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Orthopaedic Physical Therapy Practice

Special Issue: Occupational Health Physical Therapy SIG

AN OFFICIAL PUBLICATION OF THE ORTHOPAEDIC SECTION
AMERICAN PHYSICAL THERAPY ASSOCIATION

The Orthopaedic Section, A.P.T.A.
presents

1993 REVIEW FOR ADVANCED ORTHOPAEDIC COMPETENCIES

July 11 - 17
Seattle, Washington
Doubletree Suites Hotel

MEETING A: July 11 - 13

TUITION: $250 - Orthopaedic Section Members
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Joe Sutter, M.S., P.T.

THE WRIST AND HAND
Carol Waggy, P.T., Ph.D. (in progress)

MEETING B: July 14 - 17

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THE FOOT/ANKLE
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THE LOW BACK/SI JOINT/HIP
Paul Beattie, Ph.D., P.T., OCS

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The purpose of the"Review for Advanced Orthopaedic Competencies" is to provide Orthopaedic Section members and non-members with a process of review. (It is not intended to satisfy examination criteria for the Orthopaedic Physical Therapy Specialty Competency examination, but to serve as a **review process only.**) Cancellation received in writing prior to the course date will be refunded in full minus a 20% administration fee. Absolutely **no** refunds will be given after the start of the course.

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Orthopaedic Physical Therapy Practice

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- An Orthopaedic Approach to the Hip, Part I
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	$225.00 APTA Members	$275.00
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Special discounted rates are available for institutions with multiple registrants. Please call the Section office for complete information.

*If notification of cancellation is received in writing prior to the course, the registration fee will be refunded, less a 20% adminstrative fee. Absolutely no refunds will be given after the start of the course.

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***This is a repeat of a course that ran from September 1991 through February 1992**

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Editor's Note

This is the first in what I hope will be a series of dedicated issues. Each year, *OP* will attempt to showcase one of our special interest groups. Occupational Health Physical Therapy is the first recognized SIG within the Section, and this issue is but one example of their hard work to date. Dennis Isernhagen, President of the SIG, provides the guest commentary.

This is an "industrial strength" issue, packed with committee reports, bylaw changes, and other items of interest. Read, digest and enjoy!

Jonathan M.
Cooperman, MS, PT

Guest Commentary

OCCUPATIONAL HEALTH PHYSICAL THERAPY

It is an honor to be asked to write the guest commentary for this issue of *Orthopaedic Physical Therapy Practice*. This issue highlights occupational health, a rapidly growing area that offers unique and exciting opportunities for physical therapists. These opportunities provide new challenges that go beyond the traditional roles of physical therapy in clinical practice.

Occupational health physical therapy focuses on work and the injuries that occur while performing work. It deals with the functional evaluation, treatment, management and prevention of work-related injuries. Physical therapists are in an optimal position to assist employers and employees in reducing the risks associated with work injuries. A therapist's expertise in human movement and the understanding of the cause and effect of musculoskeletal conditions, especially cumulative trauma, creates a strong foundation from which can be developed the skills and techniques required to provide effective and cost efficient services to employers and employees.

To provide these services successfully many therapists will be required to make radical changes from their traditional, clinically oriented approach. Occupational health requires an aggressive approach to treatment with the goal of a "rapid" and "safe" return to work; and communication with the employee, employer, third party payor and other health care professionals. The therapist must have an in-depth understanding of the physical requirements of the job and the environment in which the job is performed. This requires the therapist to leave the clinic and visit the job site.

Knowledge of ergonomics is very important to the therapist involved in Occupational Health Physical Therapy. This knowledge enables the therapist to assist both the employer and the employee in making modifications when a job accommodation is required. In addition, ergonomic changes in the work place will benefit employees and the employer by making the job(s) easier to perform, thereby reducing the risk of injury. This will in turn reduce Workers' Compensation losses and increase productivity; all of which translates into higher profits for the company and job security for the employee.

Even though this area offers growing opportunities for physical therapists it is not without its share of problems. Work related injuries costs employers in the United States over $60 billion annually. Health care is a major cause of these growing costs. Even though physical therapy accounts for only 3-4% of the total cost of Workers' Compensation it is being targeted by many employers and third party payors as an over utilized service. The conservative approach of many physical therapists in treating individuals with work injuries supports this assumption. Passive modalities three times per week is not the prescribed treatment of choice for individuals with work related injuries. They, like the individual being treated for a sports injury, need to have an aggressive program that will get them safely back to work in a timely manner.

Occupational health physical therapy is an exciting field. Well run programs by qualified therapists have demonstrated significant benefits to both the employer and the employee. For physical therapy to become firmly established in this area of health care, it will require a concerted effort by all therapists who treat individuals with work injuries. This includes research to find new methods of evaluation and treatment of work related injuries, development of standards of care and outcome criteria, and lobbying with state legislatures to insure that physical therapy is included in Workers' Compensation laws. The analysis and implementation of these actions are part of the goals of the Occupational Health Physical Therapist Special Interest Group.

Dennis D. Isernhagen, PT
President, Occupational Health Physical Therapist Special Interest Group

PRESIDENT'S REPORT

The Combined Sections Meeting in San Antonio was another giant stride for the Orthopaedic Section towards professional growth. Our educational meetings were filled to capacity, and in some cases beyond. The Business Meeting on Saturday was well attended and enabled our members to share their professional concerns and network to identify some possible positive courses of action.

WHY WAS THIS MEETING SO EXCITING?

Personally, it was my first CSM as Section President. It was my opportunity to establish the environment in which my campaign goals could be implemented. This is one of collaboration and trust. Collaboration among members; among areas of subspecialization in Orthopaedics; among the ABPTS, Orthopaedic Specialty Council, National APTA and the Section; and among the nineteen Association Sections.

These collaborative relationships will effectively lead the section into the challenges of the decade; cost containment; managed care; expanding government control of the health care industry; encroachment by medical, allied health and non-medical practitioners; the expanding role of the physical therapist and the physical therapist assistant; and the need to validate rapid professional growth of Orthopaedics. This list is only a sample of the issues facing our membership in the 90's.

Actions taken at CSM by the Executive Committee are focused on these issues:

- The Occupational Health Physical Therapy SIG of the Section has invited the Private Practice Section and the APTA to develop a focus group to establish criteria and plan a presentation to the Worker's Comp providers across the country that will substantiate the need for appropriate reimbursement for quality physical therapy.
- We donated $2000 to the Legislative Committee of the Private Practice Section for the work on CPT Coding, RBRVS, and their lobbying activities on the Hill.
- We reorganized our Practice Committee to focus on multiple practice issues under the direction of Scott Stephens, an experienced practitioner, former Chapter President, and founding member of the Federation of State Boards.
- Our Education Committee has expanded their charge to include analysis of the many advanced degree programs available in orthopaedics, refresher programs for the returning therapist, and new continuing educational opportunities.
- More Section Roundtables are considering evolving into SIGs. Physical therapists for the Performing Artist will be petitioning the Executive Committee prior to Annual Conference to become a SIG. Head and Neck, Foot and Ankle, and Manual Therapy are all discussing similar actions. Thus we continue to attempt to meet the needs of our general membership while still recognizing the need to assist our members with specific practice orientations to organize and promote their "sub" or "supra-specialty." This proliferation of Section components will strengthen our Section while it challenges the Executive Committee to provide effective administrative structure, guidance, and appropriate financial support.
- Once again the Section will be leading the profession in certifying advanced clinical competencies. As one of the earliest Sections seeking a written examination, we are now looking into establishing clinical residency programs, practical examinations and further specialized written examinations. This evolved certification process will be added to our successful Orthopaedic Certified Specialist examination. We are initially investigating manual therapy residency standards in conjunction with the AAOMPT. The Occupational Health Physical Therapy SIG has also expressed interest in the process, as well as the other Sections that certify specialists. The APTA BOD and the ABPTS have praised our efforts and await the results of our fact finding and proposals outlining the residency programs and/or clinical practical examination processes.

Annual Conference should prove to be as exciting. At the Business Meeting on Sunday, June 13 from 8:00—9:30 A.M. you will hear updates of all Section activities, vote on important administrative bylaws, and participate in another Issues Forum. We welcome your active participation!

Z. Annette Iglarsh, P.T., Ph.D.
President

The Orthopaedic Section is pleased to offer its membership a continuing education home study course on the Lumbar Spine. This course will begin in January, 1994. Please watch for further details!

FROM THE SECTION OFFICE

Terri A. Pericak, Executive Director

UPCOMING ANNUAL CONFERENCE IN CINCINNATI

Due to the overwhelming response and success of the Section's first Practice Issues Forum during the business meeting at CSM in San Antonio, the Section will continue to offer this forum at all business meetings. Some of the topics for the forum scheduled in Cincinnati are; Health Care Reform, Reimbursement Issues, Encroachment, and an Open Forum for discussion of other issues important to the membership. Scott Stephens will be moderating this forum which will be on Sunday, June 13, from 8:00—9:30 AM. We encourage all Orthopaedic Section members to participate.

An organizational meeting will be held on the foot and ankle, Monday, June 14, from 3:30—5:00 PM. Dr. Tom McPoil, P.T. from Northern Arizona University in Flagstaff will be moderating this meeting. Anyone interested in helping to organize this foot and ankle specialty group is invited to attend.

REVIEW FOR ADVANCED ORTHOPAEDIC COMPETENCIES COURSE

The next review course will be held July 11-17 in Seattle, Washington. A full page ad with all the details is located in this issue of *OP.* A direct mailing brochure has also gone out to all Section members. If you are interested in registering for this course or would like more information, please mail, FAX or call the Section office.

Due to the large response to the July review course in 1992, a second course was offered in November, 1992, in conjunction with a co-sponsor. If you would like to be a co-sponsor for a fall review course in your area, please contact the Section office for more details.

ADMINISTRATION

The Section is becoming more and more involved in various activities within its many committees. In order to increase our efficiency and better serve the officers and committee chairs in carrying out the details of these activities, the Section office has expanded its staff. Tara Fredrickson is our new Administrative Assistant and is responsible for working with all committees on their projects as well as coordinating the review courses. Mary Geary is our new Membership Services Secretary and is responsible for all aspects of membership activity. We welcome both Tara and Mary to the administrative staff and wish them well in their new positions.

THE PHYSICAL THERAPIST'S ROLE IN JOB ANALYSIS AND ON SITE EDUCATION

By Joanette Alpert, M.S., P.T.

INTRODUCTION

Their were over 6.4 million occupational injuries, and approximately 331,600 occupational illness cases reported in private industry in 1990 (1). Disorders associated with cumulative trauma accounted for 56% of total illness cases, up from 52% in 1989, and up from 18% in 1980. As high as these numbers are, some people feel that the numbers are very much under-reported. We know not only from these startling statistics, but from the patients we treat in the clinic every day, that these injuries and illnesses are costing this country billions of dollars each year. Employers expend large sums of money for medical treatment and workers compensation—after the injuries and illnesses occur. Physical therapists can use their knowledge and experience to assist employers in preventing these disorders.

Physical therapists receive personal and professional gratification when a patient is helped to reach their optimum level of function. This can also occur in business and industry by helping employers reach their optimum level of function. Implementing an effective and comprehensive injury prevention program can lead the employer to greater productivity, less absenteeism, and better management and employee morale. The employer can also realize a direct financial gain by reducing both the number of claims and the severity of injuries and illnesses that do occur.

Occupational health physical therapy is still evolving as a specialty within the field of physical therapy. As physical therapists, we have a good understanding of the pathology and mechanics of injury and illness. Working with the injured worker is similar to working with an athlete, child, or an older patient. The common goal is to return the patient to their pre-injury or illness level of activity, or to restore optimum function. Working with the injured worker leads to an understanding of the mechanisms of injury. Although personal risk factors may be present, work related injuries are often specific to the working environment. Effective treatment requires an understanding of the interface between the worker and their environment. The best way to understand the work environment is to spend time working on site in business and industry.

As physical therapists, there are many ways that we can assist employers in preventing musculoskeletal injuries in the workplace and reducing the costs associated with them. A comprehensive injury prevention program would include a review and analysis of injury and illness records, job analysis/ergonomic evaluation, training managers, supervisors and employees, and effective injury management. This article will focus on job analysis, ergonomic evaluation and training.

JOB ANALYSIS AND ERGONOMIC EVALUATION

A job analysis is a written document identifying the work activities and how they are performed in a specific environment. Specific physical (and sometimes mental) demands are described. An ergonomic evaluation is an extension of this analysis. It identifies risks and hazards for musculoskeletal disorders, and provides recommendations on abatement of these risks. Per the Occupational Safety and Health Administration (OSHA), the objectives of worksite analysis are to "recognize, identify, and correct ergonomic hazards" (2). Job analysis and ergonomic evaluation may be done throughout the company, in a high risk area, or individually with a specific employee. Individualized analysis often occurs after an injured employee has begun their rehabilitation, and/or upon return to work. An employee that is having problems, but has not missed work might also be an appropriate candidate for analysis and evaluation. Some companies know exactly where their problem areas are, while others need assistance in identifying high risk areas. This can sometimes be accomplished by a simple, escorted walk through the facility.

The analysis has several components. The position being evaluated and the basic objectives of the position should be documented. The analysis would also include the method of data collection and whom the information was obtained from. Basic information on the employer should list what they do, who their customers are, how many employees they have, and specific information on the department or job being evaluated. Hours of operation should include number of shifts, specific hours, length and number of breaks. If the analysis is being performed on a specific individual, additional information should be taken, such as date of birth, date of hire, date of injury, height, weight, hand dominance, injury history and post injury employment history. Job duties should be identified. If the purpose of the analysis is to identify essential functions of the job (such as for a job description to aid in compliance with the Americans with Disabilities Act), several other steps, beyond the scope of this discussion, may be included. If the job duties listed do not identify the essential functions of the job, that should be stated.

The environment is described, including time spent indoors versus outdoors, temperature, lighting, flooring and other issues such as noise, fumes, vibration, special clothing and safety equipment used. Machines, equipment, tools and work aids are identified, as well as the tasks performed with them. Vision, hearing and talking demands are documented. The analysis should also include a general description of the work station, postures used, and work habits of the employee.

Physical demands of the job should also be documented. Strength demands include lifting, carrying (specific items, frequency, weights, work heights, horizontal distances, unilateral/bilateral), pushing and pulling (specific items, forces, frequency, devices, static/dynamic, floor surfaces, shoes). Upper body demands include neck, shoulder, elbow, wrist and hand movements, and manual and finger dexterity. Trunk and lower extremity demands include standing, walking, sitting, eye-hand-foot coordination, trunk bending and twisting, kneeling or crouching, crawling, climbing and balancing.

RISK REDUCTION

Once this data is collected, risks for musculoskeletal injury are identified and recommendations are made that will reduce the risks. OSHA describes 4 areas of risk prevention and control (2). One or all of these may be appropriate, depending on the situation. Implementing engineering controls is the preferred

strategy. Keeping in mind that the goal is to fit the job to the person, the first line of defense should be to make changes in work station design, modify the way the work is performed, and/or modify tools. Sometimes it is not feasible to make these changes. Another important and very effective strategy would be to implement administrative controls. Administrative controls may include job rotation, limiting overtime, decreasing production rates, or starting an equipment maintenance program. A third recommendation may be to implement effective work practices. This may include enforcing the use of proper work habits, altering the size or weights of objects handled, or performing regular tool and equipment maintenance. Lastly, personal protective equipment may be appropriate. Examples would be gloves or back supports. Caution is suggested here. It is better to get at the cause of the problem and make changes there. For example, it would be better to reduce the exposure to vibration, versus using vibration dampening gloves. It would be better to lighten the load, reduce the frequency of handling, or work at a better height than to use a back support.

Employer input is critical during the process of making corrective recommendations. Ideally, an ergonomics or injury prevention team is identified. This team may include any combination of the following people: engineers, medical/health care providers, risk managers, safety personnel, managers/supervisors, employees, labor representatives, human resource personnel, and others as needed. The evaluator should be sensitive to the environment, financial issues, and what changes have already been made. A therapist should keep in mind that their recommended solution to the identified problem may not be the best option for an employer. Internal resources, such as production engineers, safety professionals and industrial engineers should be utilized, if available. The knowledge base of these individuals often complements our own. Their strengths, such as engineering and retooling, may be our weaknesses. A cooperative team effort will be the most effective.

After the initial analysis is completed, ongoing monitoring should be implemented. The needs of the employer will determine how they go about monitoring their program. Some employers will effectively carry out recommendations using internal resources, while others will look to physical therapists for assistance with equipment purchases and modifications. Physical therapists can assist employers not only in deciding what they need to do, but how they are going to implement changes.

Various tools are utilized in onsite analysis. I have been successful in using items such as a tape measure, calculator, scale, force gauge, Polaroid camera, 35 mm camera, tally counter and a video camera. Occasionally, more complex equipment such as high speed video and digitizers may be utilized. Personal protective equipment is recommended, such as a hard hat, steel toe shoes, hearing protection, and safety glasses. Having these items with you will let the employer know that you are knowledgeable of the work environment and that you are prepared.

TRAINING

Most occupational injuries are due to poor work habits, not work place conditions (3). Teamwork, communication, and comprehensive employee training programs are critical for the success of any safety program. In its voluntary training guidelines, OSHA encourages a personalized approach to the programs offered at the worksite (4). Although changing the design of the work station may have a positive effect on the immediate problem, it is also beneficial to teach the employees why that change was made, and how to decrease their own personal risk factors. Because all "work injuries" are not 100% work related, maintaining normal flexibility, strength and endurance may decrease the employees risk for injury. These concepts should be incorporated into onsite training programs. For things that cannot be easily changed, eg, stressful posture, a repetitive motion, or a costly work station set up, managers and employees must be given tools to help them compensate for these physically stressful work conditions. This too, can come through training.

To ensure the success of a training program, define clear and measurable objectives. Then develop a program as specific to the job as possible. When conducting the training, begin by outlining what the program will include, proceed with the program and then summarize the key points. Once the training program has been completed, a program evaluation will give the employer important information on whether the objectives were met and about future training needs. It also provides useful information to the presenter on the effectiveness of the program. Program evaluation and development should be an ongoing activity.

A successful program has management and supervisor support. Training of these individuals focuses on: (1) what the common workplace musculoskeletal disorders are and how they occur, (2) how to spot the risks, (3) the importance of enforcing proper working procedures, and (4) the importance of being accountable for the people they supervise.

The employee training program should include information on common workplace disorders and how they occur, the risks for these disorders, how to prevent them, and how to treat them. Employees must be taught that they are responsible for using their body the correct way to do their job, and that they should bring a healthy body to work. It is also important to keep in mind the audience being addressed.

Training programs might be held at almost any type of industry, eg., manufacturing plants, warehouses, food service areas, or offices. Training programs must be tailored for the target audience. When trainers provide a group with industry specific examples they make it easier for employees to apply the knowledge to their own tasks and work settings. Practical demonstrations are also effective. This may include hands on lifting and carrying practice; instruction in, or reviewing the use of, company equipment such as hoists, dollies or carts; stretching exercises; or problem solving at specific work stations. This last example is an effective way to solicit input from the employees regarding work station design and work procedures.

MARKETING YOUR SERVICES

There are many ways to market your services. Take advantage of trade organizations such as the American Society of Safety Engineers or the Occupational Health Nurses Association. Consider going to their meetings or setting up a booth at their trade shows. Discover what organizations the industry you are marketing to associates with and offer to be a guest speaker. Become involved with local service organizations such as the Rotary or the Lions Club. Join the local Chamber of Commerce, a direct link to business and industry in the area. Attend their functions and utilize their resources. Offer to speak at one of their meetings. Write articles for the local paper or business journal. Work with medical clinics or hospitals in the area and provide community lectures. Develop relationships with companies who can use you as a resource, such as a safety consulting firm that doesn't have anyone on staff that pro-

vides your services, or a physical therapy practice that is too busy to spare a therapist outside of the clinic for 4-8 hours at a time.

The worksite is not the traditional environment in which therapists are used to working. Physical therapists must learn how to deal effectively with industry. Companies move slowly when making financial decisions, and proposals must often pass through several hands before a decision is made. Getting to the decision maker is often difficult. Depending on the size and structure of the company, the decision maker may be a Human Resource Director, a Risk Manager, a Safety Director or a CEO. Therapists must learn to understand the industry they are dealing with, speak their language, and present the program in a way that is meaningful to the employer. A successful plan of action includes defining the focus of your services, matching those services with industries needs, and delivering the service in a timely and professional manner.

Share the results of your previous efforts with prospective clients. Have them contact your satisfied customers. The benefits of these programs are one of the best sales tools that you have. Employers are looking for someone to help them reduce the costs associated with workplace illnesses and injuries. Physical therapists are uniquely qualified because of their educational and clinical backgrounds to work with employers to reduce the costs associated with common workplace musculoskeletal disorders. We can teach employers to address the cause of these problems. Therapists can utilize their knowledge and expertise to help business and industry work toward a healthier, more productive workplace.

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Joanette Alpert, M.S., P.T. is the President and Owner of Work R.I.T.E. in Placentia, California. She is also the Vice President of the Occupational Health Physical Therapy Special Interest Group.

ADA: A THREAT AS WELL AS AN OPPORTUNITY

By Susan J. Isernhagen, PT

First the Good News

Since passage of the Americans with Disabilities Act (ADA), there has been a concerted effort to bring physical therapists to industry to assist employers in implementing ADA policies. Physical therapists have seen this as a potential growth opportunity for their practices, as well as a way to be of service to employees, employers and the disabled. Also, the physical therapists that work with injured workers use ADA principles in the return to work process. The following are opportunities and positives of physical therapists understanding and using Americans with Disabilities Act principles.

1. Physical therapists can be used as consultants by industry in order to do the functional job analysis and develop a functional job description for a company.
2. Regarding employment, physical therapists can do functional prework screening which matches the physical abilities of the applicant to the functional demands of the job. This follows a functional job analysis development.
3. Regarding the return to work process, the physical therapist can do functional evaluation and match the worker with the critical demands of the job. Reasonable accommodations or modified work can be recommended in order to facilitate return to work for both the physicians release to return to work and the employer's job placement.
4. In work hardening programs the physical therapist can try several types of reasonable accommodations or modified work in order to accurately match the worker with the work. In addition, the physical therapist can help assess the level of functional disability which may assist the physician in determining whether the patient is "disabled" or not.
5. Regarding architectural barriers, the physical therapist can use skills in ergonomics and modifications to design reasonable accommodations that overcome architectural barriers.
6. In addition, physical therapists have a good understanding of modifications which will allow a person to work and these can be used both as a preventive measure and in ADA accommodation within the workplace.

These opportunities allow the physical therapist to interact in a very proactive way with workers and employers. The physical therapist can be a positive force in allowing the principle of ADA to be realized.

Is There Bad News???

Several troublesome areas have been identified by physical therapists currently working with ADA principles. Some of these issues were raised during the CSM pre-conference meeting in San Antonio. The following statistics were quoted. These bring the physical therapist more into the picture than previously anticipated: Approximately 60% of the claims brought by workers claiming discrimination are of a musculoskeletal nature. This has been a surprise to the Equal Employment Opportunity Commission (EEOC) as the ADA was envisioned for the traditional "disabled" who would fall under the category of wheelchair user, hearing or seeing impaired, suffering from a severe or progressive disease (multiple sclerosis, stroke, etc.) and other typical disability conditions.

Physical therapists, however, have long recognized that musculoskeletal injuries such as chronic back problems, upper extremity impairments and chronic cumulative trauma problems also bring work disability to an individual. Therefore, to the therapist it is not a particular surprise that so many musculoskeletal complaints are now brought into the ADA arena. It will necessitate, however, that we take a much stronger and closer look at what we are doing so we do not violate the ADA in our daily business of physical therapy.

Because of increased exposure through our work, we must evaluate the ADA in our practices. The following are some of the areas which could result in potential problems for physical therapists. By evaluating them in conjunction with our own practices, we as physical therapists may avoid being involved in claims brought under the ADA, regarding discrimination or privacy issues.

THREAT #1: The ADA, in stating that "disabled" can be protected from job discrimination, defines this protected person as, "a person having a physical or mental impairment (or a record of such impairment or being regarding as having such impairment) that substantially interferes with major life activities such as manual tasks, walking, seeing, hearing, speaking, breathing, learning and working." The ADA also specifically protects the employee from employer knowledge of such medical conditions although it allows work "functional" limitations to be known. The ADA has put into effect a "medical privacy" caveat in which the employer is not to know about specific medical conditions of their employees.

Applicant medical information before a job offer is made is prohibited. After offer of a job only functional information should be utilized. Once employed, no medical inquiries are allowed unless a specific problem surfaces. The purpose of this provision is to protect the employee from any intentional or unintentional discrimination by an employer who regards an employee as disabled. Therefore, medical providers must be very careful as to the information that the employer receives from them.

If any employer designates an insurance person or a hiring person as able to receive medical information, then this designated person must keep all medical information in a "locked confidential file" so that no one else at the place of employment is able to receive information regarding disability of any given worker.

We, then, must understand that if we do send any medical reports to employers, that these medical reports must be sent only to the designated person at the place of employment authorized to receive the confidential medical files. This person may be a workers' comp administrator or someone in a similar position. It would be wise for all physical therapists sending reports directly to employers, whether it be for billing purposes with records enclosed or for outcome statements after work hardening, that only the designated person receives the information. Under no circumstances should general medical information or medical reports be faxed to an employer. The risk is that if alleged discrimina-

tion occurs because of the employer's perception of work disability then the worker will sue the employer for discrimination. If it is the medical provider (such as the physical therapist) that has violated the medical privacy privilege, then the medical provider may be caught in the discrimination web.

Therefore, physical therapists need to take the following steps in order not to violate the privacy provision of any patient they see.

1. In a work injury case, differentiate between information reported that is directly related to the work injury and any other medical problem. For example, a person with a back injury may report for treatment or work conditioning and in the history the physical therapist finds that the person also has cancer. The cancer information is not necessarily relevant to the workers' compensation claims but if the information on cancer were given to the employer it could bring about an intended or unintended discrimination by the employer. Therefore, the information regarding cancer would exceed the information to be reported regarding the work injury. The physician would be the appropriate professional to receive the physical-medical information. If reports are sent to the employer, they should be sent in functional terms only regarding the person's ability to work.
2. In sending physical therapy or work conditioning progress reports to an employer, it may be prudent that history and physical information unrelated to functional outcomes be sent only to the physician and insurance company. The employer, after all, should be most interested in the functional outcomes. Can the person lift 75 pounds and/or work on the loading dock? They are not necessarily interested in spinal range of motion of 43° or blood pressure of 150/100. While limitations in range of motion or hypertension may be contraindications to heavy work, these again should be stated in functional terms and be reported to the physician only so that appropriate privacy can be given to the patient.

While these are currently grey areas in litigation, nevertheless, if the therapist understands that the intent of the ADA is to allow privacy of medical conditions to each worker, then each physical therapist department should review their own notes for what types of information is being sent to the employer. The general rule is:

- Functional information only goes to the employer.
- Medical information and functional information goes to the physician.

THREAT #2: Therapists have traditionally participated in prework screening. Numerous computerized and normed information can be gained from high tech equipment. However, in general, most high tech equipment and normative data does not specifically relate to an individual's ability to do a certain job. The ADA is very specific in stating that if a worker can do the essential functions of the job, they should get that job. There is no discussion of normative data or projections made according to nonfunctional formulas. The actual testing of the worker to deny employment or reemployment after an injury must be directed toward the physical capacities of the worker and the physical requirements of the job. If there is a match, the person should be able to work.

In addition, we must consider the classification of a potential worker or worker as "disabled." If this designation applies, then the "qualified disabled" worker can expect "reasonable accommodations to be able to perform the essential functions of the job. If the person needs reasonable accommodation on the job, then they should also be afforded reasonable accommodation during prework or return to work testing. Therapists must be cognizant of this interpretation.

The physical therapist participating in prework screening must adhere to the following guidelines to remain within ADA rationale.

1. A functional job description must be designed prior to the design of the prework screen. Essential functions must be able to be defined accurately for each job.
2. Functional tests should be designed that meet the essential functions of the job. The closer the match the greater the "content validity." In general, avoid use of norms or formulas as they take "general" data, not the specific individualized information required by the ADA.
3. The therapist, after verifying that the screen meets the job demand criteria, will only score the potential employee on a "met criteria," "did not meet criteria" basis. The therapist will not indicate or make a hiring decision.
4. The therapist should explain to the employer that endurance and the potential for cumulative trauma cannot be identified exactly from a prework screening. Due to the short duration of most screens, the most that will be able to be accomplished is to basically determine whether the potential employee has the physical capability to do the essential demands of the job on a short term basis. Strength, motion and functional outcomes can be determined from testing items. However, endurance, aerobic capacity levels, and potential for cumulative trauma will be much harder to identify. Projections that are discriminatory should be avoided. Acknowledge and maintain the limitation of a short test.
5. Safety will be an issue because the therapist could inadvertently allow an applicant to be hurt in testing, thus setting up a malpractice lawsuit. Regardless of the functional job description and the method that the worker do the work, the physical therapist will nevertheless need to make an informed decision whether the parameters of work are safe. If it is suspected that the work itself is unsafe, then the screening may also be unsafe. Merely doing a screen according to a job description will most likely not protect the therapist from a malpractice suit. The greater the screen differs from common safety precautions, the greater the likelihood of negligence.

THREAT #3: Consider the following scenario:

Mr. Jackson has come to your clinic with a diagnosis of spondylolisthesis and with an episode of back pain secondary to an injury on the loading dock. After initial active physical therapy, return to work is considered but the work is considered in the Medium to Heavy classification with considerable repetitions of lifting. The employer agrees that a work conditioning program would be helpful. At the end of the work conditioning program it is determined that the worker will not be able to progress beyond a 30 pound lifting limit. This is due both to the spondylolisthesis previously diagnosed and the injury sustained during work. At a conference that includes the employer, physician and Mr. Jackson, the physical therapist reviews the outcome data from the work conditioning program and suggests a lifting restriction of 30 pounds. Mr. Jackson believes that a vacant

position exists on the loading dock that has only light lifting and is primarily an inventory control position. However, the employer states during the conference that if Mr. Jackson cannot return to a 100%, a full time basis, that no position can be held for him. The state workers' compensation law does not require the employer to take Mr. Jackson back unless he is able to perform his previous job.

The following issues arise out of this situation, under the ADA.

1. Would Mr. Jackson fall under the classification of "disabled" because of his permanent limitation of function due to a physical disability? The physician could make this point clear.
2. If in fact Mr. Jackson could be considered "disabled," does not the employer have the responsibility to provide either reasonable accommodation or transfer to an open position?
3. If the physical therapist believes that a disability classification is likely by the physician and that the patients ADA rights are being violated by the employer who refuses to take the worker back, what is the next avenue of action?

It may be unclear what the physical therapist's role would be in this situation, but generally, any patient of a medical professional whose legal rights are being violated, has a right to be notified by the medical provider. Secondarily, inquires can be made to EEOC regarding such a situation by the physical therapist and confidentiality can be maintained. Thirdly, the physical therapist may seek the physician's position on whether a true "disability" exists under the definition of ADA. It if does exist, then a further course of action should be determined.

The physical therapist here can threaten their own practice by "blowing the whistle" too often in inadequate cases. On the other hand it is our ethical and professional responsibility to see that our patients have their cases properly handled. The extent of our ethical and legal interface in this situation needs to be further discussed in the physical therapy world.

Handling the Threats and Opportunities

The ADA provides a very positive opportunity for us to do the best work for our patients. We can help evaluate their function and match them to the demands of the job. By doing this in an accurate, reliable manner, we can help promote ability of any employee and help employers to accommodate the needs of their workers. Physical therapists have traditionally evaluated function and matched this with the physical requirements of a particular activity. Just as we have returned a stroke patient to home and the athlete to the football game, we now can assist in proper placement of an individual into the workplace. The ADA embodies the principles for which we have always stood.

On the other hand, if we do not have a good understanding of the law and its specific issues, we may unwittingly fall into a discrimination area which is harmful to our patients and ultimately will be harmful to ourselves. The following reminders will help us to avoid the threats and instead concentrate on the opportunities.

1. Know the law. Read the Americans with Disabilities Act and its interpretation. Keep current with the judgments found in ADA litigation so that we have a better understanding of who is considered disabled and how this relates to work.
2. If we are involved in prework screening we must be accountable for our actions. Screening should only be developed and done when the examiner has a full understanding of the legalities of the ADA. The issues between agility testing (pre-offer) and functional testing (post-offer) have not been addressed in this article. Any therapist interested in avoiding further ADA threats should understand those differences and legalities.
3. Use functional tests to determine function. Don't get caught up in tricky formulas or computerized equipment if they in fact don't measure aspects of the actual work. Just as we would not put a stroke patient on a stair master in order to evaluate whether they can safely ascend and descend stairs, neither should we use inappropriate equipment to substitute for our own professional ability to do a thorough objective dynamic evaluation.
4. Know our responsibilities in cases when we see abuse of ADA principles or open violation of rights.

Since the Americans with Disabilities Act is a win/win situation for both employees and employers, we as therapists can also make it a win/win situation for us. It is the most far reaching civil rights act passed since the 1960's. It is something we will live with from this point on. The sooner we understand our obligations and responsibilities as well as our opportunities, the ADA will become a positive instrument for all.

Susan Isernhagen, PT, is co-owner of Isernhagen Work Systems in Duluth, MN.

Due to the increase in enrollment and higher demand for the Review for Advanced Orthopaedic Competencies course held once a year, the Orthopaedic Section is offering to co-sponsor an additional course each year. If you or your organization would be interested in co-sponsoring this course with the Orthopaedic Section, please contact Terri Pericak, Executive Director, at 1-800-444-3982 or write to the Orthopaedic Section office at 505 King Street, Ste. 103, La Crosse, WI 54601. The annual course is currently offered in July, with the location changing every year. An additional co-sponsored course would most likely be offered in October or November.

FOOT AND ANKLE ROUNDTABLE

Sunday, June 13, 1993
11:00 AM—12:30 PM
Tom McPoil, P.T., Ph.D.

An organizational meeting on becoming a Special Interest Group of the Orthopaedic Section.

RESEARCH COMMITTEE OF THE ORTHOPAEDIC SECTION, APTA, INC.
CALL FOR PARTICIPANTS
RESEARCH PLATFORM AND POSTER PRESENTATIONS
APTA COMBINED SECTIONS MEETING
NEW ORLEANS, LOUISIANA, FEBRUARY 2 - 6, 1994

Persons wishing to make platform or poster presentations of research dealing with topics related to Orthopaedics (basic science, applied sciences and clinical sciences) are invited to submit abstracts for consideration.

LIMITATIONS:
Presenter must be a current member in good standing of the Orthopaedic Section of the APTA, Inc. or must be sponsored by a current member in good standing of the Orthopaedic Section.

Each Prospective presenter may submit no more than two abstracts. These abstracts must contain original material and may not have been presented at any national meeting or published prior to to the 1994 CSM.

SUBMISSION REQUIREMENTS:
Deadline for Receipt of Abstract: Abstracts must be received at the address below by September 1, 1993.

Address abstracts to:
Daniel L. Riddle, M.S., P.T.
Research Committee Chairman
Orthopaedic Section, APTA, Inc.
c/o Department of Physical Therapy
Virginia Commonwealth University
Box 224, MCV Station
Richmond, VA 23298

Format for Abstracts: The abstract must be typed double-spaced on one side of a single 8 1/2" x 11" sheet of paper. The type must be 10 point or larger and produced on an electric typewriter, letter quality printer (impact or laser) or a high quality dot matrix printer with near-letter-quality type. The abstract must use standard abbreviations and should not contain subheadings, figures, tables of data or information that would identify the authors or the institution. Margins for the BODY of the text must be 1" on all sides.

The identifying information must be single spaced in the 1" top margin and include 1) the title in capitalized letters; 2) the full name(s) of the author(s) with the presenter's name underlined; 3) the place where the work was done; 4) the address of the presenter enclosed in parantheses; 5) acknowledgement of any financial support for the work being presented.

In the lower left margin, type single-spaced 1) the APTA membership number of the presenter (or name and membership number of APTA member/sponsor if the presenter is not an Orthopaedic Section member); 2) the telephone number and area code of the presenter.

In the lower right margin, be sure to indicate the preferred mode of presentation (Platform or Poster).

Copies: Include one original and one copy of the complete abstract with all the identifying information as outlined above.

Include 5 copies of the abstract with only the title and the body of the text (eliminate all identifying information except the title).

CONTENT:
All abstracts must be reports of RESEARCH and must include in order 1) purpose of study; 2) hypothesis if appropriate; 3) number and type of subjects; 4) materials and methods; 5) type(s) of data analysis used; 6) numerical results of statistical test(s) where appropriate; 7) conclusion; 8) clinical relevance.

EVALUATION AND SELECTION:
All abstracts are reviewed by members of the research committee without knowledge of the identity of the authors. Abstracts are selected on the basis of compliance with the content requirements, logical arrangement, intelligibility and the degree to which the information would be of benefit to the members of the Orthopaedic Section. All selections are final.

QUALITY OUTCOMES MONITORING IN OCCUPATIONAL HEALTH PHYSICAL THERAPY

By Michelle Wiklund, RRA

FOCUS ON OUTCOMES MONITORING

Outcomes monitoring is a tool that may be used to evaluate the effectiveness of work injury programs. It helps answer the question: "How do we know we are doing a good job in returning injured workers to their jobs?" Studies of clinical outcomes have the potential to revolutionize occupational health physical therapy.

The focus on outcomes monitoring has recently intensified. At least one author has referred to outcomes monitoring as a growing area of clinical measurement.[1] Interstudy, of Excelsior, Minnesota, has developed an Outcomes Management System being used by 425 organizations in 15 countries. The Agency for Health Care Policy Research (AHCPR) was created by Congress in 1989 to focus on medical effectiveness and outcomes research. The APTA has developed outcome assessment measures under its work hardening guidelines to assess, at a minimum, patient care results, program effectiveness and efficiency.[2]

OUTCOMES MONITORING AND THE OCCUPATIONAL HEALTH PHYSICAL THERAPIST

Work injury rehabilitation programs are currently faced with pressure from managed care organizations and workers' compensation legislation aimed at cost containment.

Outcomes monitoring can help the industrial therapist remain competitive in the occupational health physical therapy arena.

Outcomes monitoring is dependent on the supplier—customer relationship. The therapist is the supplier of services, while the customer may be represented by MD's, QRC's, payors, case managers, rehab consultants, etc. The relationship is based on trust, education, understanding, mutual benefit, and mutual respect. When the supplier develops such a relationship, satisfactory outcomes in treating the injured worker and returning him to the job site will prevail.

Evaluating a program in a systematic manner will help the supplier of services to measure its clinical outcomes. Client demographics (see inset), can be researched and provided to referral sources and consumers.[3]

Client demographics may include:

- percent male, percent female, age, length of time from injury to treatment, time off work from day of injury to treatment, referral source, company representation, diagnosis, type of service, discharge data.

There are various measurable criteria which can identify the disposition of the patient upon discharge from care. For example:

- Return to work level
- Return to work load
- Perception of work capability
- Job satisfaction level
- Client use and understanding of physical abilities evaluation information

Successful outcomes monitoring requires a broad based data collection. To critically evaluate one's services provided, a provider should review the cost of evaluation, treatment, and education of the injured worker in preventing future disability.[4] Other information to be collected includes patient surveys, clinician surveys, chart reviews, etc. Steffen has emphasized the need to combine data on outcomes of medical care with patients' perceptions and goals of treatment.[5]

Two types of information may assist in monitoring outcomes associated with care and treatment of occupational health physical therapy patients.[6]

(1) information that can be analyzed to determine the techniques of patient care that can yield the best results; and

(2) information that can be used to identify opportunities to improve care of patients in the overall continuum of care in occupational physical therapy.

DEMONSTRATING YOUR EFFECTIVENESS TO REFERRAL SOURCES

To your referral sources, proof of program effectiveness can be your greatest ally in securing and retaining occupational health physical therapy referrals. Currently, physicians most often maintain the role as primary care provider in care and treatment of the injured worker. They too, are subject to cost controls as providers within HMO's, PPO's, and other managed care systems. Clinical outcomes can demonstrate to physicians the effectiveness of a facility's patient treatment, and comparative data can be used to help physicians with issues of cost effectiveness.[7]

Any data that tends to support a facility's effectiveness will generate referrals from employer groups seeking high quality and efficient care that promotes early return to work. Therapists in occupational health physical therapy should be able to respond to questions not only related to evaluation and treatment, but to outcomes associated with industrial rehabilitation as well.

Foto and Swanson[8] state three requirements that will help the therapists define new markets:

- Is the outcome of the therapy service meaningful to the patient and/or care giver;
- Is the outcome of the therapy service practical; and
- Is the outcome of the therapy service sustainable?

The goal of every occupational health program—to return injured workers to gainful employment—is attainable and benefits both employees and employers.

WHY SHOULD THE OCCUPATIONAL HEALTH PHYSICAL THERAPIST BE INTERESTED IN OUTCOMES MONITORING?

The focus of outcomes is still new. Therapists engaged in occupational health evaluation and treatment should recognize the benefits of outcomes monitoring and management. Your organization should move forward to ensure its position as a high quality provider of occupational health physical therapy services through the outcomes monitoring process. Reasons to monitor outcomes include:

- Improving the quality of care. As occupational health physical therapists, we are in the business of returning injured workers to the work site. Anything less than a quality performance by ourselves does a disservice to our patients and the employers and physicians who refer them to us. By focusing on the best outcomes possible, we help pa-

tients achieve the best functional status they can.

- It will save money. Effectiveness of care and treatment can lead to returning the worker to the job site, thereby reducing the number of lost work days and increasing productivity. Appropriate cost effective treatment attracts customers,—employers, physicians and patients alike.
- It helps you to remain competitive.[9] The organization that monitors outcomes and proves effectiveness in the care and treatment of the injured worker will position itself to survive in a very competitive industry. Through outcomes monitoring and the sharing of data with your referral sources, you will strengthen your reputation as a quality occupational health physical therapist. You will become the therapist people choose when they need industrial rehabilitation services.

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Michelle Wiklund, RRA is Director of Quality Research for Isernhagen Work Systems in Duluth, MN.

WORK HARDENING GUIDELINES

WORK HARDENING GUIDELINES OUTCOME ASSESSMENT:

Definition: Outcome assessment is a systematic data collection procedure to assess, at a minimum, patient care results, program effectiveness, and efficiency. Effectiveness is a measure of meeting established program goals including return to work. Efficiency reflects total cost and time utilized to achieve established goals.

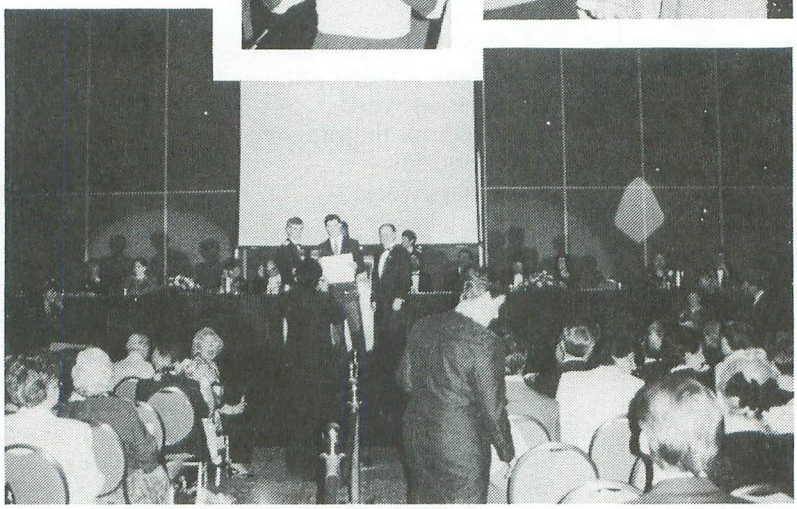
ELEMENTS:

1. Identify services provided as either Work Conditioning or Work Hardening.
2. Demographic data:
   (a) Age
   (b) Gender
   (c) Race and ethnicity
3. Occupational and injury data
   (a) Primary and secondary diagnoses
   (b) Work status prior to injury
   (c) Has the client received other treatment for this injury prior to entering the Work Conditioning or Work Hardening program? If so, identify all disciplines involved.
   (d) Date of injury
      - same injury
      - new injury
   (e) Date Work Conditioning or Work Hardening program was initiated
   (f) Is there a target job awaiting the client
   (g) Time off work
   (h) Length of the program
      - hours/day
      - days/week
      - total days
4. Discharge data
   (a) Total charges billed for the program
   (b) Program status (terminated or discharged) regarding return to work
      - same employer or different employer
      - previous job or different job
      - full time or part time
   (c) Client status at time of program termination/discharge
   (d) Referrals for additional services not available in the program
   (e) Payment source
      - worker's compensation board
      - private insurance

Guidelines for Programs in Industrial Rehabilitation
American Physical Therapy Association

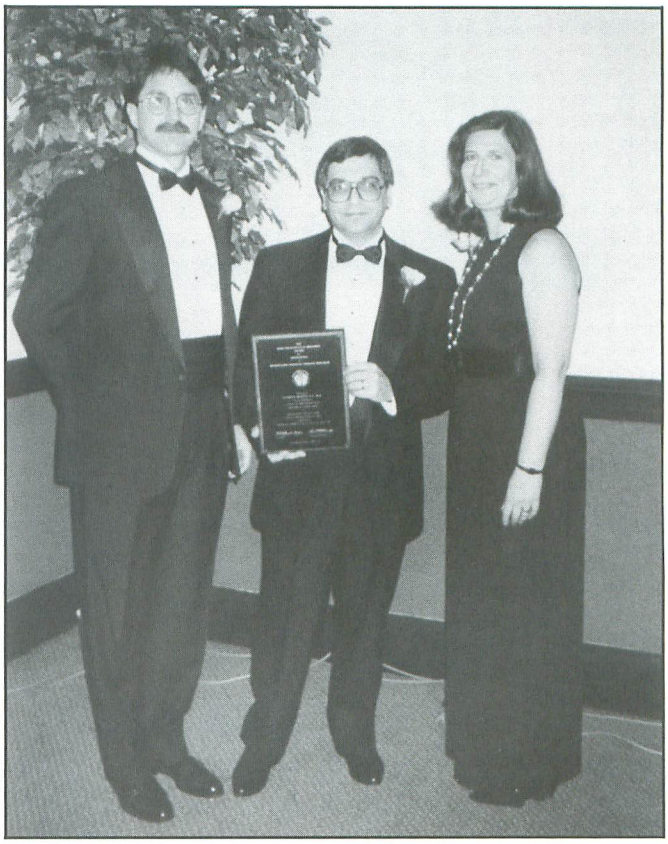
CSM '93

San Antonio, Texas

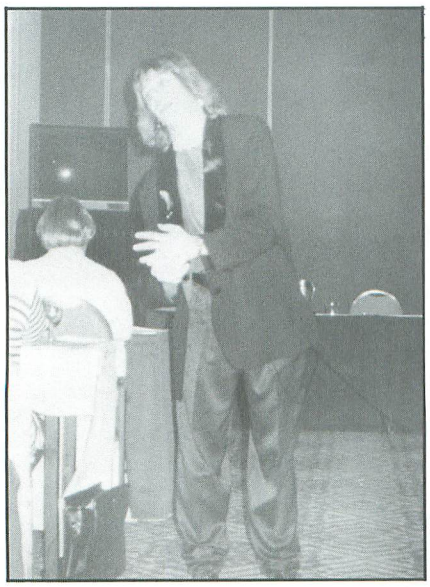


CSM '93 HIGHLIGHTS

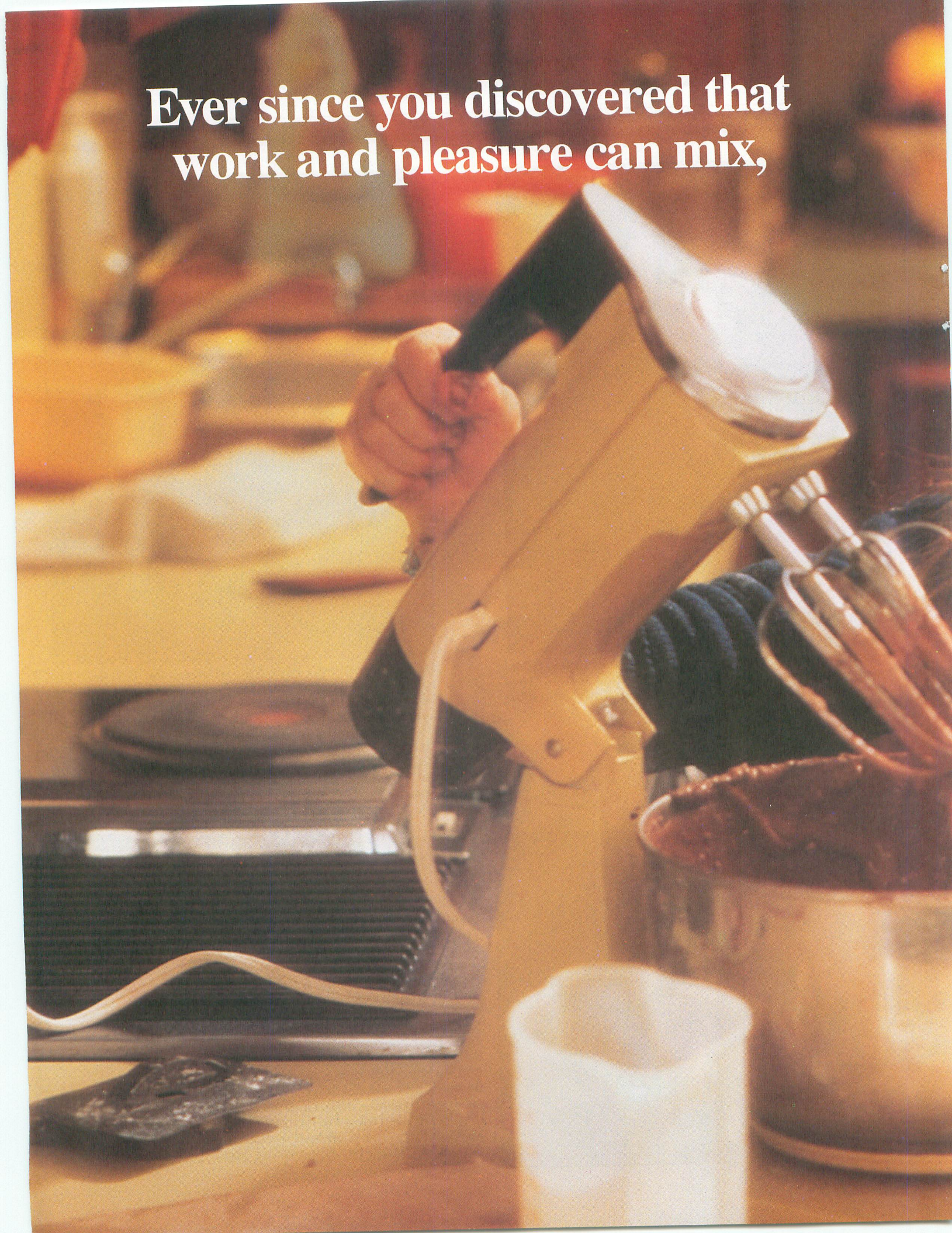
Annette Iglarsh is shown presenting a $2000 donation to Peter Towne who is President of the Private Practice Section. The funds will be used for work on CPT coding, RBRVS and lobbying activities on the Hill.



Dr. Anthony Delitto, PT was the winner of the 1993 Rose Excellence in Research Award for the publication *"A Study of Discomfort with Electrical Stimulation."* The paper was co-authored by Dr. Michael J. Strube, Dr. Arthur D. Shulman and Dr. Scott D. Minor, PT. The paper was published in Physical Therapy, Vol. 72, No. 6.
Dr. Delitto is shown above with Daniel Riddle, Chairman of the Research Committee of the Orthopaedic Section and Dr. Annette Iglarsh, President of the Orthopaedic Section.



Geri Jewell is known to millions as "Cousin Geri" from the NBC sitcom "The Facts of Life". Geri was the keynote speaker at the 1993 CSM Pre-Conference seminar entitled, "ADA-Practical Applications and the Physical Therapists Role", held in San Antonio, Texas, February 2—3. As the first person with a disability to become a regular performer on a sitcom, Geri broke important ground in an arena long hesitant to show disabled individuals as an integral, talented and able part of human society. Geri's performances captivate her listeners hearts with humor and motivation, while challenging them to open doors to new and healthier ways of perceiving themselves, others and the world they live in. Geri turns the focus from disablement to a true "Celebration of Abilities" in an inspiring, empowering and healing time for all.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AAOMPT AND THE ORTHOPAEDIC SECTION FORM JOINT TASK FORCE AT COMBINED SECTIONS MEETING

By Carol Jo Tichenor, MA, PT and Joe Farrell, PT, MS, President AAOMPT

"What a difference a year makes!" These were the words of Orthopaedic Section President, Annette Iglarsh, PT, PhD, when she met with the American Academy of Orthopaedic Manual Physical Therapists (AAOMPT) at CSM in San Antonio in February. At this time last year, AAOMPT was a newly formed organization of eight manual therapy residency programs across the country. Many discussions have occurred in the past few months which have strengthened the working relationship between AAOMPT, the APTA Board of Directors and the Orthopaedic Section. Most importantly, the Board, the Executive Committee of the Orthopaedic Section, and the American Board of Physical Therapy Specialties (ABPTS) have come to recognize the high level of commitment of AAOMPT to improve the educational process for manual therapy in the United States.

In November, 1992 AAOMPT President, Joe Farrell was invited to speak at the APTA Board of Directors meeting in Washington D.C. Joe presented to the Board the goals and objectives of AAOMPT and discussed various changes in the health care arena, including encroachment by other professions on physical therapy practice, which necessitate a serious re-evaluation of educational preparation in manual therapy. He urged the Board to consider residency training, used by medicine and other health professions, as a model for expanding the specialization process of physical therapists. A residency program in orthopaedic manual physical therapy combines clinical supervision over an extended period of time with clinical education that includes didactic and practical components.

Joint Task Force with the Orthopaedic Section: At CSM in San Antonio, the Orthopaedic Section and the Academy agreed to form a task force to study matters of mutual interest. The Task Force will examine how the AAOMPT and the Orthopaedic Section can most effectively work together to achieve the goals and then meet the membership needs of both organizations. One of the important issues which the task force will address is how manual therapy residency training will relate to the Orthopaedic Section OCS certification process.

Standards for Residency Programs: As part of the application to achieve full voting membership for the United States in the International Federation of Orthopaedic Manipulative Therapists (IFOMT), AAOMPT developed standards for manual therapy residency training, modeled after selected IFOMT guidelines. The AAOMPT Standards for Residency Programs document includes required hours for clinical supervision, and for instruction in manual therapy, in research methodology, and in the medical sciences (medical lectures, neurophysiology, anatomy, biomechanics, etc.) These standards will be available for interested physical therapists to purchase after April 1, 1993. Therapists should write: Carol Jo Tichenor, MA, PT, AAOMPT Standards Committee, Physical Therapy Residency Program in Advanced Orthopaedic Manual Therapy, Kaiser Permanente Medical Center, 27400 Hesperian Boulevard, Hayward, CA 94545. This is a preliminary document. As residency training in the United States evolves, it is anticipated that revisions in standards will occur. Cost of the standards is $15 for AAOMPT members and $25 for non-AAOMPT members.

Accreditation of Residency Programs: AAOMPT is developing a self-study document to evaluate whether a program meets the clinical and academic standards of the Academy. The self-study document will be part of a larger accreditation process currently under discussion by a joint committee of the Academy and the Orthopaedic Section. No program is currently accredited. The eight manual therapy residency programs associated with the Founding Members of the Academy (Joe P. Farrell, PT, MS; Richard Erhard, PT, DC; Michael J. Moore, PT; Ola Grimsby, PT, MNSMT, MNFF; Stanley Paris, PT, PhD; Kornelia Kulig, PT, PhD; Bjorn Svendsen, PT, DHSc; and Michael Rogers, PT, OCS) will be the first programs to complete the self-study document and subsequently undergo the accreditation review.

Development and implementation of a residency accreditation process will require many hours of hard work, adequate funding to meet the many expenses incurred, and expert consultation from many individuals across the country. Because of the time, energy, and financial demands of the process, the evaluation of the eight founding residency programs will assist the accreditation committee in ultimately streamlining the process for future programs. The process of accrediting the first eight programs should not be interpreted as one program being "better" than others. It is expected that the eight residency programs will need to make some curriculum changes to meet the Academy standards. As soon as possible, the accreditation process will be opened to all eligible programs.

AAOMPT Membership open: At CSM, applications for Associate Membership in the Academy was made available. A physical therapist in good standing with the APTA is eligible for Associate Membership. The cost of associate membership is $50. Checks should be made payable to AAOMPT. Application forms can be obtained from AAOMPT Membership Chairperson, Mike Rogers, PT, Gulf Coast Physical Therapy, 1500 45th Avenue, Suite B, Gulfport, Mississippi, (801) 864-1212.

Since the conception of AAOMPT, the founding members have volunteered several hundred hours for the development of the Academy and have privately funded the organization. As new members, your dues are an investment in the organization and will be dedicated to hiring the necessary consultants to work with the Academy and the joint Academy/Orthopaedic section task force to develop the accreditation process. The funds will also be directed toward examining the alternatives for insuring valid, reliable examination procedures, whether it be within the individual residency programs or external to the residency programs. Finally, funds will be devoted to developing conferences pertaining to manual therapy. Members will receive newsletters to keep them informed of all activities.

There are two additional membership categories, Founding Members and Fellows of the Academy. To become a Fel-

low, the physical therapist must have successfully completed a residency program which meets the AAOMPT clinical and academic standards. Many physical therapists have already completed manual therapy residency programs within the United States over the past decade. In addition, foreign trained physical therapists with residency training are working within the United States. The accreditation committee will be studying this issue and making a recommendation as to how the credentials of these individuals will be reviewed for membership as a Fellow of the Academy.

The Academy has outlined a preliminary plan for recognition of experienced orthopaedic manual physical therapists who have not had residency training and who wish to become Fellows of the Academy. During the period of 1995-1998, orthopaedic physical therapists who have already passed the APTA orthopaedic clinical specialty certification (OCS) and wish to become Fellows of the Academy, will be given the opportunity to present a portfolio of case studies and other credentials to the Academy for review. Upon acceptance of the portfolio, a practical and written examination is currently being evaluated as a second step in the process. The financial, legal and logistical considerations for such an exam will be evaluated in the coming months. The initiation of the application process will be contingent upon further work with consultants on the portfolio and the potential practical examination process. The target date for availability of the portfolio application packages is the Fall of 1993 with the deadline for submission of the application in February 1994. Applicants will be notified by October 1994 of the results of the portfolio review. For applicants whose documentation is approved, the target date for the practical examination is February 1995.

After 1998, AAOMPT has proposed that all future Fellows of the organization would have to successfully complete an accredited residency program. As the residency concept is embraced within our profession, residency programs will likely develop across the United States, allowing therapists increasing access to different programs. There are many alternatives on a part-time and full-time basis which can be developed and the AAOMPT will strongly support these efforts.

Future Conferences: The Academy will be sponsoring a pre-conference course on manual therapy at CSM in New Orleans in 1994. The Academy will be working with the Orthopaedic Section as the IFOMT liaison for the World Confederation of Physical Therapy convention in 1995 in Washington D.C.

Summary: Many activities and issues have been identified in this article. Much work is to be done over the coming months and years. The Academy will be working closely with the Orthopaedic Section through the joint task force and accreditation committee described above. Together we are in the position to make some substantial changes in the profession of orthopaedic physical therapy. We invite the participation of interested physical therapists!

CALL FOR NOMINATIONS
FOR
THE 6TH ANNUAL ROSE EXCELLENCE IN RESEARCH AWARD

The Best Research Article of 1993
Dealing with
Orthopaedic Physical Therapy

The Research Committee of the Orthopaedic Section of the American Physical Therapy Association is soliciting nominations in order to recognize and reward a physical therapist who has made a significant contribution to the literature dealing with the science, theory, or practice of orthopaedic physical therapy.

I) ELIGIBILITY FOR THE AWARD

The recipient must:
1) be a physical therapist licensed or eligible for licensure in the United States of America;
2) be a member of the American Physical Therapy Association;
3) be the primary (first) author of the published manuscript.

The article must be published in a reputable, refereed scientific journal between September 1, 1992 and August 31, 1993 to be considered for the award. Should the journal containing an otherwise eligible article experience a delay in releasing its August, 1993 issue, the article must be available to the general public no later than September 15, 1993 to be considered.

II) SELECTION CRITERIA

The article must have a significant impact (immediate or potential) upon the practice of orthopaedic physical therapy. The article must be a report of research but may deal with basic sciences, applied science, or clinical research. Reports of single clinical case studies or reviews of the literature will not be considered.

III) THE AWARD

The award will consist of a plaque and $500.00 to be presented at the 1994 Combined Sections Meeting.

IV) NOMINATIONS

Written nominations should include the complete title, names of authors, and the citation (title of journal, year, volume number, page numbers) of the research article. The name, address, and telephone number of the person nominating the research article should also be included.

Nominations (including self-nominations) will be accepted until close of business September 1, 1993 and should be mailed to:

Daniel L. Riddle, M.S., P.T.
Research Committee Chairman
Orthopaedic Section, APTA, Inc.
c/o Department of Physical Therapy
Virginia Commonwealth University
McGuire Hall, 1112 E. Clay St., Room 209
Box 224, MCV Station
Richmond, VA 23298

LIVING TRUSTS— SMART FOR YOU AND YOUR HEIRS

By Tom Berkedal, an Investment Executive who provides investment advice to the Orthopaedic Section, APTA

Being in a position to advise people on retirement planning, I'm often asked about living trusts. While I'm not an authority on the subject, I do have close contact with the professionals at various trust companies who have helped me put together some information that answers common questions about living trusts.

First, what is a living trust? It is a legal arrangement that allows one person the **trustee,** to control funds or property given by another person, the **trustor,** for the benefit of a third person, the **beneficiary.** The same person may be the trustee, trustor, and beneficiary. This means you or I could commit our funds to a trust which we control and of which we are the beneficiary.

What are the main benefits of a living trust? With a living trust, you avoid the probate court's involvement in your estate, provide for ongoing management during your incapacity, and retain more control over how your assets are distributed after you die. And in some situations, living trusts can reduce or eliminate taxes and fees.

If I have a will, do I still need a living trust? First of all, nearly everyone should have a will. When someone dies without a will, the estate goes to probate court. The court orders any outstanding debts paid with the balance of assets distributed according to state law. Heirs face a legal process that can take years and fees that could consume as much as 10 percent of the estate.

A major shortcoming of wills is that they can be easily contested. Upon your death, if you have a will, the probate court rules on its validity, then orders your debts paid and possessions distributed according to the terms of the will, unless someone contests it. Your heirs could wait a year or two to receive their inheritance.

A living trust is designed to eliminate the shortcomings of wills. Here's how it works: You transfer ownership of all or some of your assets to the trust by retitling your assets in the name of the trust. You no longer legally own the assets you give, but since you are the trustee you still control these assets. That leaves you free to buy, sell, or give away any assets in the trust. When you die, there is nothing to probate; everything belongs to the trust. Your heirs can receive their inheritance promptly and without any delay or paying court costs or attorney's fees.

What other benefits do living trusts offer? Living trusts allow you to transfer assets **privately.** Not so with estates that go through probate, with or without wills. Probate court proceedings are a matter of public record, available to anyone who takes the time to look through them.

In addition, living trusts provide for **continuity** in the management of the assets if the trustor becomes incapacitated. This avoids the delay and costs of having a guardian appointed by the court to oversee the management of the assets and the paying of bills, etc., on behalf of the trustor (client).

Living trusts can also **save estate taxes** for your heirs. One popular provision included in some living trusts is called an A-B provision, which enables a married couple to pass on up to $1.2 million to their heirs without the heirs having to pay estate taxes. When the first spouse dies, the joint assets are allocated between two trusts—the survivor's "A" trust and the deceased's "B" trust. For wealthy couples, use of two trusts enables each spouse to take full advantage of the $600,000 personal exemption.

The survivor retains full control over the "A" trust and can also receive income from the "B" trust or use principal from the "B" trust when necessary for health, support, or maintenance. When the surviving spouse dies, the assets of both trusts pass directly to the heirs. Providing each trust is worth less than $600,000, the heirs will pay no federal estate taxes.

Does a living trust provide the flexibility and assurance you've been seeking for your estate? Talk it over with a trusted investment advisor.

If you would like to receive additional information pertaining to Living Trusts, contact Tom through the Orthopaedic Section office and he will send a brochure entitled "Understanding Living Trusts."

WELCOME NEW MEMBERS

The Orthopaedic Section, APTA, Inc., would like to welcome all of our new students, affiliate and active members who have joined the Section within the last three months:

Dirk Abbott
Deborah Abosch
Janet Abramovic
Sandra Abrams
Diane Acquino
Virigina Adams
Tracey Adamus
Stanley Adelsberg
Janet Alcorn
Saud Alobaidi
Paul Amorosino
Scott Anderle
Angela Anderson
William Anderson
Kelli Anderson
Steven Anthony
Penny Apfel
Ashley Bernum
Linda Atchison
Molly Austiff
Angelica Avalos
Imelda Avila
Don Baas
Edgar Bacud
Mark Baeder
Ottavio Bagnardi
Louisa Bair
Margaret Barbino
Drew Barbabei
Stacy Barrows
Evelyn Barry
Kathleen Barry
Emery Bartek
Cheryl Barton
Traci Batts
Gayle Baumer
Stephen Baumgartner
Kenneth Bayne
Bradley Benard
Linda Bennett
Mindy Benson
Anne Benson
Ronit Berenbilt
Wendy Berger
Lois Berman
Kimberly Bernstein
Carol Bertsch
Maureen Best
Sandra Bextine
Joanne Biggins
Cyndi Bigner
Michael Biller
Wendy Birgen
Margaret Blain
Jeanette Blanken
Richard Blum-Johnston
Pauline Boivin
Cindy Bolen
William Booth
Janina Boranovsky
Marta Bosch
Patricia Boulet
Leon Bradway
Els Brady
Melicent Branch
Cheryl Brandt
Kelly Brennan
Sharon Bressler
Kimberly Brigman
Margaret Brill
Vicki Broberg
Susan Broderick
Marci Brown
Richard Brown
Lunell Brown-Collins
Stephen Brownell
Michelle Buck
Matthew Buckmaster
Florence Burgard
Kimberly Burk
Garrett Burkam
Meir Burton
Constance Butler
John Butler
Thomas Byrd
Imelda Cabitac
James Calhoun
John Callamaro
Jennylin Caranto
Wendy Carbone
Margaret Carlin
Juan Carpo
Glenn Carr
Paul Carr
Mark Carrier
Brenda Carroll
Giselle Carson
Maggie Carter
Kim Caruso
Deirdre Carway
Sherry Catacutan
Laurie Ceremuga
Rodney Chamberlain
Charo Chan
Leland Chandler
Hsiangning Chang
Kathleen Chapman
Robert Chapman
Gabriella Charles
Ilene Chazan
Steven Chenoweth
Shingpui Chow
Chris Christian
Maria Chu
William Chu
Susan Cico
Jon Clark
Janet Clements
Calvyn Coetsee
Juanita Colby
Deana Collins
Heather Collins
Andre Commenee
Rosemary Conner
Cathy Cook
Joseph Cooley
William Copeland
Gail Cornelissen
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Kevin Covington
Lisa Crago-Adams
Christopher Crank
Derrick Crass
Beth Crellin
Jack Cribb
Shelly Crockett
Nancy Croughwell
David Crume
Frederic Cudlipp
Daniel D'Andrea
Janey Dahl
Jean Dahlin
Anthony Dangelo
Fern Darling
Linda Davis
John Davis
Barbara De Luca
Cynthia Dean
Thomas DeFranco
Carol dela Paz
Linda Demers
Carson Demers
Andrea Diggs
Jennifer Divjak
Lorna Dorchuck
Barbara Dorroh
Sue Drecktrah
Veronica Drexler
Keith Driscoll
Suzanne Dufresne
Sally Dunten
Lisa Dutterer
Donna Dutton
Kenneth Eato
Sandra Edwards
Hal Egbert
Dean Eichen
Laurie Elder
Susan Elderkin
Bridgid Ellingson
John Elmore
Jarrette Embry
Kristin Eneberg
Ilonka Erades
Todd Erbst
Michael Ercole
Teresa Erickson
Heidi Erpelding
Larry Estes
Teresa Estes
Jane Evanish
Sara Fabry
Zoe Fackelman
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Edith Farrell
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Elizabeth Fieman
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Subrina Linscomb
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Joyce Lockert
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Susan McPherson
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Jane Waterman
Gwen Watson
Catherine Weaver
Michelle Wedding-Lamb
Jason Wedman
Patrick Weekhout
John Weeks
Kathy Weikel
Gerald Weiss
Lynda Welms
Kelly Welna
Susan Westervelt
Chalma Whitaker
Catherine White
Susan White
Colleen Whiteford
Mark Whitley
Bernardina Wilcox
Kelly Willey
Kenneth Williams
Myra Williams
Rob Williams
Glenn Williams
Steve Wilson
Laura Witt
Jennifer Witten
Michele Wolfner
Albert Wong
Leilani Wong
Michael Wood
Jennifer Woods
Tracey Worton
Richard Wurster
Vicki Yandell
Arlene Yang
Tzong-Shin Yang
Rita Yap
Blaine Yoshioka
Terry Young
Ligaya Yrastorza
Karleen Zerrusen
Kristina Zetterlund-Tinkl
Shanon Ziehr
Mimi Zlatkowski
Therese Zmina
Georg Zoyac
Sandy Zumwalt

PARIS DISTINGUISHED SERVICE AWARD

PURPOSE

1. To acknowledge and honor a most outstanding Orthopaedic Section member whose contributions to the Section are of exceptional and enduring value.
2. To provide an opportunity for the recipient to share his or her achievements and ideas with the membership through a lecture presented at an APTA Combined Sections Meeting.

ELIGIBILITY

1. The nominee must be a member of the Orthopaedic Section, APTA, Inc., who has made a distinguished contribution to the Section.
2. Members of the Executive Committee and members of the Awards Committee shall not be eligible for the award during their term of office.

CRITERIA FOR SELECTION

1. The Nominee shall have made substantial contributions to the Section in one or more of the following areas:
   a. Demonstrated prominent leadership in advancing the interests and objectives of the Section.
   b. Utilized exceptional ability and influence to promote the science, education, and practice of orthopaedic physical therapy.
   c. Obtained professional recognition and respect for the Section's achievements.
   d. Advanced public awareness of orthopaedic physical therapy.
   e. Served as an accomplished role model, and provided incentive for other members to reach their highest potential.
   f. Utilized notable talents in writing, teaching, research, administration, and/or clinical practice to assist the Section and its membership in achieving their goals.
2. The nominee shall possess the ability to present a keynote lecture, as evidenced by:
   a. Acknowledged skills in the organization and presentation of written and oral communications of substantial length.
   b. Background and knowledge sufficient.

PROCEDURE FOR NOMINATION

1. Any member of the Orthopaedic Section may nominate candidates for the award.
2. One original set and four duplicates of all materials submitted for each nomination must be received by the Administrative Director at the Section office by December 1, for consideration for the award in the following year.
3. The materials submitted for each nomination shall include the following:
   a. One support statement from the nominator, indicating reasons for the nomination, and clarifying the relationship between the nominator and nominee.
   b. Support statements from four professional colleagues.
   c. Support statements from two individuals who are not physical therapists, but have been involved with the Section through association with the nominee.
   d. Support statement from four Orthopaedic Section former or current officers or committee chairs.
   e. The nominee's curriculum vitae.
4. The nomination materials should document examples of how the nominee fulfills the criteria for this award.

PROCEDURE FOR REVIEW AND SELECTION

1. Nomination materials shall be submitted to the Awards Committee Chairman and members by the Section office. The Section office will retain the original set of materials.
2. The Awards Committee will review the nominations and recommend the most qualified candidate to the Executive Committee.
3. The Executive Committee will select the recipient.
4. Any member of the Awards or Executive Committees, who is closely associated with the nominee, will abstain from participating in the review and selection process.
5. The award will be presented only if there are qualified candidates, and one is selected.
6. Nomination materials are considered the property of the Awards Committee, who will maintain their confidentiality.
7. Nomination materials will not be returned. If any individual is not selected for the award in a given year, that individual may be nominated in subsequent years.

LECTURE

1. The recipient will present his lecture at a Section "Awards Session" at the APTA Combined Sections Meeting. The lecture should not last longer than thirty minutes.
2. The title of the lecture will be left to the discretion of the recipient.
3. The lecture should focus on the recipient's ideas and contributions to the Section and orthopaedic physical therapy.
4. The recipient will be invited to submit a written copy of the lecture for publication in the Section's official publication Orthopaedic Physical Therapy Practice.

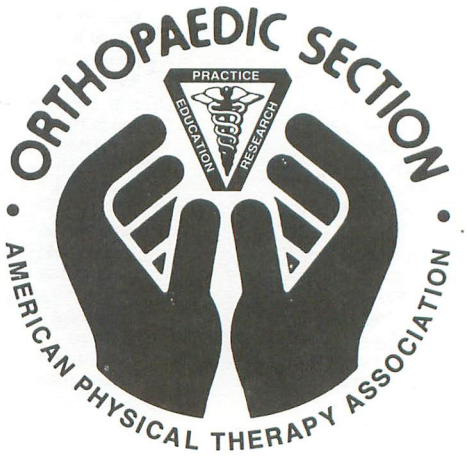
NOTIFICATION OF THE AWARD

1. The President of the Section will notify the recipient by April 1st and obtain written confirmation of acceptance from him, by May 1st.
2. The name of the recipient will be kept confidential until announced at the APTA Annual Conference following the selection, approximately 8 months before he is to present the lecture.
3. The award will be presented at the APTA Combined Sections Meeting following presentation of the lecture.
4. Those nominees not selected will be so informed in writing.
5. The nominators of individuals not selected will receive a letter thanking them for their participation and informing them of the award recipient.

THE AWARD AND ITS PRESENTATION

1. The Orthopaedic Section will reimburse the recipient for round trip coach airfare from any site in the U.S. or Canada to the Combined Sections Meeting at which the lecture is presented, two days per diem consistent with the Section's current reimbursement rates and one day's conference registration.
2. On the occasion of the presentation of the lecture, the awardee will receive an appropriate plaque and an honorarium of $250.
3. The recipient's name and date of award will also be inscribed on a Distinguished Service Lecture Award plaque that is retained and displayed in the Section's headquarters.

Please submit any nominations to the Section office by December 1, 1993.



1993 MASTER CALENDAR

May

S	M	T	W	T	F	S
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9	10	11	12	13	14	15
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23	24	25	26	27	28	29
30	31					

June

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27	28	29	30			

July

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18	19	20	21	22	23	24
25	26	27	28	29	30	31

MAY

3 OP Mailing Date
15 DEADLINE—Election ballot due to the Section office
15-16 Occupational Health Physical Therapy Special Interest Group Meeting - San Diego, CA
18 JOSPT Mailing Date
31 HOLIDAY - Memorial Day

JUNE

12-16 Annual Conference - Cincinnati, OH
13 Section Business Meeting 8:00-9:30 AM
14 Foot and Ankle Organizational Meeting 3:30-5:00 PM
21 JOSPT Mailing Date

JULY

4 HOLIDAY - Independence Day
11-17 Review for Advanced Orthopaedic Competencies - Seattle, WA
19 JOSPT Mailing Date

AUGUST

4 OP Mailing Date
18 JOSPT Mailing Date
27-29 Section Finance Committee Meeting - La Crosse, WI

August

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29	30	31				

September

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26	27	28	29	30		

October

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17	18	19	20	21	22	23
24	25	26	27	28	29	30
31						

CALL FOR PARTICIPANTS to serve as Clinical Research Consultants

The Research Committee of the Orthopaedic Section is developing a resource list of clinical research experts who would be willing to serve as consultants to section members interested in developing or completing research projects in orthopedic physical therapy. The role of the consultant may range from suggestions via the telephone to collaboration in a research project. The extent of involvement of the consultation is strictly up to the consultant and the member. Clinical research experts should have a demonstrated record of refereed publication in a specific area of orthopedic physical therapy research or practice. If you are interested in serving the Section as a Clinical Research Consultant, please send the information requested below (with an updated resume or curriculum vitae, if possible) to the Orthopedic Section office.

Orthopedic Section, APTA, Inc.
Research Consultant Program
505 King Street, Suite 103
La Crosse, WI 54601

The Section will make this information available to all members by publishing a list of consultants and their areas of expertise in *Orthopaedic Practice*.

If you would like more information, call the Section office at 1-800-444-3982.

Clinical Research Consultant Program

Name _____ Daytime phone _____

Address _____

_____

Specialty area(s) _____

_____

In what content area(s) are you interested in serving as a consultant? _____

_____

Publications (attach separate sheet, if necessary) _____

_____

ORTHOPAEDIC SECTION, APTA, INC. BYLAWS AND CONSTITUTION

ARTICLE I. NAME
The name of this organization is the Orthopaedic Section of the American Physical Therapy Association, Incorporated, hereinafter referred to as the Section and the Association.

ARTICLE II. PURPOSE
The purpose of the Section shall be to provide a means by which Association members having a common interest in orthopaedic physical therapy may meet, confer, and promote patient care through education, practice and research.

ARTICLE III. OBJECTIVES
The objectives of the Section shall be to:
1. Provide for interchange and dissemination of information about current trends and practices related to orthopaedic physical therapy; and
2. Identify resource people and materials, and address areas of concern related to orthopaedic physical therapy; and
3. Foster research in the area of orthopaedic physical therapy; and
4. Promote the development and implementation of orthopaedic specialization and special interests; and
5. Serve as a major source of information on orthopaedic physical therapy for society and the profession of physical therapy.

ARTICLE IV. MEMBERSHIP
Section 1: Classes and Qualifications of Members
The Section's classes and qualifications of membership shall be identical to those of the Association, excluding the classes of Honorary membership and Catherine Worthingham Fellows of the APTA.

Section 2: Rights and Privileges of Members
The rights and privileges of the Section's members shall be identical to those established in the Association's bylaws for the various classes of members at Section and Committee meetings.
* In the Section: Active, life, and, with the exception of the office of President, Affiliate and Life Affiliate, subject to additional eligibility requirements in the Section bylaws.

Section 3: Application for and Admission to Membership
The payment of Section dues by active, affiliate, graduate student, student, and student affiliate members in good standing in the Association shall constitute application for and admission to Section membership. Signed applications without payment of dues from life and life affiliate members in good standing in the Association shall constitute application for and admission to Section membership.

Section 4: Good Standing
An individual member is in good standing within the meaning of these bylaws if the member is in good standing in the Association.

Section 5: Disciplinary Action
A. Any member of the Section who is expelled from membership in the Association shall be expelled from Section membership.
B. Any member of the Section who fails to make timely payment of required Section dues shall be expelled from Section membership.

Section 6: Reinstatement
Any former member of the Section who is in good standing in the Association may be reinstated to membership in the Section by payment of the required Section dues.

ARTICLE V. REGIONAL AND SPECIAL INTEREST GROUPS
Section 1: Regional Groups
A. Name
The name of these regional groups is Orthopaedic Study Groups.
B. Purpose
Members of the Section residing or working in a defined geographical region may meet, confer, and promote their interests in orthopaedic physical therapy and the interests of their respective region.
* Amendment from the June 1992 House of Delegates.
C. Formation and Dissolution
Regional groups of the Section may be established and dissolved in accordance with the rules and conditions set down by the Section's Board of Directors.

Section 2: Special Interest Groups
A. Name
The name of the special interest group is Occupational Health Physical Therapy Special Interest Group.
B. Purpose
Members of the Section having a common interest in Occupational Health Physical Therapy may meet, confer, and promote their interests in Occupational Health Physical Therapy and the interests of their respective special interest group.
C. Formation and Dissolution
Special interest groups of the Section may be established and dissolved in accordance with the rules and conditions set down by the Section's Board of Directors.

Section 3: The Section shall not be obligated for any debts incurred by a regional or special interest group unless the group has been specifically authorized in writing by the Section's governing body to act on behalf of the Section's governing body.

Section 4: Limitations
Regional and Special Interest Groups are subject to the following limitations:
A. Bylaws and policies of the Section
B. No regional or special interest group shall profess or imply that it speaks for or represents the Section or members other than those currently holding membership in the regional or special interest group unless authorized to do so in writing by the Section's governing body.

ARTICLE VI. MEETINGS
Section 1: The Section shall hold an annual meeting of the Section membership for the conduct of business at the time and place of the Annual Conference of the Association. Attendance is limited to Section members and invited guests approved by the Board of Directors.

#1 ** MOVE TO AMEND ARTICLE VI. MEETINGS, SECTION 1 BY: Striking "Annual Conference of the Association" and inserting "Association Combined Sections Meeting".**

SS: Amendment will be consistent with other Sections annual business meetings and will hopefully attain greater attendance.

Section 2: A Section business meeting shall be held at the time and place of the Association Combined Sections Meeting.

#2 ** MOVE TO AMEND ARTICLE VI. MEETINGS, SECTION 2 BY: Striking entire section and replacing with "The Section shall hold two (2) informational meetings with the Section membership each year. One in July at the 'Review for Advanced Orthopaedic Competencies' course and the second at the time and place of the Association Annual Conference. Attendance is limited to Section members and invited guests approved by the Board of Directors".**

SS: Amendment will enable the Section to meet with more Section members on activities of the Section and get direct feedback from more members.

Section 3: An educational or professional program may be presented at any Section meeting. A program held at the time of the Association meeting must be coordinated with the Association schedule.

Section 4: The Section shall submit Section Business Meeting minutes to Association headquarters within 60 days of the meeting and submit election results and program summaries within 30 days.

ARTICLE VII. EXECUTIVE COMMITTEE AND OFFICERS

#3 ** MOVE TO AMEND ARTICLE VII. EXECUTIVE COMMITTEE AND OFFICERS BY: Striking "EXECUTIVE COMMITTEE" and inserting "BOARD OF DIRECTORS".**

SS: Amendment and subsequent amendments will be consistent with the APTA organizational structure.

Section 1: Composition
The Board of Directors shall consist of the President, Vice-President, Treasurer, Immediate-Past President, Member-at-Large, Editor of the Section Publications, Education Program Chair, Research Committee Chair and Executive Director.

#4 ** MOVE TO AMEND ARTICLE VII. EXECUTIVE COMMITTEE AND OFFICERS, SECTION 1, COMPOSITION BY: Striking "Member-at-Large" and inserting "Two Directors".**

SS: Amendment and subsequent amendments will create an odd number on the Board of Directors which will help break a tie vote and bring more talent to the Board.

#5 ** MOVE TO AMEND ARTICLE VII. EXECUTIVE COMMITTEE AND OFFICERS, SECTION 1, COMPOSITION BY: Striking "Editor of the Section Publications".**

SS: Amendment and subsequent amendments will remove a position which no longer exists within the Section's organizational structure.

Section 2: Qualifications
A. All active and life members of the Section in good standing shall be eligible to hold office, subject to the restrictions in these bylaws.
B. Voting on the Board of Directors
1. The President, Vice-President, Treasurer, and Two Directors shall have the right to vote.
2. The Immediate-Past President, Education Program

Chair, Research Committee Chair and Executive Director shall have all rights except the right to vote on the Board of Directors.

Section 3: Terms and Vacancies

A. Officers shall be elected for a term of three (3) years or until their successors are elected.
B. No member shall be elected to serve more than two (2) full consecutive terms in the same office. A member who has served at least one and a half (1½) years of a three (3) year term shall be considered to have served a full term in that position.
C. No elected member shall serve more than four (4) complete consecutive terms on the Board of Directors.
D. The Immediate-Past President shall serve for one year in an advisory capacity on the Board of Directors.
E. The President shall appoint replacements to fill unexpired terms, in accordance with the requirements of these Bylaws.
F. The President shall appoint an active or life member in good standing to fill any vacancy which occurs in an elected office. Upon a majority vote of approval by the Board of Directors, the appointee shall serve for the remainder of the unexpired term.

Section 4: Officers

The elected officers shall be the President, Vice-President, Treasurer, and Two Directors.

A. The President shall:
   1. Call special meetings; and
   2. Preside at all meetings of the Board of Directors; and
   3. Be an ex officio member of all committees except the Nominating Committee; and
   4. Create and appoint all special and advisory committees necessary to accomplish the functions of the Section, with the advice and consent of the Board of Directors; and
   5. Submit the Annual Report to the Association and such other reports as may be required by the Association Board of Directors by February 15.
B. The Vice-President shall:
   1. Assume the duties of the President if absent or incapacitated. In the event of a vacancy in the office of the President shall succeed to the Presidency for the remainder of the unexpired term, and the office of Vice-President shall be declared vacant; and
   2. Be an ex officio member of all designated committees as outlined in the Strategic Planning programs.
C. The Two Directors shall:
   1. Review and recommend amendment of the Section Bylaws and Section Policies and Procedures in agreement with Association Bylaws and directives from the Section membership or Section Board of Directors.
   2. Serve as Liaison officers between the Nominating Committee and the Board of Directors.
   3. Be ex officio members of all designated Committees as outlined in the Strategic Planning programs.
D. The Treasurer shall:
   1. Oversee the maintenance of complete and accurate financial records which shall be audited annually by a Certified Public Accountant, and shall submit the audited report in writing to the Board of Directors, and to the Association by April 15; and
   2. Submit an annual financial report and proposed budget to the Board of Directors; and
   3. Oversee the collection and disbursement of monies as mandated by the Section or the Board of Directors; and
   4. Serve on the Finance Committee as Chair-person.

Section 5: Duties

A. The Board of Directors shall carry out the mandates and policies of the Section membership. Between meetings of the membership, the Board of Directors may make and enforce policies which are consistent with the Bylaws and policies of the Section.
B. The Board of Directors shall appoint a Section Delegate and an alternate at the annual meeting.
C. The Executive Committee shall appoint the Editor of the Section Publications. The Editor shall serve at the discretion of the Executive Committee.

#6 ** MOVE TO AMEND ARTICLE VII. EXECUTIVE COMMITTEE AND OFFICERS, SECTION 5, DUTIES, C., BY: Striking Section C.**

SS: Amendment removes a position which no longer exists within the Section's organizational structure. All subsequent letters will be re-lettered accordingly.

C. The Board of Directors shall hire an Executive Director. The Executive Director shall serve at the discretion of the Board of Directors.
D. The Board of Directors shall appoint the Education Program Chair. The Education Program Chair shall serve at the discretion of the Board of Directors.
E. The Board of Directors shall approve meeting minutes taken by the Executive Director.

Section 6: Conduct of Business

A. Frequency of Meetings
   A Section Business meeting will be held at each Combined Sections Meeting of the Association.
   Two informational meetings with the Section membership will be held each year. One during the Annual Conference of the Association and the second in July at the Section's 'Review for Advanced Orthopaedic Competencies' course.
B. Special Meetings
   Additional national, regional, or special interest group meetings may be held during the course of the calendar year provided there has been ninety (90) days prior notice to the Association Board of Directors, no conflict with Association functions and due notice to Section members.
C. Notice of Meetings
   Notice of the time and place of meetings shall be sent to the Section members thirty (30) days prior to the date of the meeting.
D. Quorum
   Three members present at a meeting shall constitute a quorum.

ARTICLE VIII. COMMITTEES

Section 1: Nominating Committee

A. The Nominating Committee shall consist of three (3) active or life Section members in good standing, each of whom shall serve for three (3) years.
B. One member shall be elected by the Section membership each year.

Section 2: Finance Committee

A. The Finance Committee shall consist of at least four (4) members, one of whom is the Treasurer, and each member shall serve a term of three (3) years.
B. The Treasurer shall be the Chair of the Finance Committee and the committee members shall be appointed by the Section President with the advice of the Board of Directors.
C. Committee members shall be current Section members in good standing.

Section 3: Standing Committees

A. Names
   The standing committees shall be the Education Program, Publications, Research, Specialization, Finance, Practice, Public Relations, Awards, and Nominating committees.

#7 ** MOVE TO AMEND ARTICLE VIII. COMMITTEES, SECTION 3, A. NAMES, BY: Striking "Publications" and inserting *"Orthopaedic Physical Therapy Practice"*.**

SS: Amendment replaces a non-existent committee with a newly created committee.

B. Appointment and Tenure
   The chair-persons of the standing committees shall serve for a term of three (3) years or until their successors are appointed. Committee members shall also serve for a term of three (3) years. Committee members and chair-persons shall be appointed by the Section President with the advice of the Board of Directors. Committee members and chair-persons shall be current Section members in good standing.
C. Vacancies
   Vacancies on a committee due to death, resignation, or the failure to perform assigned duties, may be filled by a majority vote of the Board of Directors.

Section 4: Special Committees

Such special committees as the Section or the Board of Directors may deem necessary shall be appointed by the President, with the advice and consent of the Board of Directors. Committee members and chair-persons shall be current Section members in good standing.

Section 5: Official Publications

A. Orthopaedic Section and Sports Section
   1. *The Journal of Orthopaedic and Sports Physical Therapy* is an official publication of the Orthopaedic Section and the Sports Physical Therapy Section. It is to be edited by an Editor contracted by the Executive Committee/Board of Directors of both Sections.
   2. *Orthopaedic Physical Therapy Practice* is an official publication of the Orthopaedic Section.
B. Publication in *Orthopaedic Physical Therapy Practice* or *The Journal* of meeting notices, issues to vote upon or a slate of nominees shall constitute official notice to all members, provided *Orthopaedic Physical Therapy Practice* or *The Journal* has been mailed thirty (30) days prior to the meeting date, or deadline for receipt of a mailed ballot.

ARTICLE IX. DELEGATE TO THE ASSOCIATION'S HOUSE OF DELEGATES

Section 1: Selection

A Section Delegate and alternate shall be appointed by the Board of Directors at the Annual Meeting.

Section 2: Qualification

A. Only active or affiliate members who have been members in good standing for two (2) years immediately preceding may serve as a Section Delegate.
B. The Section Delegate may not also serve as a Chapter Delegate.

Section 3: Length and Number of Terms

A. The Section Delegate and alternate shall serve for a two (2) year term.
B. The Association shall be notified of the Section Delegate and alternate's names, addresses, telephone numbers, and terms no later than March 1st of each year, with additions and changes sent within two weeks of their selection.
C. The Section shall be represented in the House of Delegates annually.

ARTICLE X. ELECTIONS

Section 1: Nominations and Offices

A. Only those active and life members giving written consent to serve if elected may be nominated. Nominations shall be compiled by the Nominating Committee into a slate of candidates which shall be published in *Orthopaedic Physical Therapy Practice*.
B. The President and Vice-President shall be elected in the same year.
C. The Treasurer and Member-at-Large shall be elected separately in alternate years. The yearly election

sequence shall be sequenced: 1) Member-at-Large; 2) President and Vice-President; and 3) Treasurer ad infinitum.

#8 ** MOVE TO AMEND ARTICLE X. ELECTIONS, SECTION 1. NOMINATIONS AND OFFICES, C. BY: Striking "Member-at-Large", "separately in alternate years.", "Member-at-Large" and, inserting the following respectively, "one Director", "in the second year, and one Director in the third year.", "one Director", and after "Treasurer" inserting "and second Director".**

SS: Amendment to insure second Director is elected by the membership in a logical sequence with the Section's election process.

D. Newly elected officers shall assume office at the close of the Annual Section Business Meeting. NOTE: This will now be at CSM.
E. Nominees for Treasurer will have served on the Finance Committee for no less than one (1) year from the time they would assume the office of Treasurer at the end of the Annual Meeting. Exceptions to this can be considered by mutual agreement between the Finance Committee and the Board of Directors.

Section 2: Election Ballot

A. Elections shall be conducted via mailed ballot in April of each year and coordinated by the Nominating Committee. The results of the election shall be announced at the Annual Business meeting.
B. Election of an officer shall be made between two (2) candidates when a candidate receives a majority of the ballots cast. In the case where members vote for more than two (2) candidates, that candidate who receives the plurality of the votes of the ballots cast shall be declared elected. All ties shall be broken by drawing of lots by the Nominating Committee.

ARTICLE XI. FINANCE

Section 1: Fiscal Year

The fiscal year of the Section shall be the same as that of the American Physical Therapy Association.

Section 2: Limitation on Expenditures

No officer, employee or committee shall expend any money not provided in the budget as adopted, or spend any money in excess of the budget allotment, except by order of the Section's governing body. The governing body shall not commit the Section to any financial obligation in excess of its current financial resources (Article X, Section 2:).

Section 3: Dues

A. Annual dues shall be fifty dollars ($50.00) for active members, thirty dollars ($30.00) for affiliate members, fifteen dollars ($15.00) for graduate students, students and affiliate student members, and no dollars for life and honorary members. Changes in dues are to be recommended by the Finance Committee to the Board of Directors, which in turn makes recommendations to the Section membership. Changes approved by the Section must also meet Association approval before August 1st and shall become effective on the first day of the next fiscal year.

* Association and chapter dues for student or student affiliate members applying for active or affiliate membership shall be one third the regular active or affiliate dues for the first year, two thirds the regular active or affiliate membership dues for the second year, and full dues beginning the third year, according to procedures established by the Board.

B. All dues shall be for the period specified in the Association Bylaws.
C. All dues changes approved by the Section membership and approved by the Association's Board of Directors before the Association's deadline will become effective on the first of the Section's next fiscal year.
D. Before the expiration of twelve (12) months of membership, Section dues for the ensuing twelve (12) months shall be received by the Association. Section members whose dues have not been received at such time shall be considered not in good standing in the Section, and his/her Section membership shall be revoked on that date by the Association.
E. Persons wishing to join the Section or former members wishing to be reinstated shall pay current Section dues to the Association, which payment shall entitle them to membership in the Section until such time as they are billed for Association dues.
F. Special assessments must be approved by mail ballot vote of two-thirds (2/3) of the return ballots. Notice of such proposed assessment shall have been mailed to each Active and Affiliate member of the Section thirty (30) days prior to the date for action on the proposed assessment. Notification shall include the reason for the assessment, the amount proposed, and the due date. The ratio of the Affiliate and Active member assessment shall be the same as the ratio of the Affiliate and Active member dues.

#9 ** ARTICLE XI. FINANCE, SECTION 3. DUES, F. WILL BE DELETED PER AMENDMENT FROM THE JUNE 1992 HOUSE OF DELEGATES.**

Section 4: Special Interest Groups

Dues may be levied by Section special interest groups, however, non-payment of special interest group dues shall not carry punitive action at the Section or National level. All special interest group dues are collected by the Section.

ARTICLE XII. DISSOLUTION

Section 1. The Section may be involuntarily dissolved in accordance with the Association's Bylaws.

* Amendment from the June 1992 House of Delegates

Section 2. The Section may dissolve subject to a recommendation to dissolve supported by a no less than two-thirds (2/3) vote of the members of the Section's Board of Directors and adopted by two-thirds (2/3) of the Section's members.

Section 3. In the event that the Section is dissolved, all property and records of the Section shall, after payment of its bona fide debts, be conveyed to the Association.

ARTICLE XIII. PARLIAMENTARY AUTHORITY

The rules contained in the current edition of 'Robert's Rules of Order Newly Revised' shall govern the Section in all cases to which they are applicable and in which they are not inconsistent with these Bylaws and any rules of order adopted by the Section.

ARTICLE XIV. AMENDMENTS

1. The Section Bylaws may be amended in whole or in part by two-thirds (2/3) of the members present and voting at the annual business meeting of the Section, providing a copy of the proposed amendment(s) has been sent to all members at least thirty (30) days prior to the ballot return deadline. The amendments shall be in effect only after approval by the Board of Directors of the Association.
2. When Association Bylaws have been amended so as to require amendment of the Section Bylaws, the Directors shall prepare the necessary amendments and submit them to the Board of Directors of the Section for approval. Notification of the approved amendments shall be sent via *Orthopaedic Physical Therapy Practice* to each member of the Section in the next issue after Board of Directors approval. (Exception: Changes in Section dues which become effective on the first of the Section's next fiscal year following approval). The amended Section Bylaws must be submitted to the Board of Directors of the Association for approval. Such changes in Bylaws mandated by the Association will not require a vote of the Section members but will be automatically adopted, upon approval of the Board of Directors of the Association.
3. If the intent of an amendment is editorial or to bring the Section's bylaws into agreement with those of the Association, the amendment shall be made as required by the Directors and approved by the Board of Directors. The Directors shall notify the Section's membership of such amendment.

ARTICLE XV. ASSOCIATION AS HIGHER AUTHORITY

In addition to these Bylaws, the Section is governed by the Association Bylaws and Standing Rules, and by Association policies.

FINANCIAL REPORT

Orthopaedic Section, APTA, Inc.
12/31/92

INCOME (+4.64% above budget)

Our section has done very well during 1992. Membership dues were very close to the expected budget while educational course registrations and other income performed better than expected.

EXPENSES (–12.52%)

As the graph shows, our predictions were quite close for office expenses but we predicted more expense than actual in all other categories. The credit goes to all in the central office as well as the entire board for helping to keep expenses appropriate, within expectations and cost effective where possible.

INVESTMENT RESERVES

The baseline goal for the orthopaedic section to have in reserves is 75% of our annual operating expense budget each year. As of 12/31/92 we were 83.5% of the 1992 operating expense budget but only 69.2% of the new 1993 operating expense budget. The finance committee predicts that our goal of 75% of the 1993 operating expense budget will be met by April or May 1993. Upon achieving this goal, a building fund will be initiated.

FISCAL TRENDS

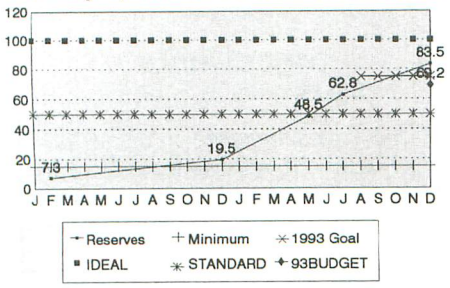
The Orthopaedic section continues to build a firm fiscal foundation for the future. Our net equity of $508,000 is down slightly from a September high of $512,994 but still very good.

AUDIT

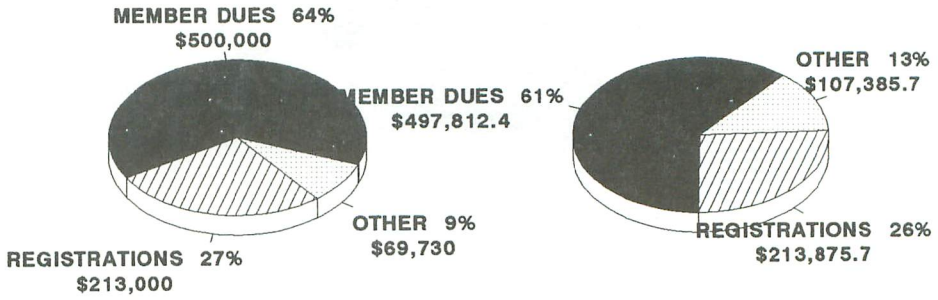
The 1992 audit is being finalized by the accounting firm of Gillette & Thompson. The final audit report will be given in the August issue of *Orthopaedic Practice.*

John B. Wadsworth, PT, MA
Treasurer

RESERVE FUND
January 1, 1991 to December 31, 1992



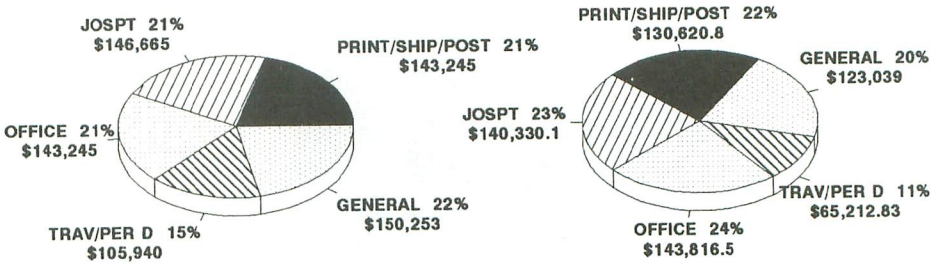
ORTHOPAEDIC SECTION APTA INC.
1992 YTD BUDGET TO ACTUAL SUMMARY
INCOME (+4.64%)



BUDGETED
TOTAL: $782,730.00

ACTUAL
TOTAL: $819,073.90

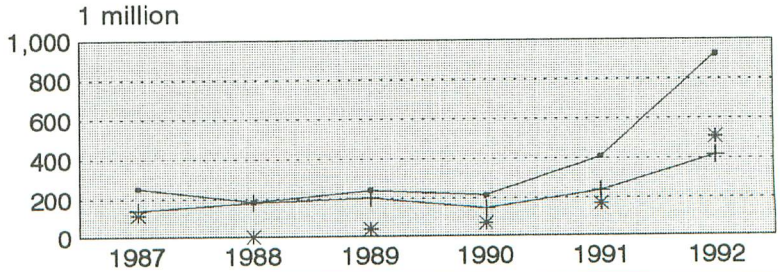
1992 YTD BUDGET TO ACTUAL SUMMARY
EXPENSES (–12.52%)



BUDGETED
TOTAL: $689,348.00

ACTUAL
TOTAL: $603,019.27

FISCAL TRENDS
1987-1992

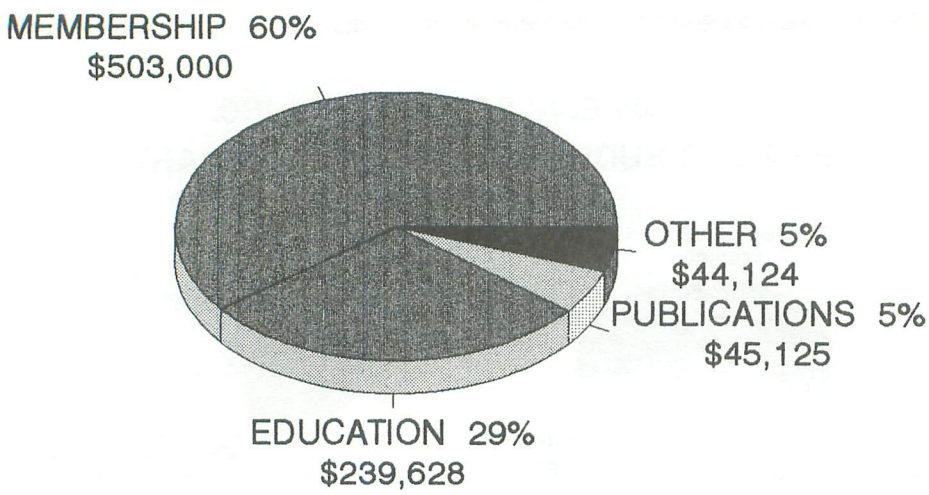


	1987	1988	1989	1990	1991	1992
ASSETS	255	185	243	217	410	925
LIABILITIES	141	183	203	148	240	417
EQUITY	114	2	40	69	170	508

ASSETS + LIABILITIES * EQUITY

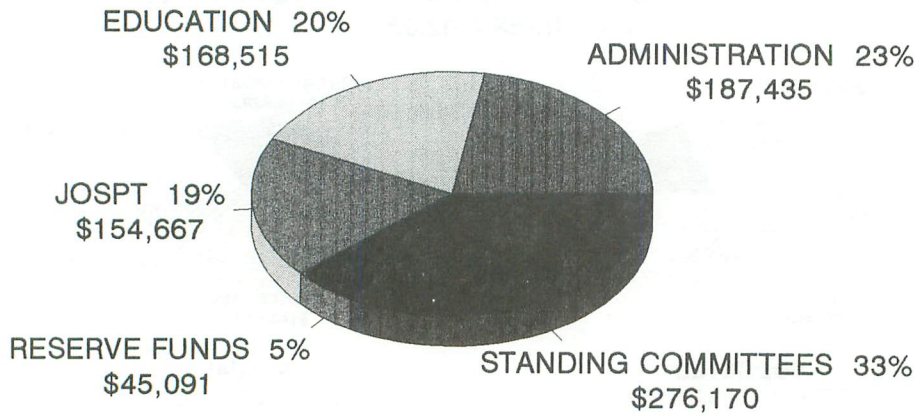
To nearest thousand

ORTHOPAEDIC SECTION APTA INC.
1993 STRATEGIC PLAN
PROJECTED INCOME



TOTAL: $831,878

1993 STRATEGIC PLAN
EXPENSES



PROJECTED: $831,878

FINANCE COMMITTEE 9/92

Orthopaedic Section Administrative Staff

Terri A. Pericak, Executive Director
Tara K. Fredrickson, Administrative Assistant
Sharon L. Klinski, Publications/Special Projects Coordinator
Mary Geary, Membership Services

Contact Terri Pericak for:
- Finance/Administration
- Section Executive Committee

Contact Tara Fredrickson for:
- Meeting Services
- Nominations
- Mentorship/Study Group Activities
- Occupational Health Physical Therapy SIG
- Review for Advanced Orthopaedic Competencies

Contact Sharon Klinski for:
- *Orthopaedic Physical Therapy Practice*
- Publication Content
- Home Study Courses
- Contract proposals for Administrative Services
- Contract proposals for newsletters & journals

Contact Mary Geary:
- Membership Services
- Address changes
- Orthopaedic Section membership labels
- Promotional items

OFFICE HOURS
8:00 am—4:30 pm CST

Please leave a message on the answering machine if you cannot call during these hours. We will gladly return the call!

MEETING MINUTES

ORTHOPAEDIC SECTION, APTA, INC.

BUSINESS MEETING,
FEBRUARY 6, 1993
COMBINED SECTIONS MEETING,
SAN ANTONIO, TEXAS

CALL TO ORDER AND WELCOME— Z. Annette Iglarsh, P.T., Ph.D.

Meeting was called to order by President Annette Iglarsh at 8:00 AM. Over 100 members were in attendance.

PRESIDENT'S REPORT—Z. Annette Iglarsh, P.T., Ph.D.

A. Approve Membership Meeting Minutes (June 14, 1992, Denver, CO)

=MOTION=To approve the business meeting minutes as printed in Orthopaedic Physical Therapy Practice.=PASSED=

B. Review and Accept Agenda.

=MOTION=To approve the meeting agenda as printed.=PASSED=

C. Review of Meeting Procedures
- Format of the Meeting
- Motion Forms

D.AAOMPT Update—Joe Farrell, M.S., P.T., President, AAOMPT

A joint task force is proposed to study the mutual interest of the Orthopaedic Section and the Academy. The Academy is also forming an accreditation committee to gather information on potential accreditation processes for post graduate residency programs in manual physical therapy. The two people on that committee are Stanley Paris from the AAOMPT and Annette Iglarsh from the Orthopaedic Section.

E. Recognition of Section members serving on APTA Committees

The Orthopaedic Section has submitted several of its members names to APTA for nomination to all of the positions available on APTA committees and APTA offices.

F. Council of Section Presidents Meeting

1. Discussion of potential motions to the floor at the House of Delegates at Annual Conference.

2. A task force was created to look at increasing political representation in the House of Delegates for Sections. Annette Iglarsh is a member of this task force.

G. Follow up with Members interested in serving on a Committee

1. The Section received 200 requests from APTA of individuals wishing to serve on a committee. The appropriate names were forwarded on to Committee Chairs and all those interested were contacted by the Chairs.

2. The Section was asked by the APTA to request that Orthopaedic Section members offer to serve as discussants, panel members and moderators at different Annual Conference sessions. All members are encouraged to participate to promote Section involvement in Annual Conference programming.

H. Section Committee Chair Awards

1. Last June, Jonathan Cooperman left his position as Public Relations Committee Chair and taken on the new role of Editor to *Orthopaedic Physical Therapy Practice*. Jonathan was recognized and thanked for his hard work.

2. Garvice Nicholson resigned from the Practice Committee last June due to professional obligations. Garvice was recognized for his hard work especially in the area of collecting information on legislative activities and dealing with the position statement on mobilization. The new committee chair for this committee is Scott Stephens. Scott will be developing a new multi-directional practice committee structure.

I. Adopt-a-Doc

An adopt-a-doc program was suggested by Mary Lou Barnes in her Mary McMillian Lecture address last June and has been initiated by the Neurology Section. The Orthopaedic Section Executive Committee would like to support this process to increase the number of doctoral prepared physical therapists to teach in our educational systems. The Orthopaedic Section will be adopting-a-doc in 1994 and the different approaches to this scholarship program are being investigated.

J. JOSPT

A contractual agreement has just been completed with Gary L. Smidt, L.C. as Editor of *JOSPT*. The Section will be developing contracts with all members who provide paid services, such as editors of the Section's publications.

EXECUTIVE COMMITTEE REPORTS

A. Vice-President—John Medeiros, P.T., Ph.D.

Primary responsibilities have been in the following two areas, to chair a task force on meeting schedules which has led to recommendations to change the Section bylaws and to provide a direction and a focus for the Practice Committee.

B. Treasurer—John Wadsworth, M.A., P.T.

1. The Section did very well in 1992. Income was 4% over the projected budget for the year and expenses were under budget by 12.5%.

2. The reserve fund is at 69.2% of our annual expense budget for 1993, typical for this time of year.

3. The 1993 budget has increases of 6.2% in income and 6.2% in expenses.

4. The Finance Committee has set a cap on the reserve fund of 75% of the Section's annual expense budget. Anything above this 75% will be allocated towards a building fund. This year's reserve fund cap should be met around February or March of 1993.

C. Member-at-Large—Stanley Paris, Ph.D., P.T.

1. Proposed Bylaw Amendments

a. That the Section's annual business meeting be moved to the Combined Sections Meeting. Presently the annual business meeting is held during APTA's Annual Conference.

b. That the Section have just one business meeting per year.

c. That the Executive Committee become the Board of Directors and consist of five voting members elected by the membership instead of the four elected members presently.

d. That the sequence of elections be changed to reflect adding a fifth Board member.

2. The Section's organizational structure will change to include a Board of Directors; Section Council which will consist of the Board of Directors, Chairs of Research, Education, Special Interest Groups, JOSPT Editor, and the Executive Director.

D. Education Program Chair—Nancy White, M.S., P.T.

1. Members are encouraged to submit suggestions they have on Section programming. Education is where we need to put our budget money because this is where we are able to serve our members the best.

2. The programming at CSM 1993 had overwhelming attendance. Due to this response a manual therapy per-conference course is being pursued for CSM 1994 in conjunction with the

AAOMPT.

3. The first annual research issues forum is scheduled for CSM 1994 in conjunction with the Research Committee.

4. In 1992 two review courses were held for orthopaedic competencies. Over 250 people attended. At least one review course will be held in July of 1993 and if the Section receives a request to cosponsor a second review course that will be held in the fall of 1993.

5. The home study course has been very well received. Over 900 people have signed up for the 1993 course on the upper extremity. Kent Timm is the Editor for the home study courses offered by the Section. Kent's request to the membership is that authors are needed for the next home study course being developed will be on the lumbar spine. Any member interested in being an author for this upcoming course, please contact either Kent Timm directly or the Section office.

6. The Education Committee will be assigning a task force to look at the different educational degrees and different types of advanced orthopaedic masters degrees. This information will be compiled to assist our members who are looking into orthopaedic masters programs. Lola Rosenbaum is the committee member working on this project.

7. Policies regarding the adopt-a-doc program will be proposed by the committee later this year.

8. A home study course is being developed to assist therapists who are reentering the field. This has evolved into a case study type format for home study. The orthopaedic specialist will assist the committee in providing case studies and feedback to the participants. The program will begin in 1994 or 1995.

E. Research Chair—Dan Riddle, M.S., P.T.

1. Over 50 applications were received for poster and platform presentations this year which is a two fold increase over last year.

2. The fifth annual Rose Excellence in Research Award will be awarded to Dr. Anthony Delitto for his article published in Physical Therapy. The award will be given during the Black Tie and Roses reception.

3. The Research Committee is developing a resource list that the committee hopes to have published on a regular basis in *Orthopaedic Practice*. The purpose is to provide the membership with a list of 'experts' within orthopaedics that they can use as contact people.

4. The topic for the first annual research issues forum at CSM 1994 will be "Classification in Low Back Pain". This will be a two hour presentation.

5. The committee is working on developing a research issues column in either *JOSPT* or *OP*. The purpose is to discuss issues that are relevant to orthopaedics and will help familiarize the readership with what the current issues are in research and what the needs are of our members.

F. Executive Director—Terri Pericak

1. The Section office recently added staff in order to accommodate all of the activities the Committees are working on. Tara Fredrickson is our new Administrative Assistant and Mary Geary is our new Membership Services Secretary.

2. A task force has been appointed to develop a membership directory proposal to be presented at Annual Conference in June.

PROGRAM REPORTS

A. Editor, *Orthopaedic Practice*—Jonathan Cooperman, M.S., P.T.

Spring, 1993, will be the next issue of *OP*. The guest editor will be Dennis Isernhagen. This issue will be devoted to occupational health physical therapy.

B. Specialization—Rick Ritter, M.A., P.T.

1. This year approximately 200 people sat for the orthopaedic specialty examination.

2. The Council is in the process of revalidating the competencies document. The first step is to conduct practice analysis interviews which are being held at this CSM.

3. The issue of a practical/residency component to the examination is being pursued and is looking more positive.

C. Public Relations—Karen Piegorsch, P.T., OCS

1. A hotline is being planned on cumulative trauma disorders. This will be conducted at CSM 1994 in New Orleans. Volunteers are being sought to help man this hotline. If you are interested in volunteering or have any ideas regarding questions that might be asked or appropriate responses, please contact the Committee. Sheila Goodwin and Mary Mohr are the two committee members working on this project.

2. Marketing the Orthopaedic Section to students—The Section will sponsor an entry level senior student to attend CSM 1994. Schools will be invited to submit the name of one person per school and the Section will draw one of those names at random. The student will have the responsibility of attending the Section's business meeting and staying for the entire conference. Someone from the Section will be assigned to mentor the student during the conference and the student will be required to report back to his or her class after CSM. The committee member working on this project is Christopher Petrosino.

3. The Education Committee is working with the Public Relations Committee on setting up special interest groups and facilitating networking among study groups. One of the first stages of this project is a resource manual which will hopefully be available to the membership this year. The resource manual will be useful for people who want to set up study groups. It will contain copies of bylaws which are used by other study groups. It will also be helpful for people who want to set up orthopaedic special interest groups at the state level. It is hoped that we will be able to develop a network across the nation where the resources at the grass roots, state and national levels will have a good channel of communication to promote the resources that are available through the Section as well as at the state level. One of those resources available through the Section is the mentor program. Michael Tollan is the committee member in charge of this project.

4. The Committee is also developing a list of other professional associations with whom the Section may want to develop liaison. Any ideas related to this project can be directed to committee member, Sharon Duffey.

D. Awards—Carolyn Wadsworth, M.S., P.T.

The Awards Committee is soliciting nominations for the Paris Distinguished Service Award for 1994 as well as nominations for APTA Awards.

E. Nominating Committee—Bill Boissonnault, M.S., P.T.

1. Section offices up for election this year are Treasurer and Nominating Committee Member. The Section received one nomination for the office of Treasurer, Dorothy Santi. Dorothy does meet the requirements for this office, the most significant is having served on the Finance Committee in the past. Dorothy has agreed to run for the office of Treasurer. The proposed slate for Nominating Committee Member is Carol Jo Chin Tichner and Michael Rogers. =MOTION=That the slate for Treasurer and Nominating Committee Member be approved as presented.=PASSED=

2. Election ballots will be mailed to the membership on April 15 and are due back to the Section office by May 15. Election results will be announced at the Section business meeting during Ann-

ual Conference on Sunday, June 13, from 9:00—11:00 AM.

F. Occupational Health Special Interest Group (SIG)—Dennis Isernhagen, P.T.

1. This group was originally called the Industrial Physical Therapy Special Interest Group. A proposal for a name change to Occupational Health Special Interest Group will be put before the membership at the SIG business meeting at this CSM.

2. The SIG is holding a hot topics presentation at this meeting on 'Competencies and Consulting in Business and Industry' by Dr. Jane Bryant, P.T.

3. The SIG also held a pre-conference course on the ADA at this meeting. Joanette Alpert, Program Chair for the SIG, was recognized for her hard work in setting up this excellent course.

UNFINISHED BUSINESS

Sean Gallagher, P.T., petitioned to start a special interest group within the Section in Performing Arts Physical Therapy. All appropriate documents are being prepared to be presented to the Section Executive Committee for approval.

NEW BUSINESS

A. Reinstitution of Physical Education in the Schools
- Phil Tygiel, P.T.

Presented Arizona motion to support reinstitution of physical education in the schools.

B. PTON (Physical Therapy Online Network)—Dennis Gyllenhaal, P.T.

Computer communication networking among physical therapists is something the Section is looking into for its members. PTON is one computer network. Any questions regarding computer networking can be directed to Dennis Gyllenhaal. =MOTION=To fund PTON with an 800# at a cost of $10,000 per year.=MOTION REFERRED TO THE FINANCE COMMITTEE FOR STUDY AND RECOMMENDATION TO BE PRESENTED AT THE NEXT BUSINESS MEETING IN JUNE.=PASSED=

C. A donation of $2,000 will be awarded to the Private Practice Section during the Black Tie and Roses Reception at this meeting. The donation is to recognize the work done by the Private Practice Section in the area of CPT coding and other reimbursement issues.

PRACTICE ISSUES FORUM—Stanley Paris, P.T., Ph.D., Chair
John Medeiros, P.T., Ph.D., Co-Chair

More than one hundred members attended the forum and a lively discussion took place on the following issues: Federal Health Care Reform, Practice Privileges For Physical Therapists, Self Referral For Profit, Reimbursement, Encroachment, Workers' Compensation, Medicaid Reform, and Direct Access. The interest and needs expressed by members will ensure that the Practice Issues Forum will be part of the next business meeting at CSM.

Adjournment—10:00 AM

ANNUAL CONFERENCE BUSINESS MEETING

Sunday, June 13, 1993
8:00—9:30 A.M.

FORUM TOPICS
Moderator: J. Scott Stephens, MS, PT, FFSBPT

- Health Care Reform
- Reimbursement Issues
- Encroachment
- Open Forum for Discussion

RESIDENCY PROGRAMS

The Orthopaedic Section, APTA, Inc. is not endorsing the following programs. We are just providing a listing as a service to our membership. If you know of any other residency programs that would like to be included in this listing, please contact the Section office for more details.

Gulf Coast Physical Therapy
Residency Program in Orthopaedic Manual Physical Therapy
1500 45th Avenue, Suite B
Gulfport, MS 39501
601-864-1212
Director/Contact Person: Mr. Michael D. Rogers, PT, OCS

Folsom Physical Therapy Residency Program
115 Natoma Street
Folsom, CA 95630
916-985-3115
Contact Person: Ms. Emily Moore

Orthopedic Manual Physical Therapy Series
Program in Physical Therapy
School of Health Sciences
Oakland University
Rochester, MI 48309
313-370-4041
Coordinator/Contact Person: Ms. Kornelia Kulig, PT, PhD

Kaiser Hayward Physical Therapy Residency Program in Advanced Orthopaedic Manual Therapy
27400 Hesperian Blvd.
Hayward, CA 94545
510-784-4259
Director/Contact Person: Ms. Carol Jo Tichenor, MA, PT

Kaiser Permanente Los Angeles Orthopaedic Physical Therapy Residency Program
6041 Cadillac Avenue
Los Angeles, CA 90034
Director/Contact Person: Mr. Joe Godges, PT, OCS

The Ola Grimsby Institute, Inc.
1742 Garnet Ave., Suite 386
San Diego, CA 92109
619-483-7246
Director/Contact Person: Mr. Ola Grimsby, MNFF, MNSMT
(Full-time and part-time residency programs are available regionally)

Therapy Specialists, Inc.
Residency Program in Orthopaedic Physical Therapy
1221 Kapiolani Blvd., Suite 201
Honolulu, HI 96814
808-526-0108
Director/Contact Person: Mr. Alan J. Lee, MS, PT, OCS

Institute of Graduate Physical Therapy
201 Health Park Blvd., Suite 215
St. Augustine, FL 32086
1-800-241-1027
Contact Person: Ms. Patricia King Baker, MA, PT

The SOMA Post Graduate Professional Training Program in Orthopaedic Physical Therapy
3737 Executive Center Drive, Suite 158
Austin, TX 78731
1-800-441-SOMA
Contact Person: Mr. Ty Lawrence

Residency Program in "Medical Exercise and Orthopedic Manual Therapy"
Lansing General Hospital/Svendsen Consultants, Inc.
Physical Therapy Center
3315 E. Michigan Ave.
Lansing, MI 48912
1-800-697-2405
Director/Contact Person: Mr. Bjorn Svendsen, DHSc, PT

Orthopaedic Physical Therapy Practice
American Physical Therapy Association
505 King, Suite 103
La Crosse, WI 54601

The Orthopaedic Section of A.P.T.A. presents

1993 REVIEW FOR ADVANCED ORTHOPAEDIC COMPETENCIES

SEATTLE, WASHINGTON
Doubletree Suites Hotel
July 11-17, 1993

The purpose of the "Review for Advanced Orthopaedic Competencies" is to provide Orthopaedic Section members and non-members with a process for review. (It is not intended to satisfy examination criteria for the Orthopaedic Physical Therapy Specialty Competency examination, but to serve as a **review process only.)**

See inside front cover for registration and hotel information.