sec x 2 sets
Veterans Affairs

Residency Training Program

Submitted by:
Bill Wenninger MSPT

The Department of Veterans Affairs (VA) started a Physical Therapy (PT) Residency training program ten years ago. The program has grown from 1 resident to 42 positions heading into the second decade of the program. This is the largest PT Residency training program in the country. The program is funded by the Office of Academic Affiliations (OAA) who also supports the PT pre-professional stipend program in VA. The program continues to grow and to consistently provide quality educational experiences to meet the growing demand for this kind of training both in VA and in the overall health care system in the country.

VA PT Residency training consists of 27 programs at 17 facilities and include Orthopedic Clinical Specialist (OCS), Cardio-pulmonary Clinical Specialist (CCS), Neurological Clinical Specialist (NCS) and Geriatric Clinical Specialist (GCS). Aside from the 7 latest programs just added in June 2018, all the programs have been accredited by the American Board of Physical Therapy Residency and Fellowship Education (ABPTRFE). Accreditation reviews curriculum of the program, mentorship by the faculty, consistency with the Description of Residency Practice which is published by ABPTRFE, outcome measures of the program, and satisfaction of the residents in the program. The initial accreditation is for 5 years and now several programs have successfully passed the second round of accreditation and are accredited for 10 years. See the listing of programs in the following table:

<table>
<thead>
<tr>
<th>Location</th>
<th>Residency Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ann Arbor, MI</td>
<td>Cardiovascular and Pulmonary¹</td>
</tr>
<tr>
<td>Boston, MA</td>
<td>Neurologic¹</td>
</tr>
<tr>
<td>Cincinnati, OH</td>
<td>Geriatric¹, Neurologic¹ &amp; Orthopedic²</td>
</tr>
<tr>
<td>Cleveland, OH</td>
<td>Geriatrics¹ &amp; Orthopedic¹</td>
</tr>
<tr>
<td>Denver, CO</td>
<td>Geriatric¹, Neurologic¹ &amp; Orthopedic¹</td>
</tr>
<tr>
<td>Durham, NC</td>
<td>Geriatrics¹ &amp; Orthopedic¹</td>
</tr>
<tr>
<td>Gainesville, FL</td>
<td>Geriatrics¹ &amp; Orthopedic¹</td>
</tr>
<tr>
<td>Greater Los Angeles, CA</td>
<td>Orthopedic²</td>
</tr>
<tr>
<td>Madison, WI</td>
<td>Cardiovascular and Pulmonary¹</td>
</tr>
<tr>
<td>Milwaukee, WI</td>
<td>Neurologic¹</td>
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<tr>
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<td>Neurologic¹</td>
</tr>
<tr>
<td>Mountain Home, TN</td>
<td>Orthopedic¹</td>
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<tr>
<td>Palo Alto, CA</td>
<td>Geriatrics¹</td>
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<td>Orthopedic¹</td>
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<tr>
<td>St. Louis, MO</td>
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<tr>
<td>Tampa, FL</td>
<td>Neurologic¹ &amp; Orthopedic¹</td>
</tr>
<tr>
<td>Washington, DC</td>
<td>Orthopedic¹</td>
</tr>
</tbody>
</table>

¹ Accredited programs, ² Developing programs

There has been high demand to create programming across the VA system and the VA residencies have had high numbers of Physical Therapists applying to be accepted to one of the programs. The last request for proposal announcement that was issued by OAA had 19 applications for 7 positions. The review panel selected 5 facilities to distribute the new positions bringing the total number of PT residents starting in the summer of 2019 to 42. The application process for PT Residency programs has been equally competitive – for academic year 2017, VA had 60 applications for 27 positions, in academic year 2018, VA had 66 applications for 33 vacancies. VA recruits new Physical Therapy graduates and Physical Therapists that have been practicing in the private sector. Approximately half of the PTs that accept VA Residency positions have been practicing for more than a year. This means that they are leaving higher paying private sector jobs to come to the VA training program for, sometimes, half the salary they had been receiving.

The quality of the programming is consistently being monitored. In addition to the success in accreditation, the VA is also measuring the pass rate for the board examination administered by the ABPTRFE. To date, VA has had 104 graduates eligible to take the board certification test in their respective specialties, 95 have become board certified – 91% have passed the test. ABPTRFE indicates that the normal pass rate is 60% so the VA training is rigorous and is preparing the residents well for passing the board examination. The program has produced 11 CCS, 18 GCS, 30 NCS and 36 OCS.

Physical Therapy in the VA continues to be in high demand and the Physical Therapists remain the difficult to recruit and retain list as published by VA Workforce Management. Training programs like this have enabled VA to provide excellent opportunities for both recruitment of highly qualified therapists and to encourage retention of existing staff by providing mentoring and teaching opportunities to existing dedicated Physical Therapists. To date, VA has hired 48 of the 104 graduates – just under 50%. Initially this hiring had been primarily at the facilities that have the residency programs, however, as the program has grown, more graduates have been willing to accept PT positions at other VA facilities as they have enjoyed their experience and seek to make a career out of serving Veterans.

The future of the program is bright and there is no sign of the popularity of the program diminishing. VA is looking at new initiatives for this program such as VA resident presentations at the Combined Sections Meeting of the American Physical Therapy Association and at recording continuing education which can be distributed to other Physical Therapists for continuing education. One of the Missions of the VA is to provide education that not only supports the VA but also the healthcare system across the country. The VA PT Residency program is an excellent example of a successful program making a significant contribution to the overall needs of the VA and beyond.
FPTS Student Liaison Message

Amber Horn, SPT, University of Miami, Department of PT

As the Federal Physical Therapy Section’s Student Liaison, it is my pleasure to be a part of an organization that is focused on promoting quality health care to those served by therapists employed by the Federal government, which include the United States military, Department of Veterans Affairs, Public Health Service, and other federal agencies.

Every year, the Student Liaison and other Federal Section leaders attend the APTA’s National Student Conclave and Combined Sections Meeting to provide face-to-face information sessions and learning opportunities to students and other therapists who are interested in serving in the Federal government. At these national events, I am privileged to be able to meet my fellow student therapists from across the country and provide them with information on residencies, scholarships, and job opportunities provided by the federal sector. Additionally, Federal Section student members who are interested in providing care to those with limb loss have the opportunity to join the Amputation Care Special Interest Group, which is an excellent resource for cutting edge education on limb loss. Finally, the Federal Physical Therapy Section provides an excellent opportunity for student members to build their professional network with those who are experts in providing care to those in the Uniformed Services and our nation’s veterans.

Joining the Federal Section as a student has been such a rewarding experience and I look forward to serving as an information source to other students who are interested in serving our population.
CSM Scholarship

The FPTS is offering scholarships to cover the cost of early bird registration for Combined Sections Meeting 23 JAN – 26 JAN 2019 in Washington, DC for (3) qualified students interested in pursuing physical therapy careers within the federal government and (1) for an early career section member.

Student Physical Therapist Scholarships (2)
• Student must be a FPTS member
• Student must be a second or third year DPT student
• Student should be seriously considering federal employment upon graduation
  Student must submit the following to federalptsection@federalpt.org as a PDF packet
    o Brief statement (no more than 1 page) outlining why you wish to work as a federal PT
    o Professional resume
    o 1 letter of recommendation from a PT or professor

Post professional Student Scholarship (1)
• Student must be a FPTS member enrolled in a post professional graduate educational degree program or residency program for physical therapists
• Student should be seriously considering federal employment upon graduation
  Student must submit the following to federalptsection@federalpt.org as a PDF packet
    o Brief statement (no more than 1 page) outlining why you wish to work as a federal PT
    o Professional resume
    o 1 letter of recommendation from a professor/residency director

Early Career Member Scholarship (1)
• Applicant must be a FPTS member
• Applicant must have graduated from a PT or PTA program no more than 5 years from Sept 1, 2018
• Applicant must submit the following to federalptsection@federalpt.org
  o Brief statement (no more than 1 page) outlining how attending CSM would enhance the applicant’s professional or clinical practice

Submission Deadline: 21 September 2018

Selection:
All applications will be submitted to the FPTS board of directors. Those with the most relevant qualifications will be selected and be notified via e-mail no later than 26 October 2018. Those selected will be given a check at the FPTS business meeting at CSM 2019.
Getting a Federal Job

How can I get a job in the federal sector or in the military? This is one of the most frequently asked questions we receive. There is no simple answer to this question. We've compiled information from the various service areas that will be helpful.

Employment in the Navy
Those interested in becoming an Active Duty Navy PT should contact their local medical recruiter. The recruiter will be able to provide the number of opportunities available for joining the Navy that year and guide you in the administrative processes for recruitment. Information about Navy PT can be found at [HERE].

To qualify for Active Duty employment consideration as a Physical Therapist in the Navy Medical Service Corps, you must meet these basic requirements:

- Be a U.S. citizen currently practicing in the U.S.
- Master of Science or doctoral degree in physical therapy (entry-level or advanced) from an institution accredited by the American Physical Therapy Association (APTA)
- GPA of 3.0 or higher on a 4.0 scale
- Be willing to serve a minimum of three years of Active Duty
- Be between the ages of 18 and 41
- Be in good physical condition and pass a full medical examination

You may also be expected to meet certain preferred requirements:

- Previous experience as a physical therapist (constructive credit for work experience now offered to physical therapists)
- Letter of recommendation from a physical therapist currently serving in the military
- Professional and personal recommendations (letter of reference from professor[s] for new graduates, or letter of reference from supervisors in physical therapy for workforce applicants)
- Current licensure required for workforce applicants (newly graduated therapists have one year to become licensed)
- Personal interview with an Active Duty Physical Therapist

Employment in the VA
USA JOBS, VA CAREERS: Keep an eye out here for any job postings and set alerts in USAJOBS to be automatically notified when a job opens.

Reaching out to your local VA HR department and Chief of PT/ Documents to include are your resume, license, certifications and transcripts (DD214, SF15, Rating Letter, if a Veteran Applicant). Additional avenues if you’re a student:

a. Seek out internships that your program already has with the VA or, if that relationship doesn't already exist, inquire about how to start one. If you're successful getting your foot in the door at the VA this way, if nothing else you can at least use people there as references and that experience/reference can be valuable.

b. Residencies and/or applying to positions that are not local – we have several residencies throughout the country in different specialties and usually there is a variety of openings across the country. If you are open to the idea, applying to a residency and/or accepting a position that is not local to your area is a great way to get in the system. Once you are in the VA, it sometimes is easier to move laterally within the VA as opposed to applying outright from outside the system.

Employment in the USPHS
Attention potential U.S. Public Health Service Commissioned Corps applicants!

When: Continuous starting June 1, 2017

Who: The general public, Uniformed Service members and Civil Service employees that meet the following criteria:

- Hold a qualifying/eligible degree in Physical Therapy
- Currently hold an unrestricted, valid licensure/registration
- U.S. native or naturalized citizen
- Less than 44 years of age (this may be adjusted based on eligible federal PHS civil service and uniform service active duty time)
- Less than 8 years of prior active duty service in any uniformed service other than the Commissioned Corps
- Meet suitability, professional, medical and security requirements

Interested in becoming a USPHS Commissioned Corps Officer? Visit the [www.usphs.gov] website for details.

The priority is to fill clinical vacancies specifically with an emphasis on the Indian Health Service (IHS).

Potential applicants should direct their recruitment process and eligibility-related questions to the Commissioned Corps via 1-800-279-1605 or corpsrecruitment@hhs.gov.

The updated clinical vacancy list for therapists in the USPHS can be found at [HERE].
Physical Therapy’s Role in Disaster Management

Submitted By:
Stephanie Christman PT, DPT, OCS, WCC
Michael Heinrich PT, DPT

On September 23, 2017, Hurricane Maria made landfall on Puerto Rico after an already busy tropical storm season. In response, Federal Emergency Management Agency (FEMA) coordinated disaster management services to assist with infrastructure repair, medical relief, and resource management (i.e. food, water, utilities). Veterans Health Administration (VA) became involved when deployed by FEMA to assist with medical services at Manati, Puerto Rico. This was a relatively novel incorporation of joint federal services into a Field Medical Shelter (FMS) including Health and Human Services, Army, National Guard and VA.

The VA supports such missions by calling on a national volunteer resource called Disaster Emergency Medical Personnel System (DEMPS), deploying VA clinical personnel for 14 day deployments (or waves) into disaster areas. DEMPS involvement included mainly inpatient services required to assist with the care of an array of patient needs from acute injury, through long term care and hospice. Personnel included nursing and medical providers alongside some ancillary services such as respiratory therapy and pharmacy.

During the fourth wave, Physical Therapy was included in personnel requests for deployment. Pooled from the established DEMPS roster, two physical therapists (PT’s) volunteered for service and were incorporated into FMS operations by November 3rd and 5th. One PT with a background in orthopedic care and Emergency Room service, and one PT with inpatient rehab and long term care experience.

Without previous staff to lean on for established care patterns, the priority for the incoming PT’s was to establish services, requiring strength in specific professional skillsets. Communication and networking with existing onsite teams was imperative. Understanding that many providers have limited knowledge regarding the expertise and competence of today’s PT is critical. Offering this initial piece of information to other clinical staff in an effective and efficient way is crucial if physical therapy is to be utilized in impactful clinical care. Otherwise, PT’s can fall into traps of being underutilized and assigned to tasks or roles that undercut the full clinical potential. This may lead to a loss for the clinical team as well as the patient’s they serve.

Secondly, the therapists needed to develop a needs assessment based on the current system in place. This requires identification of existing services and resources, building an awareness of patient management, and gain an understanding of current patient needs. Services and resources included FMS Manati emergency services, medical triage, minor procedures or long term care shelter, wound care, and supportive clinical care. Only those patients with the most complex or critical needs were transported to either nearby medical facilities or the USNS Comfort.

Once the initial FMS needs were assessed from a systems perspective at Manati, the therapists could identify and take on specific responsibilities. All patients required evaluations to determine general history and current function. A large portion of patients were found to have mobility limitations, partially due to
to limited activity in recent weeks related to staff availability and safety concerns. Based on initial encounters with all ‘inpatients’, PT determined plans of care including recommendations, equipment, and fall precautions. From this point, the physical therapists established care and treatments on a daily basis with consideration for modalities, orthopedic interventions, wound and skin care, interdisciplinary care, and more.

RESPONSIBILITIES

There were approximately 40 patients on PT caseload leading to a question of staff availability and realistic expectations for covering patient care. During deployment, clinicians were responsible for 12-hour shifts each day, allowing for larger than typical daily caseload (i.e. 8-hr days). However, utilization of local resources and creative thinking were also needed. Local physical therapy assistant students from Atenas College were already pursuing volunteerism at FMS Manatí when the DEMPS PTs arrived. These students were able to be mentored and utilized to maximize patient treatments during weekdays. DEMPS PTs, in collaboration with school faculty, could provide oversight to the students’ treatment assignments and interventions while completing clinical experiences. Patient recreation groups were used to increase overall physical activity levels and social engagement each afternoon as well. Further, connecting, networking, and supporting with other clinical staff allowed for functionally therapeutic encounters throughout the day alongside of routine nursing care.

FMS Manatí also provided medical triage services to the local community including wound care, minor orthopedic assessment, and in some cases, more urgent medical assessment. Physical therapy contributed to active wound management including debridement and application of electrical stimulation. There were cases that also allowed the therapists to assist in more aggressive limb management and orthopedic interventions aimed at preserving limb function and viability until permanent interventions were available in community hospitals or at patients’ final destinations on mainland US.

A unique experience during deployed service included the austere conditions where clinical staff bunked together very near the area of patient care. This inevitably shifts clinical perspective somewhat from the more typical patient-focused clinical setting to one of total community care. From a physical therapy perspective, staff health and wellness and the ability to serve the surrounding community were inextricably connected. In shifting focus somewhat to include personnel, the physical therapists encouraged other clinicians in physical activity, safe patient handling practices, and recreation. Likewise, other clinical staff promoted, general wellness in nutrition and immune support practices.

As alluded to, the living conditions at FMS were austere in that potable water and electrical resources were limited and or unstable. Power failures were frequent. Water, sanitation, and sewage pressures were unreliable. That said, all personnel and patients had permanent shelter at a local sports arena in a secure complex. Food was available consistently from local vendors, Veteran's Canteen Services, and Meals Ready to Eat (MRE's). Workdays were long and required a significant amount of teamwork and resilience. By utilizing strong team-oriented organization and human resource management practices, such as morning and evening meetings, daily motivations, and celebration of small and large successes, the personnel of FMS Manatí could...
OUTCOMES
From a physical therapy standpoint, specifically, positive outcomes were achieved within a small window of time (13 days) considering the full deployment period of FMS Manati (63 days). Patients who were mostly non-ambulatory upon arrival were able to transition from FMS care to lower levels of skilled care or even home in some cases. Some patients required long travel plans to connect with family in the mainland US or across the island of Puerto Rico, requiring medical clearance and physical tolerance to such travel. There were cases of collaboration between medical, nursing, and physical therapy staff to offload and optimize wound care. One case of limb salvage occurred requiring rigid casting and offloading in preparation for both travel and eventual surgery.

Beyond this, PT services facilitated a change in culture and paradigm that is often overlooked in medical facilities, a culture of movement and utilization of conservative management. The addition of PT services strengthened and focused clinical perspectives to patient activity. With trained PT personnel, this can be paired with expertise in a wide range of patient management, differential diagnosis, and creative delivery of conservative interventions. It is the hope of these writers that two perspectives can be highlighted based on the experience at FMS Manati. The first lies on the shoulders of the physical therapy profession. Physical therapists are touting ever growing skill levels and a doctoring profession. The individuals within the profession, then, have a responsibility to embrace the growth of the field into less traditional clinical settings that further test and strengthen the full scope of practice. Deploying to a disaster location is a prime example. Physical therapy can play a role in outreach to communities in need or may take the form of volunteerism in underserved communities or austere healthcare systems. Regardless of the program or outreach, true medical differential diagnosis, collaborative patient management, and excellence in resource management should be an expectation.

The second paradigm shift would require leadership in outreach and managing organizations. There needs to be a shift in understanding the competencies and benefits of physical therapists in these austere practice settings, both in patient care delivery as well as personnel management / support. To date, there are no positions in Health and Human service DMAT teams (Disaster Medical Assistance Teams) that are first responders to natural and man-made disasters. Including education beyond the physical therapy realm to community and federal organizations and leadership, is integral to physical therapy consideration. Organizations that contain physical therapy need to ensure staff are aware of opportunities for inclusion in the DEMPS program, as well as any other roles that may be outside the normal realm of physical therapy.

Functional success at FMS Manati was directly due to physical therapy participation at the level of a doctoring profession. It was a fantastic example of how a higher level of practice can impact patients in meaningful ways that allows a more rapid recovery, return to prior function, and re-integration into a community that needs as many viable members as it can get, to also recover in and of itself. The field of physical therapy is moving forward, and these opportunities will begin to present themselves with greater frequency and it is up to leadership, and the profession, to embrace our role and prepare future leaders to recognize potential avenues for successful physical therapy integration that are challenge our traditional scope.