March MADNESS

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Do you toss and turn at night? Can’t seem to find a comfortable position? Does your back ache when you awake? These are signs that your mattress may not be supporting you properly, robbing you of the sleep you need. SUFFER NO MORE!

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Best of all, each side of the SLEEP NUMBER® bed adjusts independently, making it the perfect bed for couples.

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*Descriptions of clinical studies conducted on the Sleep Number bed are available at 1-800-831-1211. †If not satisfied after 30 nights, call within 45 days of delivery to arrange return. No returns or exchanges on Precision Comfort® Adjustable Foundation, dressside or demo bed models. ‡Up to $1,784.99, depending on bed. Reflects King Sleep Number® i10 bed set with 2 wireless remotes. Other applies to Sleep Number® core beds and is subject to change at any time. Valid through 12/31/10 at all Select Comfort Sleep Number® retail locations. Not valid in combination with current in-store promotional offer. Limit one discount per person within an offer period. Not valid on Refurbished or Factory Outlet beds, Precision Comfort® Adjustable Foundation, Sleep Number® Special or Limited Edition beds, accessories or at Retail Partners. Not valid on previous purchases. Must present valid and current state professional license at time of purchase. Shipping and billing address must be the same. ©2010 Select Comfort.
A New Paradigm: The Patient as Consumer
Ready or not, here they are. They're not just patients. They’re not just clients. They’re also consumers: purchasers of health care with strong likes and dislikes who spend money to achieve their health goals. Your challenge: Develop effective ways to market to, then treat and retain, your consumers.

Free to Lead
Student-run pro bono clinics are benefiting patients and future PTs.

Contemporary Topics in Health Care: The Patient-Centered Medical Home
Think of a hub, a home base, or a patient’s personal network in which the mix of providers—including physical therapist, primary physician, other health professionals—and family collaborate with the patient within the patient’s plan of care.

Health Care Technology Today
A look at physical therapy’s presence on YouTube.
A physical therapist’s story...

Get to the clinic by 8:00 a.m. Review the day’s schedule. Discover treadmill is acting up again. First patient is a 46 year old woman. She had arthroscopic knee surgery and is back for her third visit. Review her chart and reassess. Since last appointment her range of motion has improved by 20%. Provide manual techniques and add to home program. Tell her this will gain another 10%. Patient leaves with a smile. Document each patient’s findings throughout the day... Their pain level. The treatment provided. What goals were (or weren’t) achieved. And the next visit’s treatment plan. I can’t believe it’s already lunchtime. Call service company to repair treadmill. Recall reading lawsuits due to equipment malfunctions result in an average settlement of $30,000.*

Thank goodness I have coverage through HPSO!!

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*CNA HealthPro Physical Therapy Claims Study, September 2006. To read the complete study along with risk management recommendations visit www.hpsocom/ptclaimstudy

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*Rate is for full-time, employed physical therapist. Rates may vary by state.

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Minding Your PQRI
By participating in the Physician Quality Reporting Initiative, you can receive a 2% bonus payment from Medicare.

Opening the Gift
The keys to fully tapping each individual’s talents.

Retired but Not Retiring
A veteran PTA looks back—and ahead.

Discomfort Zone
Ethical concerns when optimal care-giving becomes a stretch.

Community Service
A PT gets himself, then his neighbors, moving.

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Fed up with forms?

It’s not your imagination. Over the past decade, in order to get reimbursed for patient care, your efficiency has been compromised by an avalanche of forms. ECLIPSE can help put you back in the driver’s seat by automating part or all of this tedious process. Forms can be imported, scanned, or designed from scratch. Create fields on the form and tie them to data (e.g. patient names, addresses, etc.) with simple dropdown lists. Or, create your own fields and we’ll store the data as part of the patient’s Electronic Health Record. Of course, we already maintain a library of form templates that you can select from.

Our extensive billing & scheduling capabilities have received accolades from your colleagues, management consultants, provider networks, and other independent sources for years. Now, see what it’s like to go truly paperless. Any report can be generated as a PDF, saved, and annotated in a WYSIWYG environment. All PDF files are encrypted and cannot be opened outside ECLIPSE without the user’s password.

ECLIPSE is a complete practice management system & has been in daily use at thousands of locations throughout the United States for over 20 years. ECLIPSE includes billing, scheduling, EHR (electronic health record), WYSIWYG daily notes, an extensive alerts system, certified HIPAA compliant electronic claims & remittance, security features that include patient data access tracking to help you run a HIPAA compliant facility, and myriad reports fine-tuned by two decades of client feedback. Retrieve multiple patient folders as you need them without backing out of previous activity. You save time & money by keeping your office at peak efficiency. Patient folders have simple point & click tabs so novices can learn quickly. The appearance of the patient ledger and appointment scheduler can even be customized for each workstation in your office.

The Alerts system is an automatic database that can target specific users, specific patients, or all office personnel with different priority alert messages. Alerts are displayed as both system wide and patient specific text messages.

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6 March 2010

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APTA-Endorsed Member Benefits are designed to offer you exceptional benefits at great value.

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- **Credit Card Program - Individual**
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To learn more about these benefits visit [www.apta.org/endorsedbenefits](http://www.apta.org/endorsedbenefits).

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  Protects your health, your family, and your livelihood.

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  Enables business owners who become disabled to cover normal monthly operational expenses such as rent, utilities, and employees’ salaries.

- **Professional Liability Insurance for PTs, PTAAs, and Students**
  Protects your assets and covers your expenses in the event of a suit being brought against you for malpractice.

- **Student Injury and Sickness Insurance**
  Helps students cover the costs of health care for themselves and their families.
The group takes ownership of the quest for change when the leader facilitates learning. Therefore, the leader needs to facilitate the change process, not be the path breaker.

Six principles for effective practice in facilitating a learning approach to innovation and change include: voluntary participation; mutual respect; collaborative spirit; cyclical process; critical reflection; and self-direction. Using this approach, the team can become autonomous, proactive, initiating, creative learners.

As one book on leadership puts it: “Grand dreams don’t become significant realities through the actions of a single person. It requires a team effort. It requires solid trust and strong relationships. It requires deep competence and cool confidence. It requires group collaboration and individual accountability. To get extraordinary things done...leaders have to enable others to act.”

—Jennifer E. Wilson, PT, MBA

References
A successful practice attracts patients and has automated its marketing, unlike a practice that is constantly struggling to stay in the game. Let’s look at one strategy that will allow your clinic to transform itself from an average practice into a booming one. That strategy is specialization.

Most successful private practices have very clear definitions of their ideal patients and how to find such patients. Try a simple exercise. Take a close look at your practice and the general clientele.

- What is a typical profile of your most common patient? For example: Does your practice primarily see 60- to 70-year-old males suffering from osteoporosis, arthritis, and low back pain?
- Can you clearly define your target market?
- Can you put together a program, an advertising campaign, and a referral generation campaign in order to attract, appeal to, and reach out to your precise audience?

Once you can define your target market, the next step is to attract the audience. The more precise the strategy, the faster it can succeed. Most private practice owners tend to copy other practices or competitors in an effort to stand out. This is similar to playing a game of blind archery. Instead of trying to mimic other practices, establish your own identity. This often is best achieved with focus on a particular field of physical therapy, and a unique style and personality that is established by the physical therapist or therapists within that practice.

The key question to ask here is this: When a patient leaves your practice, is he or she going to be able to remember you, your personality, and the feel of your practice several months from now?

The answer will tell you whether you:
- Are a unique practice that stands out, in terms of working style, internal ambience, staff camaraderie, and services,
- Know your typical customer well, and
- Can put together a strategy to serve that particular customer and attract him or her to your practice.

—Nitin Chhoda, PT
Clowning Around

One Halloween, the entire staff where I worked dressed up in costumes. That probably seems normal to most Americans. But that day, I was seeing the wife of a foreign diplomat. I had to wonder what the patient must have thought when first a “clown” (me) began treating her. Even worse—I then called in another “clown” to consult with me! Only after the fact did I realize how funny it must have looked.

—Jeannie Bryan Coe, PT, DPT, PhD

Compiled by Michele Wojciechowski, an award-winning writer, editor, and humorist and frequent contributor to PT in Motion. Do you have a funny story that you’d like to share? If so, e-mail donaldtepper@apta.org.

Apple’s iTunes recently released the My Therapy Exercise application. Its developer, a physical therapist, claims it’s the world’s only custom exercise video application for the iPhone and iTouch designed specifically for physical therapy. The app consists of 170 videos of stretches, ROM, and strengthening exercises for the body, in addition to Swiss Ball, dumbbell, and foam roller exercises. Each video presents performance of proper technique with an audio voice-over instruction. A PT may identify a specific video for a patient, or link several together to create a custom physical therapy routine that can be named, saved, and even edited for future use. For more information, go to www.mytherapyexercise.com.

Text messaging could significantly improve medication adherence among young liver transplant patients, according to a study published online in Pediatrics last fall. Researchers at Mount Sinai Hospital in New York sent text message medication reminders to 41 pediatric patients for one year. Those patients were more likely to take their medications than they had been previously.

Tamir Miloh, assistant professor of pediatrics and surgery at Mount Sinai Hospital and lead author of the study, said, “Text messaging could be used with almost any chronic disease and with anyone who has memory problems.”

Awards Program Recognizes Firms Promoting Health Care Consumerism

URAC, a nonprofit health care accreditation organization, is seeking entries for its 2010 Best Practices Awards in Health Care Consumer Empowerment and protection to recognize firms that are advancing the role of consumers as active participants in health care.

Awards are given in 2 categories: practices that (1) educate consumers about their health care needs and promote consumer empowerment, and (2) relate to patient safety improvement such as disease prevention or care coordination.

The entry deadline is March 15. For more information, visit http://webapps.urac.org/bestpractices/login.asp or call 202/216-9010.

Art by Mike Ferrin
14 tracks, 89 courses, 3 full-day labs, 2.1 CEUs, 15 preconference courses, and 155 nationally and internationally renowned speakers including:

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- Becky Craik
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- Rob Manske
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- Steve Tepper
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www.apta.org/AnnualConference
Employment Indicators and Trends

The Monster Employment Index edged down 4 points in December, amid a relatively mild seasonal fall in online recruitment activity. On a year-over-year basis, the index is down 12%, the mildest rate of annual decline in 18 months.

Online hiring demand rose in 6 of the 24 occupational categories. Health care support registered the strongest monthly rise with a 15 point increase, climbing from 159 to 174. The category of health care practitioners and technical was relatively flat at 134.

Meanwhile, though, The Conference Board reported that online advertised vacancies rose by 255,000 to 3,642,000 in December. Nationally, growth in job demand has been mildly positive since the low point in April 2009.

Among the top 10 occupational groups, health care practitioners and technical occupations—the largest category in terms of volume—posted the largest December gain, 45,100. Job demand was up in a wide variety of health care occupations, including registered nurses and physical and occupational therapists. Labor demand for health care support occupations rose 9,200 to 111,900.

Advertised vacancies in management occupations were up 16,400 in December to 370,000. Largely responsible for the increase were medical and health services managers and marketing managers.

Juju.com, a job search engine, has released its Job Search Difficulty Index. It measures the difficulty of finding employment in each state in the country. It’s calculated by dividing the number of unemployed workers in each state, as reported by the Bureau of Labor Statistics (BLS), by the number of jobs in Juju’s index of online jobs.

The least job search difficulty is found in the District of Columbia, with 1.65 unemployed individuals per advertised job. Following D.C. are Virginia at 3.21 and North Dakota at 3.77. The most difficult job searches are in Idaho (12.19 unemployed individuals per advertised job), Mississippi (13.20), and Michigan (18.97).

### Economy at a Glance

<table>
<thead>
<tr>
<th>Quarter</th>
<th>Nov 2009</th>
<th>Dec 2009</th>
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<tbody>
<tr>
<td>Unemployment Rate</td>
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<td>10.0</td>
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<tr>
<td>Change in Payroll Employment</td>
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<td>Consumer Price Index</td>
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<tr>
<td>Producer Price Index</td>
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<tr>
<td>Employment Cost Index</td>
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</table>

*All data seasonally adjusted

### Average Hourly Earnings of Production Workers Offices of Specialty Therapists, NAICS Code 62134

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<thead>
<tr>
<th>Year</th>
<th>Hourly Earnings</th>
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<tr>
<td>2006</td>
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<tr>
<td>2007</td>
<td>20.92</td>
</tr>
<tr>
<td>2008</td>
<td>23.38</td>
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<tr>
<td>Nov 2009</td>
<td>24.54</td>
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### Stock Market Performance Of Selected Health Care Companies

<table>
<thead>
<tr>
<th>Company</th>
<th>HLS</th>
<th>THC</th>
<th>ASGR</th>
<th>USPH</th>
<th>RHB</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recent Price</td>
<td>20.12</td>
<td>6.07</td>
<td>15.96</td>
<td>15.94</td>
<td>33.68</td>
</tr>
<tr>
<td>Market Value (millions)</td>
<td>$1,910.0</td>
<td>$3,030.0</td>
<td>$149.8</td>
<td>$187.6</td>
<td>$825.0</td>
</tr>
<tr>
<td>Price Performance (last 52 weeks)</td>
<td>+93%</td>
<td>+424.2%</td>
<td>+62.7%</td>
<td>+37.9%</td>
<td>+131.9%</td>
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<tr>
<td>Revenue Growth*</td>
<td>4.66%</td>
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<tr>
<td>Income/Employee**</td>
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<tr>
<td>Revenue/Employee (last fiscal year)</td>
<td>$86,150</td>
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* All data seasonally adjusted

** Preliminary

### Data Points

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### Notes

- Preliminary
- Percentage
- In thousands
- All items, 1-month percent change
- Finished goods, 1-month percent change
- Civilian workers, 3-month percent change


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** Last 4 quarters

### Sources

- Fidelity Investments: Available at [www.Fidelity.com](http://www.Fidelity.com)
It’s Your Brand.
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The following candidates were chosen by APTA’s Nominating Committee for Association National offices. The elections will take place during the 2010 House of Delegates meeting in Boston, Massachusetts.

Complete biographical information for each candidate and responses to candidate questions will be found on the Candidates Web Page of the APTA Web site at the following address: www.apta.org/candidates.

Candidates
For APTA Offices

Laurita M. Hack, PT, DPT, PhD, MBA, FAPTA
Practice Setting: Self-employed, adjunct faculty and consultant in accreditation, education, and research
Chapter: Pennsylvania
Sections: Education, Geriatrics, Health Policy and Administration, Home Health, Orthopaedics, Private Practice, Research

William F. McGehee, PT, MHS
Practice Setting: Assistant professor, director of clinical education, Bradley University Department of Physical Therapy and Health Science; physical therapist, Professional Therapy Services, Inc.
Chapter: Illinois
Section: Cardiovascular and Pulmonary, Education, Health Policy and Administration

Charlene Portee, PT, PhD
Practice Setting: Physical Therapist Assistant Program director, Chattahoochee Technical College
Chapter: Georgia
Sections: Education, Health Policy and Administration, Sports
Director
(Three to be elected)

Sharon L. Dunn, PT, PhD, OCS
Practice Setting: Associate professor and director of DPT Program, Louisiana State University Health Sciences Center-Shreveport; co-owner, The Edge Physical Therapy
Chapter: Louisiana
Sections: Education, Orthopaedic, Private Practice, Research

Dianne V. Jewell, PT, DPT, PhD, CCS
Practice Setting: Assistant professor, Virginia Commonwealth University, Department of Physical Therapy
Chapter: Virginia
Sections: Acute Care, Cardiovascular and Pulmonary, Education, Health Policy and Administration, Private Practice, Research

Roger A. Herr, PT, MPA, COS-C
Practice Setting: Director of product management for home health and hospice, OCS HomeCare
Chapter: Washington
Sections: Geriatrics, Health Policy and Administration, Home Health

Steven Lesh, PT, PhD, SCS, ATC
Practice Setting: Chair of physical therapy department, professor of physical therapy, Southwest Baptist University
Chapter: Missouri
Sections: Education, Health Policy and Administration, Sports

Richard W. Rausch, PT
Practice Setting: Senior vice president, Sovereign Rehabilitation of Illinois
Chapter: Illinois
Section: Private Practice

Nominating Committee
(Two to be elected)

Joe Black, PT, DPT, SCS, ATC
Practice Setting: Clinician/manager of outpatient rehabilitation, Blount Memorial Hospital
Chapter: Tennessee
Section: Sports Physical Therapy

Jeannette Elliott, PT, DPT, MS
Practice Setting: Physical therapist, disability resources and education services, University of Illinois at Urbana-Champaign
Chapter: Illinois
Section: Education, Orthopaedic

Dean McCall, PT, DPT
Practice Setting: Director, Physical Therapy, Martin General Hospital
Chapter: North Carolina
Section: Acute Care, Orthopaedic, Sports

Karen O’Loughlin, PT, DPT, MA
Practice Setting: Assistant program director and academic coordinator of clinical education, Doctor of Physical Therapy Program, Department of Health Sciences, Cleveland State University
Chapter: Ohio
Section: Education, Health Policy and Administration, Research
A New Paradigm:  
The Patient as Consumer

By Stephanie Stephens

Ready or not, here they are. They’re not just patients. They’re not just clients. They’re also consumers: purchasers of health care with strong likes and dislikes. Consumerism increasingly is driving the demand for goods and services provided in the U.S. health care system.

Your consumers “get” the variance in service, quality, and costs. They compare physicians, clinics, medications, devices, health plans, and self-remedies. They’re exploring alternatives to conventional approaches and spending money to achieve their health goals.

Your initial interactions—in fact, the ways you position yourself even before that first contact—can profoundly affect how consumers ultimately respond. Your challenge: Develop effective ways to market to, then treat and retain, your consumers.

Read Their Labels

Consumers have many traits in common. Consumers are capable of behaving responsibly in their self-interest and are willing to do so in an active role, according to the Deloitte Center for Health Solutions in its 2009 Survey of Healthcare Consumers.\(^1\) Deloitte puts it this way: “For most consumers, the system of care in the U.S. is complicated and often frustrating. When making purchasing decisions, most rely on perceptions of service, quality, and costs based on their personal experiences with doctors, hospitals, insurance companies, and others, although consumers’ use of more objective information is on the rise.”
But does that mean that all consumers are seeking the same thing? Not at all.

Consumers all may seek good quality care, but they’re not all using the same rating methodology to select their care or their care provider. Deloitte explains: “Consumers interact with the health care system based on deeply personal beliefs and attitudes that vary widely. Most adhere to a belief that traditional Western medicine is adequate and comprehensive; others seek non-conventional approaches that are thought to be more holistic. Some use the Internet religiously to compare and contrast treatment options, self-care options, and health plan features; others appear to be offline and disinterested. Some pursue healthy living; others are oblivious. Some are price-driven in purchasing health care goods and services; others care little about costs.”

Understanding what different groups of consumers are seeking may assist physical therapists (PTs) in both attracting and in retaining those patients and clients, as well as best addressing their health needs.

Deloitte identified six very different groups of health care consumers. Each group is distinguished by various preferences and behaviors, such as their care preference, their degree of adherence, their receptiveness to innovation, and the methods they use to obtain information about treatments and providers. In brief:

**Sick and Savvy.** This group makes up 25% of the population. They’re the highest users of the health care system. Their care preference is traditional, but they want to be engaged with providers in making decisions. They’re likely to ask for drugs by name. They have the strongest sense of quality differences and are likely to seek coverage details and trust Web sites.

**Online and Onboard.** This group makes up 8% of the population. They’re high users of the health care system. And while their care preference is traditional, they are open to nonconventional items (such as retail clinics). They’re most likely to compare physicians, use cost/quality information, and trust Web sites. They’re likely to participate in wellness programs and contact their plan for advice.

**Out and About.** This group makes up 8% of the population. They prefer holistic approaches and natural remedies. They’re the least satisfied of all the groups with their health care, and they’re the least compliant. They’re least likely to trust a physician’s advice. They’re likely to delay a physician’s recommendation and most open to traveling out of the United States for treatment.

**Content and Compliant.** This group makes up 28% of the population. They’re the least satisfied of all the groups with their health care system. Their care preference is traditional; they are most likely to prefer authoritarian doctors. They’re the least likely to seek information and compare alternatives, least likely to switch providers or plans, and most confident in the effectiveness of medications.

**Shop and Save.** This is the smallest group, making up barely 2% of the population. They’re medium users of the health care system. They seek lower-cost physicians. They tend to be less compliant and less satisfied with their health care. They’re most likely to switch plans, change insurance, and switch physicians. They may not fill prescriptions due to costs.

**Casual and Cautious.** At 28% of the population, this is one of the largest groups, but they’re the lowest users. They’re likely to prefer a standard approach to care. They’re disengaged, but lean toward the traditional and seek lower-cost physicians. Their satisfaction and adherence are both relatively low.

They’re all consumers. It’s just that they have different needs and approaches to health care.

**From a PT’s Perspective**

Deloitte’s categories aren’t the only ones that are being applied to health care consumers, of course. Each of the PTs in this article has a particular way of looking at patients and clients. But it’s clear from both the Deloitte approach and those of the PTs that various segments of health care consumers have different expectations and even different attitudes toward health and rehabilitation.

Tannus Quatre, PT, MBA, has developed a structure somewhat similar to Deloitte’s. Quatre, principal and consultant of Vantage Clinical Solutions in Bend, Oregon, has identified 4 different groups of patients based on a combination of four primary and secondary “drivers”: outcome, experience, price, and convenience. For each consumer...
group, one driver will trump the other three, says Quatre.

**Outcome.** These consumers are most driven by their desire to achieve the best clinical outcomes. They believe they can distinguish between good, better, and best outcomes. They are drawn toward messaging and brands that communicate these elements. Outcome consumers are less influenced by price (co-pay, responsible portions, or out-of-pocket expenses) and are willing to drive greater distances to obtain services. These consumers also are less concerned about elements that don't affect outcomes, such as bedside manner and ambiance.

**Experience.** These consumers are most driven by their desire to achieve the best clinical experience. These consumers value health care as an overall experience that is readily distinguished between providers and clinical facilities. These consumers believe that outcomes are comparable—satisfactory—throughout most of the health care arena. The differentiator is the connection that a consumer feels with the establishment and providers. Hence, these consumers are less influenced by claims of best outcomes. They are drawn more toward providers and facilities that demonstrate and promise compassionate, personal care in a pleasing and comfortable environment. They are willing to drive longer distances and pay higher prices to receive that quality of care.

**Price.** These consumers are most driven by their desire to minimize out-of-pocket expenses. They believe that a reasonable portion of their health care is the responsibility of insurance companies and the government. Therefore, they are drawn to providers, facilities, and services that fall within the preferred payment circle of insurance coverage plans. The price-sensitive consumer is willing to evaluate substitute services (e.g., chiropractic), and price is often the determining factor when deciding which service ultimately to purchase. For that reason, these consumers are less influenced by claims of best outcomes. Distance and drive time is a slight issue, to the extent that it correlates with the monetary and time-cost of accessing services.

**Convenience.** These consumers are most driven by a desire to achieve good outcomes through a minimal expenditure of time and energy. These consumers consider their time to be very valuable. Therefore, efforts to “shop around” for a provider or facility place less emphasis on best service, best experience, or lowest price. They want to be able to access care quickly and easily. They respond well to messages that speak directly to the benefits of easy access, ample parking, flexible payment plans, and extended hours.

“Know the segments that constitute your practice, communicate messages, and develop services to address those needs and wants,” Quatre advises. “If a large segment of your client/patient

PASS Summit: A Paradigm Shift to Consumers

The PT & Society Summit (PASS), held February 27–28, 2009, in Leesburg, Virginia, brought together thought leaders from physical therapy with caregivers and visionaries from other medical professions, engineering, health information technology, industry, academia, and government to focus on how physical therapists can meet current, evolving, and future societal health care needs. One of the topics it addressed was a redefinition of the patient/client as a consumer. Here are a few excerpts from the conference summary that address the relationship between the PT and the consumer:

**Paradigm for Professional Success In the 21st Century**

In the pre-PASS paradigm, the focus was on individual physical therapists’ interactions with their patients/clients (consumers). In the post-PASS paradigm, consumers of health care are at the center and physical therapists are an integral part of a collaborative, multidisciplinary health care team—a construct that is within the recognized cultural and societal framework of consumers.

Consumers are everyone’s primary focus; they drive the system and demand imagination, inspiration, and innovation from all of their health care providers, including physical therapists. Their health and ability to heal are affected by personal and environmental factors at the health care team, community, and societal levels.

**Implications of a Paradigm Shift**

Shifting to the post-PASS paradigm requires physical therapists and physical therapist assistants to understand that patients/clients (consumers) are a driving force in health care, and that each patient/client (consumer) brings a lot more than a diagnosis and purely personal determinants of health to each health care transaction. This reality highlights the need for the profession to revamp its educational offerings to include greater emphasis on fine-tuning clinical acumen within the behavioral sciences as well as cognitive and social psychology dimensions.

For more information on PASS, go to www.apta.org/events and select “PASS.”
Contemplating Contemplation

In addition to understanding that consumers may have varying preferences—as suggested by Deloitte and Quatre—any consumer, regardless of preference, may be anywhere along the spectrum of commitment to act or change.

“The health care system is built upon a premise for action and maintenance,” says Janet Bezner, PT, PhD and APTA’s deputy executive director.

One place to start, Bezner suggests, is the transtheoretical model of behavior change developed by psychologist James O. Prochaska, PhD. It avows that “Change is a process, not an event.”

This model, focusing on decision-making in the individual, proposes five stages of change:

Precontemplation. Participants do not intend to start the new behavior in the near future, or are unaware of the need to change.

Contemplation. Participants intend to take action in the next 6 months. However, the balance between the costs and benefits of changing can produce profound ambivalence.

Preparation. Participants intend to take action in the immediate future, and have a plan of action.

Action. Participants make specific overt modifications in their lifestyles.

Maintenance. Participants changed their behavior more than 6 months ago. They need to be aware of situations that tempt them to revert to their past behaviors.

Bezner says that not understanding these stages can lead to frustration for both the patient and the PT. “We try to get consumers to take action when they’re not, in fact, ready, and our efforts fail,” says Bezner. Understanding behavioral change can help avoid these problems, and are highly applicable to PT-patient interaction.

For example, if you’re dealing with a precontemplator, says Bezner, you may ask: “Did you know that being inactive increases your risk for cardiac disease or cancer, and reduces your energy level?” With him, you must educate, educate, educate about the benefits.”

She also points out that the same patient may be in different stages for different conditions. For example, when patients come to PTs seeking interventions for their shoulder, stroke, or balance, she says, “we can help them in other ways, but we have to know how to have that conversation and how to ‘get on the patient’s radar.’ Patients come to us seeking expertise in one area, but we have an obligation to address global health.”

Not Like You

“If we as PTs aren’t good at listening, reading our patients, and determining their individual needs, we simply not going to achieve good outcomes,” confirms Alecia Helbing Thiele, PT, DPT, MEd, ATC, and an associate professor of physical therapy at Clarke College in Dubuque, Iowa.

Thiele is also an expert on generational differences, yet another way to understand consumers’ learning styles and personality traits. Sociology trumps psychology in this model in which one’s view of the world is determined by what transpired during the first 10 to 15 years of life. These models describe 4 generations: Traditionalists, Baby Boomers, Generation Xers, and Millennials.

Traditionalists. Born between 1900 and 1945. Disciplined, patriotic, fiscally conservative and with a strong appreciation for top-down hierarchies, their key trait is loyalty.

Baby Boomers. Born between 1946 and 1964. Influential in fueling the economy of the 1990s. Idealistic, competitive, and ambitious, their chief quality is optimism.

Generation Xers. Born between 1965 and 1981. Independent, technoliterate, and entrepreneurial, Xers have been marked by skepticism.


In terms of these types of physical therapy patients and clients, Thiele explains, Traditionalists may be very fiscally conservative and not big spenders. Traditionalists respect authority and are highly compliant, adds Bezner. “That patient will do it because I tell her to—and I don’t want to take advantage of that. Give him a home program, if there’s a reason to do it, and he’ll find a way.”

Gen X? “This generation is not very trusting. Conversely, Gen Y or Millennials have heard the word ‘hero’ a lot. These patients may ask, ‘Why do I have to do this?’ and can get frustrated.”

Strive to make the most of what resonates with your patient, Bezner says. “Trade in the patient’s currency to personalize and tailor information to the individual.”

Beth Phillips, PT, DBA, is an associate professor of physical therapy teaching at California State University, Northridge. Phillips subscribes to the Kolbe Index. Instinct-driven behaviors—said to be more than 90 percent reliable over a lifetime—are represented in 4 Action Modes: Fact Finder, Follow Thru, Quick Start, and Implementor—and individuals typically initiate in one or two of the modes. PTs, by the way, frequently turn out to be Follow-Thrus: “They’re really good at identifying and following a pattern,” says Phillips.

“A Fact-Finder asks ‘What?’ or
Getting to Know Them

Just “who” is this patient? Understanding an individual’s particular personality style allows you to more quickly cue into critical core needs, according to Brad Cooper, PT, MSPT, MBA, MTC, ATC, and CEO of US Corporate Wellness in Littleton, Colorado. Doing so is efficient and smart, Cooper says, because “investing into that first evaluation visit will buy you loyalty; you can make it or break it.”

Author of the book Quick Guide to the Four Temperaments and Sales, Cooper likes the Keirsey Temperament Sorter (KTS®-II) which asserts that each temperament has its own unique qualities and shortcomings, strengths and challenges. Temperament is a configuration of observable personality traits, such as habits of communication, patterns of action, and sets of characteristic attitudes, values, and talents. This system categorizes people as Guardians, Idealists, Artisans and Rationals.

Artisans are concrete in communicating, and utilitarian in implementing goals. Rationals are abstract in communicating, and utilitarian in implementing goals.

Guardians are concrete in communicating, and cooperative in implementing goals. Idealists are abstract in communicating, and cooperative in implementing goals.

Preferences, Not Stereotypes

What’s the bottom line for PTs and consumers? Deloitte emphasizes that “Consumerism in health care is not a threat to stakeholders that recognize the value of connecting with end users who ultimately drive demand for the goods and services sold in the U.S. health care system. It is threatening only when stakeholders conclude that consumers are incapable of acting responsibly in their self-interest and are unwilling to take an active role.”

The very fact that various PTs have different methods of categorizing their consumer patient/clients is clear evidence that there’s no one “right” way to assign patients to specific consumer groups. Further, all the PTs interviewed cautioned against pigeonholing patients or making assumptions based on superficial indicators.

Thiele, for example, says, “You can’t stereotype, whether by generations, personality types, or cultural background. You need to gather perspective on where they’re coming from and what’s the best way to connect with them. If we aren’t [individually] reading our patients and understanding their needs, we’re not going to get good outcomes.”

Cooper, meanwhile counsels that categories are enlightening, but within each “you always have hundreds of options. You don’t treat a hand patient like a knee patient.” His company motto, he says, is “One Size Fits One.”

Stephanie Stephens is a freelance writer.

Reference

The student takeover started halfway across the country and gained wings at an airport. Jill Lattanzi, PT, EdD, a clinical assistant professor at Widener University’s Institute for Physical Therapy Education, and her colleague Kerstin Palombaro, PT, PhD, IPTE community engagement coordinator at the Chester, Pennsylvania, school, envisioned a faculty-driven clinic at which physical therapist (PT)-supervised students would provide a community service and gain valuable experience by providing free services to patients who were uninsured or whose physical therapy benefits had been exhausted.

Widener students had lobbied for such a facility, many having volunteered at a pro bono clinic in nearby Philadelphia and hoping to similarly serve residents of economically depressed Chester. The value was clear: A needs assessment had determined that many local physical therapy practices could and would send patients to a pro bono clinic, with children with disabilities and patients who had had strokes being in particular need of care beyond what their insurance could pay. Rent-free accommodations were available, too—the university owned a house at the edge of campus that had space available.

Student-run pro bono clinics are benefiting patients and future PTs.

By Eric Ries
There was, however, one “looming monster,” in Lattanzi’s words: Who would run the clinic? Neither Lattanzi nor Palombaro had the time to be a hands-on clinic manager, and budgetary constraints ruled out hiring another PT for the role. When the PT educators learned that university-related pro bono health care clinics were to be the subject of a national conference in Omaha in January 2009, they jumped at the opportunity to pick the brains of others, in search of a viable model. They brought along two Widener DPT students, Beth Sander and Amber Bennick.

The conference, sponsored by the University of Nebraska Medical Center (UNMC) in association with the Society of Teachers of Family Medicine, was titled “SHARING the Vision: A Student-Run Conference on Student-Run Clinics.” Still, “we really didn’t go into it thinking about the student-run part,” Lattanzi says. “Kerstin and I wanted to learn more about how to set up a clinic at which students worked as volunteers under the supervision and direction of PTs. We invited students to accompany us because we wanted to foster student buy-in to that model.”

What they saw and heard in Omaha, however, transformed the faculty members’ thinking and electrified the students. “The conference was great, and it truly was entirely student-run,” Lattanzi says. “We learned that the pro bono clinics that were represented there”—including host UNMC SHARING Clinics—“were being run, and run quite well from everything we could see, by medical students. Faculty and other licensed health professionals were involved, but they were very much in the background. So then we asked ourselves, ‘Could physical therapist students be doing the same thing?’ The more we thought about it, the more we thought, ‘Why not?’

“The four of us consulted with each other and brainstormed throughout the conference,” Lattanzi says. Over lunch at Cincinnati-Northern Kentucky International Airport on the way home, she and Palombaro shared with Sander and Bennick an organizational chart and bylaws they’d drafted. The students enthusiastically contributed their edits, and by the time the plane touched down in Philadelphia, the makings of a formal presentation were set.

A subsequent vote by Widener faculty was unanimous in favor of a student-run model. “The sentiment was, “Let’s give it a go. Let’s empower students to be successful,” Lattanzi says.

Sander now serves as co-coordinator of the Chester Community Physical Therapy Clinic, which opened its doors in September 2009 and through mid-December had hosted 52 patient visits. In January it doubled its weekly hours to eight and its days of operation to four. Student volunteers do everything from evaluation and treatment (under the supervision of alumni PTs, who also serve without pay) to scheduling patients, requisitioning supplies, and keeping records.

“It’s been absolutely great,” says Sander, adding, “Other schools easily could customize what we’ve done, even if they don’t have a separate building for the clinic like we do. You definitely can do something like this within your school’s physical therapy space.” In fact, Sander is readily available to share her insights with other students, as co-chair of the Student-Run Free Clinic Networking Committee of the APTA Section on Health Policy’s Cross-Cultural/International Special Interest Group. (See box on page 26.)
medical student-dominated arena, PT in Motion located and contacted five different physical therapy-inclusive clinics for this article. In addition to Widener’s Chester Community Physical Therapy Clinic and the University of Florida’s Equal Access Clinic (which operates for two hours every Thursday night at nearby Gainesville Community Ministry), PT students at the following schools are or have been engaged in running pro bono clinics:

**University of South Florida.**

The BRIDGE Clinic (Building Relationships and Initiatives Dedicated to Gaining Equality) is a multidisciplinary health care clinic featuring medical and social work services as well as physical therapy. It’s located in the Hillsborough County Health Department building and is open Tuesdays from 5 to 9 pm. “We see people mostly for musculo-skeletal injuries—neck pain, lower back pain,” says participating PT student Amy Holz. “All of our patients are well below the federal poverty line, so most of them are day laborers, house workers, people with very demanding, physical jobs. DPT program students see patients in teams of two, with a licensed faculty PT who’s also volunteering serving as our preceptor for the night. We have a whole steering committee of students who run the clinic, and PT-student volunteers from first, second, and third year.”

**Nazareth College.** While employed at the Rochester, New York, school, Jennifer Wilson, PT, MBA, developed a student-run pro bono clinic that operated in physical therapy department space and was tied to a required business course. All participating students received course credit, and student managers earned a 3-hour credit waiver. Dan Bajus, PT, DPT, who’s now employed at BrownStone Physical Therapy in Newark, New York, a few years ago was one of the Nazareth clinic’s student managers. He says he acquired invaluable motivational and communication skills while serving as what he somewhat jokingly calls a “powerless leader” among peers.

Wilson, who left Nazareth in 2008 and runs a consulting company called the Leadership Institute, is a huge advocate of the benefits of student-run pro bono clinics to PT students and the profession. In her role as director of LAMP: The Institute for Leadership in Physical Therapy within APTA’s Health Policy & Administration Section, in fact, she recently led a leadership program at Widener for the Chester Clinic’s student board.

**University of South Alabama.** From 3 to 5 pm on Tuesday and Thursday afternoons, PT students, who receive course credit for their participation, run a pro bono clinic located in physical therapy department lab space. It’s a small-scale effort now, but “we’d really like to expand it,” says the clinic’s faculty advisor, Jean Irion, PT, EdD, SCS, ATC. “We envision not only provid-
ing pro bono services here at the school, but going out into the community to offer prenatal and postpartum exercise for teen mothers, and exercise classes at a shelter for battered women.” One unforeseen benefit of the clinic’s creation, Irion says with a laugh, has been heightened respect for the faculty. “In the clinic setting, students find out that we’ve actually got some real-world knowledge to share—we’re not just sitting in our ivory tower.”

**Gratis and Grants**

The nice thing about pro bono clinics, budget-wise, is that services to patients aren’t the only aspects of the operation that are free. The university or a community service organization often provides rent-free space, students volunteer their time or work for class credit, PTs play supervisory roles sans pay, and alumni and community well-wishers often come through with donations of cash and/or equipment and other materials in support of a good cause. Still, that’s not to say that clinics are totally without start-up and continuing costs. The need for revenue streams exists.

Fundraisers undertaken by clinics contacted by *PT in Motion* vary from the mundane to the creative to the highly ambitious. Students at the University of South Florida, for example, have conducted a raffle and receive proceeds from a golf tournament. In Gainesville, Florida, the Equal Access 5K Run is that clinic’s biggest fundraiser. At Widener University, PT students put their bats where their mouths were by challenging the Philadelphia Phillies Ball Girls to a benefit slow-pitch softball game that netted more than $300 for the Chester Community Physical Therapy Clinic. (Not only that, but the PT students kicked opposition butt, winning 12-4.)

PT students at Nazareth College, meanwhile, coordinated and hosted a one-day continuing education workshop for area PTs that netted close to $10,000 over 2 years for clinic activities. Students conducted a needs assessment, secured the participation of big-name speakers such as APTA President R. Scott Ward, PT, PhD, who waived their honoraria, and heavily promoted the event in the local community. “It was a big undertaking,” Jennifer Wilson says, “but students started working with me 9 to 10 months in advance to ensure its success.”

Grants are another funding option, but pro bono clinics report rough going with that route in the current economic climate. “Kerstin has submitted applications for eight grants in the recent past,” Lattanzi wrote in a mid-December e-mail message, “but only one was awarded, in the amount of $1,000. Grant pursuits have been disheartening,” she continued. “Thankfully, the Chester Community Physical Therapy Clinic isn’t dependent on such funding to stay in operation.”

The SSRFC’s Web site (see “Resources” on page 26) offers “25 Steps to Starting a Student-Run Clinic” that include tips for acquiring donations and obtaining grants. Though slanted toward medical school students, it features helpful and translatable advice for any student-run pro bono clinic about everything from identifying key players to empowering students, engendering community support, reaching out to other health professions, and working smoothly with peers. Regarding that last point, step 24 emphasizes humility and states, “No task is too small. The clinic leaders are the ones who also take out the garbage.”

**Building Confidence**

Clearly, pro bono clinics offer significant benefits to patients who receive free, PT-supervised care from students. And altruism and social responsibility—two tenets of Professionalism in Physical Therapy: Core Values1—are significant motivators for the participating PT students. (APTA also specifically encourages its members to “render pro bono physical therapy services.”) But student-run pro bono clinics offer many benefits to participants beyond the warm feeling engendered by service to others.

**Leadership skills.** Dan Bajus isn’t kidding about the value of having been a “powerless leader” of Nazareth College’s student-run pro bono clinic.
“My biggest challenge was learning how to motivate my classmates to meet objectives,” he says. “My most effective strategies for doing that, I found, were, first, doing my best to get everyone all the tools they needed operationally to make their jobs easier, and, second, adapting my interpersonal skills to get my peers to do what I wanted them to do.” Even now, in a non-leadership role at the outset of his working career, Bajus finds that he can “use those skills backwards.” He explains, “I’ve taken that situational leadership model and adapted my interpersonal style so that I’m more effective than I might have been otherwise in pleasing my boss and building good relationships with my co-workers.”

Serving on the Chester Clinic’s board is giving Sander, a third-year student, “a lot of management experience,” she says. “Learning what it really takes to open a clinic isn’t something that’s covered in our classes anywhere,” she notes. “And I’m working with the different schools at Widener to get things done. Our university president came to tour the clinic, and I had the opportunity to show him around.”

**Clinical skills.** Sander’s tour guide experience hints at another oft-cited benefit of clinic involvement: the heightened confidence that comes from being thrown into the breach and forced to learn and adapt on the spot.

“Working at my school’s Equal Access Clinic has been a great, great experience,” says second-year student Jennifer Prugh. “To be able to go in and do an initial evaluation and start with a patient from scratch is the best learning experience ever. It’s wonderful. It’s intimidating at first, but you know there’s a faculty member there if you need help. Hands-on is the best way to learn. You can never have too much of it, especially before you go on your first full-time internship. The experience has been a big boost to my confidence.”

As Jennifer Wilson puts it, “When students are the ones making the clinical and business decisions, they come out of those experiences walking a little taller.”

Bajus confirms that. “When you’ve participated in running a clinic, it takes away so much of the unknown. I went into my first job feeling very good about my ability to handle anything that might be thrown my way.”

**Communication skills.** Per those Widener students who sought out physicians for patient referrals, even at physical therapy-specific pro bono clinics students are gaining experience in working with the medical profession. At multidisciplinary student-run pro bono clinics, that relationship-building process can begin at the peer level.

“I feel very comfortable going up to our medical students to ask how a patient is doing,” says University of South Florida’s Amy Holz. “We’re used to talking and asking each other questions. There’s no barrier between us. We’re setting a foundation,” she says. “I’ll embark on my career expecting to have good relationships with physicians. I’ll have better knowledge of and respect for their role than I would have had without this clinic experience.” She notes, too, that DPT and medical students at her school share first-year basic science and physical-diagnosis courses. Given all the inter-professional communication, “I believe our med students will enter their careers with similar appreciation of the work of PTs,” Holz says.

**Brand Boost**

None of the students or educators involved in these efforts says it’s a snap to start and maintain a student-run pro bono clinic. It’s an involved process that takes time, organization, and desire—and perhaps as well, Wilson suggests, a culture of openness.

“The PT education program has to be really comfortable with being student-centered,” she says. “It must be open to and oriented toward expe-
tential and service learning types of activities. Some administrators might consider an approach like the one we took at Nazareth College a little bit risky, because it takes some classroom learning out of the classroom and tries to do something different with it.

“When I first went to my department chair at Nazareth and said, ‘OK, this is how we could try it,’ I had no idea the clinic would be so successful in so many ways,” Wilson says. “But after having overseen that effort for 5 years, I can tell you with great enthusiasm that such models absolutely can work, and work extremely well.”

The profession of physical therapy has much to gain from the success of student-run pro bono clinics, say the PTs involved. Per Vision 2020,3 “The beauty of what’s happening here at Widener,” Jill Lattranzi says, “is that our students are learning so much about what it takes to be an autonomous practitioner.”

Wilson, for her part, can’t think of a better, more vibrant way to advance the profession’s brand message.4 “Imagine,” she says, “if all PT education programs were able to set up these models, with students learning things like practice management and marketing in a safe environment with experienced mentors, and with patients from the community receiving high-quality pro bono services. If we’re looking for ways to make our brand come alive, that’s the way to do it.”

Eric Ries is associate editor, manuscripts. He can be contacted at ericries@apta.org.

### Reference


Supports APTA’s Strategic Plan www.apta.org/strategicplan
Meet J.L.*, a 54-year-old male who experienced a stroke. Poststroke, he became an inpatient at the Courage Center Transitional Rehabilitation Program, in Golden Valley, Minnesota, just outside Minneapolis. J.L. is being treated within the Courage Center’s Healthcare Home Initiative, a new approach to care designed to encourage collaboration and communication among many different patient constituents.

J.L. receives services from multiple providers: primary physicians, cardiologists, a nutritionist, physical therapist (PT), social worker, occupational therapist, and others. Friends, family, and other important members of his immediate community are involved and able to communicate with others in the mix of providers tasked with his plan of care. J.L. likes being involved with set-

*J.L. is an actual patient whose initials have been changed to protect his privacy.
ting goals for his health care and enjoys an active role, along with the physician, care coordinator, nurses, therapists, and social workers, in creating his plan of care. His story is a part of a new and growing health care paradigm: the Patient-Centered Medical Home (PCMH).

PCMH, sometimes called “medical home,” is defined as “a health care setting that facilitates partnerships between individual patients, and their personal physicians, and, when appropriate, the patient’s family.”1

APTA explains: “The medical home model is built on the principle that each patient will develop an ongoing partnership between specialty providers (via the primary physician, nurse practitioner, or physician assistant). This would ideally improve patient access to preventive care, and shift the focus of health care by providing incentives for the coordination and delivery of efficient, high-quality patient care.” (See “What is Medical Home?”)

Seamless Communication

Real-time communication is a critical element of PCMH. Erin Simunds, PT, is the director of therapy service for the Courage Center’s Healthcare Home Initiative. Simunds says one challenge is making sure that accurate and complete information is included with the patient and travels with the patient. She says having the patient’s information available to all providers is the ideal, and it will yield great benefits for physical therapists and other care providers.

J.L.’s medical history and information flows to other providers in real-time. For example, if one of the care givers notices a possible problem outside of that practitioner’s scope of practice, he or she can note it and have that information flow to the appropriate professional.

With such a satellite of resources serving the patient, valuable information is less likely to be lost or overlooked. For the patient, it is clear that someone is listening. And that, in turn, reflects positively on the providers. “From the inpatient to the outpatient setting, [my] perspective was great and really pushed me to get better,” says J.L. “I have nothing but praise for all of the physical therapists at Courage Center. They are very personable and very professional.”

The concept of the free flow of information is in line with APTA’s revised code of ethics, which becomes effective July 1. Principle 3C states: “Physical therapists shall make judgments within their scope of practice and level of expertise and shall communicate with, collaborate with, or refer to peers or other health care professionals when necessary.” In addition, Principle 2C states: “Physical therapists shall provide the information necessary to allow patients or their surrogates to make informed decisions about physical therapy care or participation in clinical research.” Principle 2D states: “Physical therapists shall collaborate with patients/clients to empower them in decisions about their health care.”2

Tim Fox, PT, DPT, founder and executive director of Fox Rehabilitation Geriatric Therapy at Home in Cherry Hill, New Jersey, also believes that accessible medical information is an important part of an intervention. He predicts that the overall quality of care will improve, with benefits to the PT as well.

“Patients with cognitive impairment often are admitted and readmitted to an emergency department (ED),” says Fox. “Often, those EDs, and therefore the medical records, are not the same, and medications are often changed as physicians are not privy to the details of the patient’s previous medical record. An electronic medical record will coordinate and improve the flow of this data. Physical therapists will realize gains in efficiencies through reducing time spent taking histories or merely confirming the data gained from a systems review that was performed that morning by the physician. The result: more time spent one-on-one with the patient.”

Simunds adds that medical and non-medical services meld together to provide overall better care for the patient. Many of the patients at the Courage Center are adults with disabilities, often accompanied by lifelong conditions that also need treatment. For such patients, Simunds says that services beyond what can be provided in one primary care visit are critical to that patient’s well being. PCMH makes that possible.

She cites the example of many patients with spinal cord injuries: “They also have high blood pressure and high cholesterol, and then they have to deal with the pain. Their conditions are very complicated. A seven-minute visit isn’t going to get to all that. Primary care is challenged with reimbursement when it’s necessary to get people in and out and keep them moving. With somebody who needs time, that’s an issue.”

She emphasizes the importance of integrating the services of all providers. “Our specialty will be to bring primary care to that group, and then to provide the appropriate additional services: physi-
What Is Medical Home?

The American Academy of Pediatrics (AAP) introduced the medical home concept in 1967, initially referring to a central location for archiving a child's medical records. In its 2002 policy statement, the AAP expanded the medical home concept to include these operational characteristics: accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective.1

The AAP—with the American Academy of Family Physicians (AAFP), American College of Physicians (ACP), and the American Osteopathic Association (AOA)—define the patient-centered medical home (PCMH) as “a health care setting that facilitates partnerships between patients, their personal physicians, and when appropriate the patient's family.”

The AAFP and the ACP have since developed their own models for improving patient care. The AAFP’s, adopted in 2004, is termed “medical home” and the ACP’s, adopted in 2006, is called “advanced medical home.”

Increased attention is being drawn to the concept of medical home for a variety of reasons. For example, a report by the Deloitte Center for Health Solutions states: “Two trends are helping to build momentum around the medical home model: 1) a growing shortage of primary care clinicians due to adverse practice conditions; and 2) the increasing prevalence of chronic diseases among the U.S. population.”

During the 2008 presidential campaign, Barack Obama endorsed the medical home concept, citing the increase in chronic disease. In July 2008, responding to a question from the American Academy of Family Physicians, he said: “I support the concept of a patient-centered medical home, and as part of my health care plan, I will help providers establish them. Rates of chronic diseases have skyrocketed in the last 2 decades; over 133 million Americans have at least one chronic disease. With proper care, the onset and progression of these diseases can be contained for many years. In addition to the needless suffering and early death they cause, these chronic conditions cost a staggering $1.7 trillion yearly....

“As president, I will encourage and provide appropriate payment for providers who implement the medical home model, including physician-directed, interdisciplinary teams, disease management and care coordination programs, quality assurance mechanisms, and health IT systems which collectively will help to improve care for those with chronic conditions.”

Different models appear to envision different roles for the physician and for other service providers. For example, one principle of the AAP model is that “the personal physician leads a team of individuals at the practice level who collectively take responsibility for the ongoing care of patients.” Further, “the personal physician is responsible for providing for all the patient's health care needs or taking responsibility for appropriately arranging care with other qualified professionals. This includes care for all stages of life: acute care, chronic care, preventive services, and end of life care.”

Goodemote sees great merit in integrating information. “Services improve most when practitioners shift their perspective to what is best for the patient, collectively, versus what is best through a single provider perspective. The great potential lies in individual professionals performing their respective professions and staying out of the other professions’ business, while at the same time sharing with other professionals and the patient openly to achieve the best collective results.”

Annlee Burch PT, MPH, EdD, and chair of the Physical Therapy Department at Arizona School of Health Sciences of A.T. Still University, soon...
expects PCMH to be an important part of physical therapy educational curriculums. She says that the concept is presented informally now, but it will become more pronounced and formalized.

She believes that the evolution of PCMH will highlight the value physical therapists bring to patient care. “There’s a huge portion of the population that we’re not accessing. The concept of the medical home is going to improve access for a large part of the community,” says Burch. “The pluses definitely outweigh the minuses.”

Questions and Concerns

However, PCMH has raised some questions and concerns.

Burch sees technology as one of the challenges to implementing PCMH. The ability to transfer salient data across organizations representing health care non-physician providers regarding a proposed government demonstration project on medical home stated: “The demonstration project should not be exclusive to physicians. It must include all health care professionals that provide primary care services to beneficiaries. To limit the demonstration to physicians would be to undermine the demonstration given that so much of primary care received in the U.S. today, particularly in rural and urban underserved areas, is not actually provided by physicians.”

Another question is whether medical home is simply the managed care gatekeeper model in a new guise. Its supporters argue it isn’t. For example, Jane Brody wrote in the New York Times: “It is unlike managed care, in which primary doctors act as gatekeepers to specialists and the overriding goal is not managing care but managing costs.”

References

**Lansdale Clagett**  
Diagnosed with polio at age 18 • Received PT beginning at age 38 • Walked at age 58

**Leaves a gift in his will—Establishes a legacy**

Lansdale Clagett spent most of his life in a wheelchair. A successful businessman, Maryland legislator, and county commissioner, Clagett dreamed of getting out of his wheelchair and walking. Grateful for the physical therapy he received, Lansdale Clagett and his wife, Gladys, left a gift of more than $500,000 to the Foundation for Physical Therapy in their will. The Clagetts leave behind a legacy of supporting physical therapy research.

Their generous gift supports discoveries by physical therapy researchers that make dreams like Lansdale’s become possible. To honor their legacy, the Foundation has named its newest research grant the Clagett Family Research Grant.

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that this medical home model inclusion of language to ensure part: “We would encourage the Grassley (R-IA) that said in Baucus (D-MT) and Charles Committee members Sens. Max joined with 9 other health care organizations—ranging from the American Occupational Therapy Association to the American Psychological Association—in signing a joint letter to Senate Finance Committee members Sens. Max Baucus (D-MT) and Charles Grassley (R-IA) that said in part: “We would encourage the inclusion of language to ensure that this medical home model is not simply utilized as a way to funnel health services to facilities owned and operated by physicians for financial gain.”

The groups urged the addition of the following statement in the committee report on the legislation: “The medical home must not restrict a patient’s freedom to access a health care provider of choice according to Medicare’s regulations. The medical home concept is just a way for coordinating knowledge of all the provider care a patient receives through a single medical home, without the need for prior authorizations for such care. Effectively implemented, the medical home can improve health care coordination and advise the patient on quality health care options.”

Other hurdles deal with ensuring that PCMH’s benefits reach all patients and clients. Burch explains: “The challenge in making the medical home model real for physical therapists is probably the same challenge for other primary care professionals. How do we provide access to populations that don’t see themselves as candidates for health care services currently? Perhaps they’ve never had insurance, or they mistrust primary care providers, or they’re become accustomed to using the ED as their place to go for all illnesses. Or they’ve experienced poor-quality care. So, despite the emphasis on the medical home and its importance, the question remains for those populations who currently don’t feel that they’re candidates for primary care, to [accept] this new concept.”

Burch lists a number of other barriers: “Not everybody is invested in free-flowing information that encompasses physical therapists because they might not have the knowledge, the resources, or a setting that allows for it. Another challenge to the concept is confidentiality and how that patient information is used or [made] available to people outside the health care community.”

Overall, however, PTs who are familiar with the medical home concept seem to welcome it. “This is the opportunity of a lifetime for our profession,” says Tim Fox. “This is what I have been calling for for my entire career. Physical therapists are integral players in the PCMH. Physical therapists should be recognized and utilized as primary non-physician practitioners. We are well trained [and] able to screen for and make medical referrals.”

“I think patients will love it,” says Erin Simunds. “We have a pilot group of clients coming in to our primary care clinic for our health care home and they are very happy to have somebody who understands them and listens. PT.”

Jim Romeo is a freelance writer.

Reference

caregivers, and an ability to create and store medical records, requires sophisticated information technology. Such technology can be expensive and complex, and the ability of a PT practice to invest in and implement sufficient technology to enable the medical home increasingly will become a resource challenge.

Other concerns involve the way the model will function. For example, when the Centers for Medicare and Medicaid Services (CMS) recently was planning a demonstration project to assess PCMHs, APTA joined with 9 other health care organizations—ranging from the American Occupational Therapy Association to the American Psychological Association—in signing a joint letter to Senate Finance Committee members Sens. Max Baucus (D-MT) and Charles Grassley (R-IA) that said in part: “We would encourage the inclusion of language to ensure that this medical home model is not simply utilized as a way to funnel health services to facilities owned and operated by physicians for financial gain.”

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Physical Therapy on YouTube

With so many health care consumers—and providers—going online for information, physical therapists and physical therapist assistants ought to know what those Internet surfers are looking at. If, for example, someone searches on YouTube for “physical therapy,” what videos will come up, and which of those are most popular?

Here are some of the videos most likely to appear, based on relevance to the term “physical therapy.” Included for each video is the number of times it has been viewed, and a description written from information provided by the source of the video.

This is a selective list—we’ve omitted some videos that are part of a series or are closely related to others included below. The information and images are intended simply to give you a sampling of what people find when they search YouTube. Please note that a listing here does not constitute an endorsement or recommendation of the video or the video’s source. Nor have the videos, or any techniques contained in them, undergone review for appropriateness or efficacy.

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Physical Therapy Diagnosis: Rotator Cuff Strength
**Description:** This video demonstrates a rotator cuff strengthening exercise as performed in a physical therapy clinic.
**Source:** Medical Arts Rehabilitation, Inc.
**URL:** http://www.youtube.com/watch?v=BJihkZ5RBJM8

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Achilles Tendon Physical Therapy Exercises: Achilles Tendon Massage Techniques
**Description:** Shows how to perform a massage to help relieve pain in the Achilles tendon, and includes tips and instruction on caring for Achilles tendon injuries.
**Source:** Expert Village
**URL:** http://www.youtube.com/watch?v=VUWKLJufji8

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You Can Be Me— A Career in Physical Therapy
**Description:** Considering a career in health care? This American Physical Therapy Association (APTA) video shows what you might do as a physical therapist (PT) or physical therapist assistant (PTA).
**Source:** American Physical Therapy Association
**URL:** http://www.youtube.com/watch?v=C8Da1TRcCG-k

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Move Forward: Physical Therapy Brings Motion to Life
Description: Physical therapists help you restore and improve motion to achieve long-term quality of life. That’s the brand promise of the American Physical Therapy Association (APTA) and its member physical therapists. Learn how a physical therapist can help you regain the motion you need for everyday life and avoid expensive and painful surgery and the side effects of medication.
Source: American Physical Therapy Association
URL: http://www.youtube.com/watch?v=TjDEm2FE_3w

continued on page 39
These multimedia courses use a lecture format and include slides, handouts/spreadsheets, and references. Learn from renowned physical therapists in the comfort of your own home. Key resources for all practicing physical therapists.

**Basic EKG Interpretation**  
Steven Tepper, PT, PhD  
(.5 CEU, 5 contact hours / $75 members, $125 nonmembers)

**Business and Marketing**  
Laurita M Hack, DPT, MPB, PhD, FAPTA  
(1.0 CEU, 10 contact hours / $150 members, $250 nonmembers)

**Cancer Rehabilitation: Principles and Practice**  
Charles McGarvey, PT, DPT, MS, FAPTA  
(.3 CEU, 3 contact hours / $45 members, $72 nonmembers)

**Coding and Reimbursement Issues in Rehabilitation**  
Stephen Levine, PT, DPT, MSHA, RP, Helene Fearon, PT  
(1.5 CEUs, 15 contact hours / $225 members, $360 nonmembers)

**Clinical Decision Making: Utilizing The Guide to Physical Therapist Practice**  
Andrew Guccione, PT, DPT, PhD, FAPTA  
(.6 CEU, 6 contact hours / $90 members, $150 nonmembers)

**Developmental Neuroplasticity: Translating the Science to Clinical Practice**  
James C (Cole) Galloway, PT, PhD, Anna Klintsova, PhD, John Martin, PhD  
(.3 CEU, 3 contact hours / $45 members, $72 nonmembers)

**Endurance Impairments: Examination, Differential Diagnosis and Interventions: A Case-Based Approach**  
Steven Tepper, PT, PhD  
(1.0 CEU, 10 contact hours / $150 members, $250 nonmembers)

**Evidence-Based Physical Therapy Management: DVT and Pulmonary Embolus**  
Charles D Ciccone, PT, PhD, FAPTA, Daniel Riddle, PT, PhD, FAPTA, Steven Tepper, PT, PhD  
(.5 CEU, 5 contact hours / $75 members, $125 nonmembers)

**Human Resource Management**  
Jonathan Cooperman, PT, DPT, JD, MS, Ron Scott, PT, EdD, LLM  
(.8 CEU, 8 contact hours / $120 members, $200 nonmembers)

**Legal and Ethical Issues for PTs: Considerations in Risk Management**  
Jonathan Cooperman, PT, DPT, JD, MS Ron Scott, PT, EdD, LLM  
(.95 CEU, 9.5 contact hours / $142.50 members, $237.50 nonmembers)

**Medical Imaging in Rehabilitation**  
Lynn McKinnis, PT, OCS  
(1.2 CEUs, 12 contact hours / $180 members, $288 nonmembers)

**Pharmacology in Rehabilitation**  
Charles D Ciccone, PT, PhD, FAPTA  
(1.4 CEUs, 14 contact hours / $210 members, $350 nonmembers)

**Screening for Medical Disorders**  
William Boissonnault, PT, DHSc, FAOMPT  
(.9 CEU, 9 contact hours / $135 members, $216 nonmembers)

**Screening for Medical Disorders, Part 2**  
William Boissonnault, PT, DHSc, FAOMPT  
(.5 CEU, 5 contact hours / $75 members, $135 nonmembers)

**Screening for Medical Disorders, Part 3**  
Steven Tepper, PT, PhD  
(.1 CEU, 1 contact hour/$15 members, $25 nonmembers)

**Wound Management Overview**  
Katherine Biggs Harris, PT, DHSc  
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Minding Your PQRI

Changes and Guidance for 2010.

Physical therapists (PTs) in private practice, physicians, and other health care professionals who successfully report on quality measures in 2010 will receive a 2% bonus payment from Medicare under the Physician Quality Reporting Initiative (PQRI). Passed as part of the Tax Relief and Health Care Act of 2006, the PQRI program was developed to reward health care providers for reporting on measures of quality designed to improve patient care. While providers who have participated in PQRI have expressed frustrations with the program, Congress and the Centers for Medicare and Medicaid Services (CMS) have continued to signal their support.

Each year since PQRI’s inception in 2007, CMS has expanded the list of quality measures available for PQRI reporting. Congress, for its part, not only has continued to authorize PQRI, but also has increased the bonus percentage from 1.5% for the 2007 and 2008 program years to 2% for 2009 and 2010.

PTs and other health care providers wonder what direction PQRI will take beyond 2010. Will the program become mandatory? If so, will those who do not participate see payment reductions under Medicare? While these questions remain unanswered, PTs must be prepared for this possibility. It is important, too, that PTs recognize the potential of PQRI and other value-based purchasing programs for improving patient care and health outcomes.

Addressing Concerns

PQRI started in July 2007 as a 6-month reporting program, paying successfully participating health care providers a 1.5% bonus on their total allowed charges under Medicare. Of the 74 measures available for the 2007 program, only one—for screening patients at risk of falls—was available to PTs. Some providers were confused and frustrated during the 2007 reporting period, and this frustration became widespread when the 2007 incentive payments were distributed in mid-2008. Many providers who felt they had successfully reported learned that errors—made by them, their billing clearinghouse or CMS—had prevented them from earning the incentive. In 2008, CMS conducted an extensive assessment to determine what had occurred during the 2007 program year—and what the agency might do to improve the chance of successful participation by health care providers.

 CMS identified many issues outside its control that caused provider failure to earn the incentive. For example, CMS decided that, moving forward, if it could identify claims carrying the same date of service, beneficiary identification number, and NPI that had all the necessary information on separate claims, it would rejoin these claims so the provider would become eligible for the incentive.

Despite the frustrations and concerns of providers, Congress reauthorized the PQRI program for 2008 with a 1.5% bonus, and CMS expanded to 119 the list of measures. PTs now were eligible to report on a total of eight measures,
Compliance

Matters

and needed to report on those measures for the entire calendar year. The Medicare Improvements for Patients and Providers Act (MIPPA), passed in July 2008, required that CMS publicly report the names of providers that successfully participated in the PQRI program starting in 2007. This is a permanent aspect of the program.

In 2009, providers were eligible for a 2% bonus, and PTs remained eligible to report on eight measures. But frustration with the PQRI program continued, despite CMS's efforts to improve provider success rates and satisfaction. Of concern to providers were three primary issues: 1) lack of real-time access to feedback that would help providers determine if they are successfully participating in the program, 2) prompt payment of incentives, and 3) the inability to participate of providers such as rehabilitation agencies, outpatient hospitals, and skilled nursing facilities (Part B) that submit claims via the UB-04 form or its electronic version.

For 2010, CMS has continued to stress its desire to address concerns. By using registries and electronic health records, CMS hopes that providers using the UB-04 claim form for billing purposes ultimately will be able to participate in PQRI.

By using registries and electronic health records, CMS hopes that providers using the UB-04 claim form for billing purposes ultimately will be able to participate in PQRI.

(N365) and a message that confirms that the claim passed into the National Claims History file. N365 reads: “This procedure code is not payable. It is for reporting/information purposes only.” The N365 remark code does not indicate whether the quality-data code is accurate for that claim or for the measure the provider is attempting to report.

Regarding payment delays, CMS hopes to improve processing time but faces a procedural hindrance. The law authorizing the PQRI program specified that providers have until the last day of February of the following year to submit their information to CMS. So, a provider had until February 28, 2010, to submit its information to CMS for the 2009 program year. This means CMS did not begin analyzing this data until March 1. The agency is working to prevent such substantial payment delays in future program years, but, for now, providers should not expect incentive payments earlier than April each year due to the program's legislative requirements.
Compliance Matters

While providers have voiced concerns about the continuation and possible expansion of PQRI, CMS has released data showing an increase in successful participation by Medicare providers. Approximately 85,000 providers satisfactorily reported quality-related data to Medicare under the 2008 PQRI program and received incentive payments totaling more than $92 million, according to CMS.1 The average incentive amount for an individual provider was more than $1,000, with the largest payment to an eligible professional totaling more than $98,000. In 2008, 153,600 health care professionals participated in the program, and the number of eligible professionals who met the requirements for reporting and earned an incentive payment increased by one-third from 2007, from 56,700 to more than 85,000 providers.

Added Measures

In 2010, PTs in private practice may report under the PQRI program using individual measures or measures groups. PTs remain eligible for eight individual measures and for the first time are eligible to report on a measures group related to back pain. PTs may choose to report data on PQRI quality measures through claims or via a qualified registry such as CONNECT or FOTO. In addition, for 2010 PTs may decide to report for a period of 6 months—from July 1 to December 31—or for the entire calendar year.

CMS has established 179 quality measures for the 2010 PQRI, up from 153 in 2009. The following are available to PTs:

Individual

- Falls: Plan of Care (#154)
- Falls: Risk Assessment (#155)
- Health Information Technology: Adoption/Use of Electronic Medical Records (#124)

- Diabetes Mellitus: Diabetic Foot and Ankle Care, Peripheral Neurology—Neurological Evaluation (#126)
- Diabetes Mellitus: Diabetic Foot and Ankle Care, Ulcer Prevention Evaluation of Footwear—Preventive Care and Screening (#127)
- Body Mass Index (BMI) Screening and Follow-up (#128)
- Documentation and Verification of Current Medications in the Medical Record (#130)
- Pain Assessment Prior to Initiation of Patient Treatment (#131)

Back Pain

- Back Pain: Initial Visit (#148)
- Back Pain: Physical Exam (#149)
- Back Pain: Advice for Normal Activities (#150)
- Back Pain: Advice Against Bed Rest (#151)

Today and Tomorrow

Providers have a variety of resources with which to prepare for PQRI reporting, all of which are available via the APTA and CMS Web sites (www.apta.org/pqri and www.cms.hhs.gov/pqri).

Of primary importance to any provider is a fundamental understanding of the requirements for each quality measure. These requirements are summarized in the specifications for each measure. For example, the measure specifications detail the patient demographic characteristics to which a measure applies, including age, gender, and, in some instances, diagnosis. The specifications note the CPT codes with which to report quality data, and how often the quality action must be performed. The American Medical Association has developed data-collection sheets that not only serve as documentation for the medical record but also help the provider determine if the measure is applicable to the patient.

Once the program year is complete, providers can access confidential feedback reports, which may provide clues as to why they may or may not have qualified for an incentive payment. These reports are particularly helpful for providers who did not qualify for an incentive, because it can let them know what corrective action they may need to take for the following year.

Currently, PQRI has not been authorized by Congress beyond 2010. That has not stopped CMS from preparing for future program years, however. The agency has requested new measures for the 2011 program. Additionally, there are proposals in Congress to reduce bonus payments over the next few years and begin penalties for lack of participation in 2015.

Many private payers have instituted value-based purchasing programs similar to PQRI, while others have been closely monitoring the situation to determine whether to follow suit. Beyond these carrot-and-stick initiatives, providers must consider the implications for patient care. Many of these measures are selected because evidence suggests that if the care processes reflected in the quality measures are conducted, improved patient health will be the result.  

Reference


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[Image of Sarah Nicholls-Sharp]
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Dang, am I ever a slow learner!

I was working with a new group of wellness coaches one afternoon several weekends ago. We put our coaches through extensive training that teaches them, among other things, the incredible importance of treating each participant in a wellness program as an individual—of tuning in to his or her distinct style and temperament. I was in the midst of bringing that point home when it hit me: In least one aspect of my life, I hadn't been practicing what I'd been preaching.

Let me backtrack: That morning, I'd ducked out of the training session for a few hours to coach my son's basketball team. The team, made up of fifth and sixth graders, had been playing pretty well overall, but I'd been beat against the wall trying to figure out how to get a few of the kids to play in a certain style.

For weeks, I'd been working closely with my son, Joshua, and a couple of the other boys to get them to "play tough" under the boards. They were smaller players who'd been forced by the team's makeup to play forward. Conventional wisdom dictated that we needed those kids to play down low on defense and, doggone it, they were going to learn to do that if it killed me! I'd tried leading demonstrations, running drills and scrimmages, offering incentives, and everything else that came to mind. Still, I wasn't getting the desired results.

Until, that is, the answer came to me during the training session with the wellness coaches. I'd been describing how, in many companies, families, and other groups, certain people are expected to fill certain roles in certain ways. In such cases, it doesn't matter what you might feel you're "meant" to be doing, or what your talents might dictate. Rather, your job simply is to fill your assigned role. Obviously, I was mocking this approach as a waste of talent and a killer of spirit. But as soon as the words left my mouth, my mind chastised me, whispering, "Hey, isn't that exactly what you're doing with these kids, Brad?"

Clearly, it was.

A little background. I'm obviously kind of prejudiced, but, honestly, Joshua is one of the greatest kids you'll ever meet. He's sweet to his sisters (I'm not kidding), respectful to adults, kind to his friends, gentle with animals, and helpful when asked. He loves to play, joke around and make people laugh. If he thinks he hurt someone's feelings, his sensitivity toward others is clear. So, here I was, hell-bent on turning this nice young man into a rough, tough, mean power forward!

I realized it was time to try something, as they say, completely different. We changed our player rotation to allow for a couple of extra guards and one less forward. I sat down with Joshua and asked him what he thought about moving to guard. I told him he might have to run harder, play more quickly, and take on additional responsibilities on offense. He told me he was game.

The result? Well, let's just say there's been quite the transformation. Joshua started practicing dribbling between his legs while watching television in the family room, and he requested contact lenses to help him improve on his already solid shot. Several parents have asked me during the games since, "What's gotten into Joshua? He's really playing well!"

What happened? His dad/coach opened the gift of Joshua's individual talents and preferences. As physical therapists (PTs) and physical therapist assistants (PTAs), and as clinic managers or owners, how often do we fail to open the gifts our patients and employees bring to the table? Far too frequently.

See if this scenario sounds familiar. You have a patient who strikes you as bright and motivated, yet he's noncompliant. You've given him very basic home exercises—12 reps each, to be performed two times a day. Several of your other patients are complying, or doing similar home exercise programs, with good results. What, you ask yourself, is this guy's problem?
Here’s another situation that may ring a few bells. One of the PTs working for you is extremely disciplined and organized. She always is on time, keeps exceptional notes, and never has to be asked anything twice. But when it comes to getting out and marketing to physicians, she simply cannot get it done. You’ve sent her to classes and accompanied her on the visits, but nothing seems to help. “What, exactly,” you feel like asking her, “is wrong with you?”

You can guess at this point what’s really wrong here. In some ways, it’s as if we’re treating a patient’s arm for pain that’s actually referred from the cervical spine. And as any PT or PTA knows, it’s a lot harder to fix a misdiagnosis than it is addressing the real source of the problem in the first place.

I should stress here that individualism and autonomy are two different things. While it’s important to exploit individual talents, it’s imperative that all members of the basketball team work on their dribbling, shooting, passing, defense, knowledge of the rules, and so on. Similarly, there are certain things all patients, peers, and employees must do to maximize outcomes. But often, altering our own approach a little can facilitate others tapping their strengths more effectively, alleviating the need to swim upstream.

Here’s a simple exercise you may want to try with your patients, employees, family members, or basketball team of fifth and sixth graders:

1. Jot down each person’s name and list his or her strengths. (If you can’t come up with much, the problem may be your own lack of knowledge and awareness.)
2. Next, make a list of the tasks, assignments, or goals you’d like to see accomplished or met.
3. Then, play a little “connect-the-dots” game between the two lists, stretching your mind to match strengths to tasks in ways that will bring results.
4. Open those gifts and observe the outcomes.
5. Repeat.

You’ve never seen a fish climb a tree or a squirrel swim across a river, right? So, you understand the importance of identifying and using people’s natural gifts. Those gifts are there for the giving. They need only be opened. That’s where we come in. PT.

Brad Cooper, PT, MSPT, ATC, MTC, MBA, is CEO of US Corporate Wellness Inc, a provider of employee wellness programs that has comprehensive wellness accreditation from URAC, an independent, nonprofit accreditation and certification body. For information on the benefits of wellness services to employees, as well as employers’ bottom lines, contact him at BCooper@uscorporatewellness.com or 800/910-9425 and visit uscorporatewellness.com.

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Retired but Not Retiring

A veteran PTA looks back—and ahead.

Thirty-one years—what an adventure! In 1978 I was working in a computer lab, debugging a punch card program written in COBOL, an early computer language. I was all by my lonesome in a room about the size of a gym.

What in the world was I doing there? What I really needed was to use some of my athletic skills, and to be around other folks. It struck me that I'd found my niche after I'd spent about 500 volunteer hours teaching people with paraplegia how to swim in the pool at Santa Clara Valley Medical Center's physical therapy gym complex.

DeAnza College in beautiful downtown Cupertino had a physical therapist assistant (PTA) program in which I enrolled. They had great instructors who really cared, and excellent “slave labor” opportunities (clinical education experiences). I had been working as a physical therapy aide/receptionist/biller/“gofer” at Alexian Brothers Hospital in San Jose. Hal Pfluger was the owner/boss, and he told me, “Remember everything you learn in PTA school for when you take your exam … and remember what I've taught you for when you come back to work.” I did remember what he'd taught me, and also what I learned from PTs at Alexian Brothers who were named Carol, Jeanie, and Thiara. I spent three years at the knee (and heart) of Dr. Thomas Roberts, who taught me about osteopathic medicine. I also learned a lot there during weekend seminars taught by the likes of Robin McKenzie, Sue Adler, and Jerry Hesch.

During the course of my career, I believe I worked in every kind of clinical practice. I think my favorite practice setting was the acute care hospital. The challenges there are many, as PTs and PTAs must work with patients with all diagnoses—patients with burns in the ER, patients in comas in the ICU, 5-year-old children with cerebral palsy in the outpatient clinic. I really enjoyed the diversity of my work in that setting.

Memorable patients? Where do I start? From the 5-year-old “old lady” with rheumatoid arthritis to the pitcher for the Toronto Blue Jays, they all added something to my bag of tricks. Yes, I said bag of tricks. Because if any PT or PTA tells you there is only one thing that will work for a given patient, you should turn around and leave! I love osteopathic techniques, for instance, but it’s my feeling that a good dose of PNF (proprioceptive neuromuscular facilitation) or some myofascial release often are indicated, as well.

When you get down to the type of technique to be used, it kind of depends on where you are in your professional life and what the evidence says. It seems the profession is moving toward specialization rather than focusing on things that work well for the majority of patients and clients. It seems to me that we’ve gotten hung up on labels. What is a “manual” or “orthopedic” clinician to do if he or she has a neurologically involved patient?
As we move toward becoming a doctoring profession, I believe that PTAs—whether they’re working in hospitals, big cities, or rural areas—will have opportunities to move up the ladder, too. If so, I think it’s important that we start adding management classes and seminars that will count toward PTAs’ continuing education units or degrees. For the final 9 years of my working career, I was the director/manager of the physical therapy department at a rural hospital. Fortunately, along the way I was able to take advantage of leadership opportunities from Tom Kessinger and NovaCare. Learning how to manage people is a lot harder than one might think.

So, now, retirement. I’m finding it is not for the faint of heart! I woke up at 6 am the first day, got dressed, and then realized I didn’t have to go anywhere. But soon I was handed my “honey do” list, which keeps me busy. I also am continuing my volunteer activities at New Mexico Search and Rescue (SAR)—I’m an operations section chief and founder and president of the Hot Springs Desert Crawlers SAR group. I also am a ham radio operator, which helps in SAR communications.

Not that I’ve stopped thinking about physical therapy and its place in the health care system. “Managed care”—now, there’s an oxymoron. There are too many bean counters at insurance companies who expect complicated patient diagnoses like complex regional pain syndrome (also known as reflex sympathetic dystrophy) to be better in three treatments. It’s not going to happen! Perhaps we need more retired PTs and PTAs serving as case managers for insurance companies—people who can read the evaluations and patient history to get a clearer idea of where the patient is in his or her rehabilitation and recovery.

I feel I related well with patients. One time, I remember, a lady with a fractured hip told me I didn’t know what she was going through and how hard it was for her to stand up straight. We were seated on the mat, and I asked her to hold my leg for a moment. As she picked it up, she realized it was prosthetic. “I guess you do understand,” she said. Just this morning that same lady had 9 o’clock tee time at the golf course. Now, that’s what I’m talking about.

The other day I spoke to a young lady on the phone who told me she thought she might like to be a PT or PTA. “Are you out of your mind?” I challenged her. “Do you want to be poor for the rest of your life?” No, I didn’t really say that. I’m just kidding. I told her physical therapy was something I’d done for 31 years and that I’d loved almost all of it. I closed with an observation that I’ll repeat here: If you really like people and want to help them succeed in doing whatever they want to do, then being a PTA or a PT is a great life!  

Ross Holbrook, PTA
most recently was director of physical therapy services at Sierra Vista Hospital in Truth or Consequences, New Mexico, where he still resides.

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This column's new single-scenario-followed-by-guided-discussion format kicked off last month with a case involving questionable practices and continuing education.1 This month we'll look at a different twist on that same theme.

But first, to recap: in Ethics in Practice columns published from October through December 2009 we examined coming changes in APTA's ethical guidelines for physical therapists (PTs) and physical therapist assistants (PTAs),2 compared and contrasted the old and new documents,3 and applied all of the documents to selected clinical scenarios.4

The complete texts of those columns, and of all APTA ethics documents, are available at www.apta.org. (Click on the existing or "old" ethics documents for links to the pending or "new" ones.) Also, reference online the column "Ethical Decision Making: Terminology and Context" from the February 2006 issue of PT Magazine for further insights into this month's guided discussion.

Handed a Choice

Harold has been a successful solo private practitioner for 17 years. Recently, however, his caseload has declined a bit, and he’s been finding it harder to collect on patient accounts. He’s intrigued when he spots a practice-development course being offered locally. Harold signs up and finds the content thought-provoking. He’s particularly struck by the suggestion that he might enlarge his patient/client pool by offering services he heretofore has considered outside his comfort zone.

Shortly after taking the course, Harold receives a call from the mother of a young man he had seen 3 years earlier. At that time, Jon was a high school senior who had sprained his ankle in a basketball game. Those sessions had yielded good results, so his mother calls on Harold again when Jon, now two weeks postsurgical tendon transfer in his dominant (right) hand, is home on winter break from his pre-med studies.

Harold’s first thought is that it might be more appropriate for Jon to see a physical therapist (PT) located about an hour’s drive away who is a hand specialist. But before he can express that thought, the words of the recent course-presenter echo in his head: “Don’t sell yourself short. You are a skilled professional.” Harold reminds himself that he is highly capable and has a broad base of knowledge. He tells Jon’s mother to bring the young man in.

During the initial evaluation, Harold again has misgivings. He’s just about to voice them when Jon’s mother starts gushing about Harold’s talent and saying how fortunate it is for Jon that Harold can jump into the breach at such a critical time in Jon’s recovery. The PT concedes, in his own mind, that he does offer Jon a convenient alternative to the hand specialist, who is not located nearby and often is booked for weeks in advance. Harold reassures himself that he need only consult pertinent Web sites and scour the evidence-based research in order to get the guidance he’ll need to successfully address Jon’s needs.

Considerations

Realm. While this is obviously an issue involving the provider, Harold, and the patient, Jon, there are societal ramifications as well, in terms of how the profession of physical therapy is regarded by the public. It is important to the profession’s integrity that practitioners recognize their own strengths and limitations. What is Harold’s individual and collective responsibility for ensuring he can provide optimal patient care in this instance?

Individual process. Consider Harold’s judgment. Can he sufficiently justify encouraging patient convenience over the most appropriate treatment venue?

Situation. Harold is discomfited by the unfolding events. Should he act on his doubts?

Ethical principles. Consider Harold’s truthfulness when it comes to disclosing his skills. Is he truly beneficent in considering Jon’s convenience, or might he have another motivation?
Furthermore, is Harold in a position possibly to harm Jon—either directly, by his actions, or indirectly, by unknowingly omitting a critical element of care? The current Code of Ethics addresses aspects of this scenario across several principles. Consider Principle 4: “A physical therapist shall exercise sound professional judgment.” Also, Principle 5 reads, “A physical therapist shall achieve and maintain professional competence.” Principle 6 states, “A physical therapist shall maintain and promote high standards for physical therapy practice, education and research. Principle 8, meanwhile, directs PTs to “provide and make available accurate and relevant information to patients/clients about their care.”

The new Code of Ethics offers very specific guidance regarding Harold’s best course of action. Principle 3C, related to the core values of excellence and integrity, reads, “Physical therapists shall make judgments within their scope of practice and level of expertise and shall communicate with, collaborate with, or refer to peers or other health care professionals when necessary.” Principle 2A, related to the core values of altruism, compassion, and professional duty, states, “Physical therapists shall adhere to the core values of the profession and shall act in the best interests of patients/clients over the interests of the physical therapist.” Principles 2C and 2D direct PTs to provide patients with the information they need to make informed decisions, and to empower patients through collaboration with the PT, respectively.

Furthermore, Principle 4A of the new code, related to the core value of integrity, tells PTs to “provide truthful, accurate, and relevant information,” and to avoid “misleading representations.”

Finally, new code principles 3B and 6B address the need for PTs to critically assess themselves and the literature, respectively. Principle 3B states, “Physical therapists shall demonstrate professional judgment informed by professional standards, evidence (including current literature and established best practice), practitioner experience, and patient/client values.” Principle 6B directs PTs to “take responsibility for their professional development based on critical self-assessment.”

What do you believe Harold should have done in this situation, and why? I encourage you to e-mail me at the address below and share your reasoning.

References

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Pre-Conference
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Pre-Conference
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20 Hours, 3.0 CEUs (No Prerequisite)  
**$959**

<table>
<thead>
<tr>
<th>Location</th>
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<tr>
<td>Boston, MA</td>
<td>Mar 24-28</td>
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<tr>
<td>Little Rock, AR</td>
<td>Mar 29-4 Apr</td>
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<tr>
<td>Harnissburg, IL/PA</td>
<td>Apr 21-25</td>
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<tr>
<td>Sarasota, FL</td>
<td>Apr 28-5 May</td>
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<tr>
<td>St. Augustine, FL</td>
<td>May 9-13</td>
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<tr>
<td>Atlanta, GA</td>
<td>May 19-23</td>
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<tr>
<td>Milwaukee, WI</td>
<td>Jun 2-6</td>
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<td>Denver, CO</td>
<td>Jun 9-13</td>
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<td>Lansing, MI</td>
<td>Jul 14-18</td>
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<td>Orlando, FL</td>
<td>Aug 10-22</td>
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<td>Minneapolis, MN</td>
<td>Aug 20-26</td>
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<td>New Orleans, LA</td>
<td>Aug 25-31</td>
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<td>Las Vegas, NV</td>
<td>Sep 3-9</td>
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<td>Denver, CO</td>
<td>Sep 10-16</td>
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<td>St. Augustine, FL</td>
<td>Oct 2-8</td>
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<td>Milwaukee, WI</td>
<td>Oct 20-29</td>
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<tr>
<td>Chicago, IL</td>
<td>Oct 27-31</td>
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<td>Boston, MA</td>
<td>Nov 5-11</td>
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### E1 - Extremity Evaluation and Manipulation
20 Hours, 3.0 CEUs (No Prerequisite)  
**$959**

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<td>Boston, MA</td>
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<td>St. Augustine, FL</td>
<td>Nov 10-14</td>
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### S2 - Advanced Evaluation & Manipulation of Pelvis, Lumbar & Thoracic Spine Including Thru  
21 Hours, 2.1 CEUs (Prerequisite S1)  
**$959**

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<tr>
<th>Location</th>
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<tr>
<td>New York City, NY</td>
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<td>Chicago, IL</td>
<td>May 24-30</td>
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<td>Jun 6-16</td>
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<td>Baltimore, MD</td>
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<td>Sep 10-17</td>
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<td>New York City, NY</td>
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<td>Houston, TX</td>
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### S3 - Advanced Evaluation & Manipulation of the Cranial Facial, Cervical & Upper Thoracic Spine
27 Hours, 2.7 CEUs (Prerequisite S1)  
**$959**

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<td>Mar 18-21</td>
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<td>Ft. Lauderdale, FL</td>
<td>May 6-9</td>
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<td>Grand Rapids, MI</td>
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<td>Chicago, IL</td>
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<td>St. Augustine, FL</td>
<td>Sep 28-31</td>
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<td>Columbus, OH</td>
<td>Nov 1-8</td>
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### S4 - Functional Analysis & Management of Lumbo-Pelvic-Hip Complex
19 Hours, 1.5 CEUs (Prerequisite S1)  
**$545**

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<td>May 22-27</td>
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<td>Compton, CA</td>
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<td>Cleveland, OH</td>
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<td>Sarasota, FL</td>
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<tr>
<td>Milwaukee, WI</td>
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Please send a letter of interest accompanied by curriculum vitae and names of three references to:
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Rangos School of Health Sciences
Department of Physical Therapy
Duquesne University
600 Forbes Avenue
Pittsburgh, PA 15282

For additional information about Duquesne University and the physical therapy department, please visit our website at www.duq.edu

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Director of Clinical Education and Search Committee Chair
Waldron College of Health and Human Services
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Study Finds Total Gym Can Be Used to Measure Patients’ Functional Status
Efi Sports Medicine has announced the results of a rehabilitation study using the Total Gym. The study, recently published in the *North American Journal of Sports Physical Therapy* (NAJSPT), was conducted by researchers at San Diego State University (SDSU) and the University of Toledo’s Health Science Campus. The study found that Total Gym could be used to accurately measure functional status of patients recovering from lower extremity injuries. The study’s lead investigator was Daniel Ciprinai, PT, PhD, an associate professor at SDSU.

MediConnect Global Acquires PassportMD
MediConnect Global, Inc, has acquired Passport MD, Inc, a consumer-directed health care information company with software for creating and maintaining personal health records. PassportMD has been selected by the Obama Administration as one of four vendors to provide electronic personal health records for Medicare beneficiaries in a pilot study. MediConnect is ranked at number 172 on Deloitte LLP’s Technology Fast 500.
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This Is Why
by Chaim Backman, PT

Community Service
A PT gets his neighbors moving.

I graduated in 1996 from the physical therapist (PT) education program at Hunter College in New York City. Two years later I opened a private practice in my home community, the Crown Heights section of Brooklyn. The area is known as “the headquarters of Chabad-Lubavitch,” a Hasidic movement in Orthodox Judaism to which my wife and I and our four children belong.

Once my practice was established, I had time to sit down and analyze my patients and the conditions that had brought them to me. I came to realize that, more and more, my recurrent message to them was, “You need to start living a healthier lifestyle. You need to start exercising.”

More often than not, my patients would respond, “I don’t have the time.” Sometimes they’d ask, “Do you?” The fact was, I’d been very physically active in my teens and even into my 20s, swimming and running regularly, but like a lot of people I’d grown more and more sedentary as the demands of school, family, and career took over my life. My patients’ reminder that I wasn’t taking the time to exercise, combined with the example my wife was setting by running up to 5 miles a day on the treadmill, eventually motivated me to start running again.

It long had been a dream of mine to someday run a marathon, so when I turned 39 I decided the time had come. I signed up for the nearby Yonkers Marathon and started training. I successfully completed it, and then I was hooked. I ran another marathon the following year. Later I completed my first triathlon.

Training had become part of my life, and I began encouraging my friends and patients to join me. I took a course and became a USA Triathlon-certified triathlon coach. Before long I was giving classes in Brooklyn’s Prospect Park for people who’d never run before. Word quickly got around. People started coming up to me to say they wanted to join my class. I was urged to start exercise programs for schoolchildren. People thanked me for finally getting this relative or that friend off of his or her “fat tuchus” (that’s Yiddish for “backside”). The rabbi even made reference in synagogue one Saturday to the health craze that was under way in Crown Heights.

A few months later, on a drizzly, overcast afternoon, a friend and I went to the park for a run. The place seemed almost deserted at first, but before long we started meeting up with small groups of runners—first one, then another. They all were people from the neighborhood who I’d encouraged to start running.

Finally my friend looked at me and said “Look what you’ve done. You’ve really started a revolution here! The park is full of your students and friends—people who are running because of you.” I got to thinking about that. The whole reason I’d become a PT was to live the lesson I’d learned in Yeshiva: that we all should strive to make positive change in the world, one person at a time. As I ran through Prospect Park that day, watching my friends and neighbors literally taking the steps necessary to improve their health, it hit me that the fruits of my career choice were right before my eyes. PT.
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