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Orthopaedic Physical Therapy Practice

Special Issue: Foot & Ankle

AN OFFICIAL PUBLICATION OF THE ORTHOPAEDIC SECTION
AMERICAN PHYSICAL THERAPY ASSOCIATION

The Orthopaedic Section, APTA, Inc.

presents

1995 Combined Sections Pre-Conference Course

"Performance Based Documentation"

Wednesday, February 8, 1995 --- Reno, Nevada

Instructors: Donna El-Din, PhD, PT
Gary J. Smith, PhD, PT, OCS

Schedule: 8:00am - 12:00pm
1:00pm - 4:30pm

Tuition: Orthopaedic Section Members: $125.00
APTA Members: $175.00
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(Tuition fee includes a refreshment break prior to the seminar and two breaks during the seminar)

Educational Credit: 7.5 Contact Hours

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(Tuition fee is separate from the Combined Sections Meeting registration fee)

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Cancellations 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.

Course Description: This course will focus on a description of the DEP model of documentation, a model which promoted documentation based on functional outcomes. Basic to the model are performance goals. Practice sessions based on clinical applications will be included. There will be opportunity for open discussion.

Course Objectives: *Review basic concepts of documentation *Determine third party payor requirements for documentation *Define functional outcomes *Select measureable data *State physical deficits in functional terms *Hypothesize causes of dysfunctions *Relate physical therapy interventions to the hypotheses *Develop measureable functional outcomes *Document the plan of client care *Utilize the DEP procedure in the current clincial setting *Transfer the knowledge of the DEP approach to other areas of practice *Review options available for computerized documentation.

Orthopaedic Physical Therapy Practice

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EDITOR'S NOTE

Rude Awakenings

Up until last year, I worked for many years as the physical therapist for a University Health Center, where students paid a "health fee" which included physical therapy. Everyday was sunny (metaphorically speaking), without concern for billing, accounts receivable or insurance carriers. So it was with a great expectation of third party culture shock when I took a position in the "real world" as a staff therapist. Still, I was unprepared for what hit me. I was thrown into a maelstrom of managed care, PPO's, HMO's, capitation and denied service.

Although I was resigned to accept the loss of my third party virginity, it did not mean that I had been naive with regard to political issues that affect the profession. I believe I can speak somewhat intelligently about direct access, specialization, entry level masters, etc. In fact, referral for profit has found its way onto my own agenda *(see Editorial, Spring '93)*.

Recently however, I have been staggered by a new vision of greed and its potentially concomitant reduced quality of care. I'm speaking of **Non Referral for Profit**. For those of you who don't recognize the term, here's one scenario describing how it works. . .

Physician practices contract with managed care companies to deliver care to their subscribers. Often, there is a contracted for, guaranteed, flat fee paid to the practice each month. This is especially applicable to "captive" HMO's. These managed care companies recognize that referral out of the physician's office to a specialist or alternative practitioner—read, physical therapist—cost them more money. So, they have generated a budget for those physicians. If the physicians stay under budget, by not referring out of the office, they receive a monthly "bonus"—read, kickback, based on a percentage of the budget. This is justified as cost management.

In the past ten years, I have seen the practice of medicine take on a decidedly defensive posture. Physicians have been quick to work up their patients and refer them to a specialist or order a barrage of tests for fear of missing a diagnosis and thereby suffering the slings and arrows of the most litigious society on earth. Now however, they are being asked to keep *everything* in house. What will happen when physicians are faced with the choice of ordering tests and/or physical therapy or managing these patients themselves and making a bonus? Will greed rear its ugly head? I think I know the answer, and it causes me great concern.

Along these lines, a California court recently ordered an HMO to pay $89.1 million dollars to the family of a woman who died from breast cancer after the insurer refused to pay for a treatment they claimed was experimental. (1) Reportedly, there was evidence offered that the HMO offered a financial incentive to executives who saved the company money by denying coverage.

I'd ask someone to wake me up, but its more than a bad dream!

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[1] Stauffenger LW, Knoll JT, Insurance Companies and Experimental Treatment, Ohio Lawyer 1994; 8:8-16.

Jonathan M. Cooperman,
MS, PT, JD

President's Report

Writing this president's message before the political dust settles over Washington appears somewhat premature; however, despite the changing of the guard in both Houses and the Republican gains in the states, a few basic assumptions can be safely made even at this time. According to their pre-election position statements the Republican leadership will be implementing insurance reform which should make it easier for people to purchase insurance. Without major health care policy reform this action should improve accessibility to health care. While the White House will, by many accounts, attempt to pen a health care reform plan that will more easily win acceptance by striking compromises with all individuals involved.

As we all know, despite what goes on in Washington, Health Service Reform (as health care reform is now being called) has continued to progress on the state level and in the private payor sector. Consequently, the outcome of many state political races will have an even greater impact on health care than the activities in Washington. States that implement programs with increased accessibility to health care and managed care products will avoid significant federal government interference. Therefore, involvement in state association legislative and reimbursement committees will become even more vital to safeguarding the role of physical therapy in health care in the coming year. You may be able to influence practice by using your business relationships with payors to communicate the clinical and fiscal value of physical therapy. By assisting the payors to appropriately manage care in physical therapy, you will be able to guide the profession through this transition period.

The Orthopaedic Section continues to attempt to help its members in these efforts to meet the challenges of this decade. These challenges should be viewed as opportunities for the profession not obstacles; the glass is definitely "half full" and not "half empty."

Thus the Section:

- continues to be a major supporter of the Worker's Comp Focus Group as it defines practice parameters by reviewing data on the top fifteen diagnoses in Orthopaedic Physical Therapy to establish treatment protocols and acts as a conduit for communication of data regarding reimbursement activity to the membership
- in conjunction with the BOD of the APTA support the efforts of the Industrial Rehabilitation Advisory Committee (IRAC) to evaluate the efficacy of work hardening and work conditioning
- continues to seek a method of collecting member data on practice outcomes to further the process of identifying quality, efficient approaches to patient care
- supports the development of specialization through the orthopaedic specialist certification process, review course, continuing education programs and publications
- continues to work with the APTA, the Commission on Accreditation, ABPTS, and other sections in investigating the possibility of accrediting residency programs

In addition to member services the BOD of the section is charged with implementing policies that will protect and promote the section fiscally without relying solely on dues income. To address these challenges the section funds have been conservatively invested to promote slow but relatively safe growth. To be even more cautious in this time of uncertainty in health care, the operating budget is protected by a reserve fund that is 75% of the annual budget. Due to our conservative and prudent operations and expenditures, the section also has a growing Building Fund. The BOD has been actively seeking a location to purchase or build in La Crosse to reduce increases in future rental costs and also provide an additional investment entity for the Section. An update on this process will be presented at the Business Meeting at Combined Sections in Reno.

In closing, I would like to take this opportunity to thank the skilled, hard-working administrative staff in La Crosse, the section BOD for their commitment to the profession and the Section, and the membership for your hours of volunteer time and continued input into the operations and focus of the Section. I sincerely wish you and your families the healthiest and happiest of new years in 1995.

Z. Annette Iglarsh
PT, PhD
President

The ABPTS office is looking for a nomination for an orthopaedic certified specialist. This is a four year term which would begin in July, 1995. Please call the specialty department at APTA for further information at 800-999-2782, ext. 3150

From The Section Office

Terri A. Pericak, Executive Director

The Board of Directors met at the end of September in Scottsdale, Arizona. The minutes from this meeting are on page 16. Highlights from the meeting include:

- passing a balanced budget for 1995 (financial graphs are shown on page 15),
- manning a booth at all future Student Conclave meetings,
- actively pursuing educational programs for PTA's as well as working to get a PTA on the Education Committee and the Board of Directors, and
- establishing future goals for the Section.

At the time of this writing the Section is actively pursuing the purchase or construction of a building in La Crosse, Wisconsin to house the Section office. An update on this will be presented at the Section business meeting during the Combined Sections Meeting (CSM) in Reno, Nevada on February 11 from 8:00-10:00 AM. If you are unable to attend that meeting the minutes will be published in the May issue of *Orthopaedic Physical Therapy Practice.*

The Section once again has a lot of excellent programming planned for CSM. The complete schedule is listed on the inside back cover. As always the Section is looking forward to its Black Tie and Roses Reception Saturday evening, February 11 from 7:00-10:00 PM at the Reno Hilton. The Rose Excellence in Research Award will be presented during the reception. This year the award goes to Dr. Karen Hayes, PT from Northwestern University in Chicago.

Prior to the Black Tie and Roses reception will be the Paris Distinguished Service Award lecture. This year the Paris award goes to Joe Farrell, MS, PT from California. Joe will be presented with his award following his one hour lecture from 6:00—7:00 PM, Saturday, February 11 at the Reno Hilton. We hope you will be able to attend both of these prestigious events.

Happy New Year from all of us at the Section office. We enjoyed working with you in 1994 and look forward to working with you in what we hope will be another prosperous year in 1995. See you in Reno!

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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!

Guest Commentary

Foot and Ankle Special Interest Group

By Tom McPoil, PhD, PT, ATC

In the past decade, the physical therapist has become extremely interested in the function, assessment and management of the foot and ankle. The recognition of the influence of foot anatomy and mechanics on the overall alignment of the lower extremity as well as on specific foot disorders has fueled this interest. A major challenge facing the profession has been the fact that most physical therapists who have been practicing for more than ten years received little information on foot mechanics and management principles in their entry-level education. Thus, there has been a substantial increase in the number of continuing education courses or workshops to meet this demand for more information regarding the foot and ankle. In general, these continuing education courses and workshops have introduced an evaluation and management protocol borrowed from other health care professionals, primarily podiatry, which may or may not be well founded. To strengthen the future role of the physical therapist in providing foot and ankle care, a solid foundation must be established through both clinical research and practice in order to create a "physical therapy model" for the management of foot and ankle disorders. Considering the current and potential changes that will effect the way the physical therapist provides health care, it makes the most sense to have a strong special interest group in the area of the foot and ankle, supported by physical therapists from the Orthopaedic Section as well as all specialty areas of practice. This will help to develop a "physical therapy model" for the management of foot and ankle disorders.

It was for this primary reason, as well as other specific goals and objectives, that the Foot and Ankle Special Interest Group (FASIG) of the Orthopaedic Section was formed and is introduced in this issue of *Orthopaedic Physical Therapy Practice* which focuses on the foot and ankle. The recognition by the Orthopaedic Section of the FASIG this past June in Toronto would not have occurred without the efforts of numerous individuals dedicated to creating a forum for the discussion of issues affecting the assessment and care of foot and ankle disorders.

While there has been a Foot and Ankle Roundtable in place for several years at annual Combined Sections Meeting, the formation of the FASIG allows us as a group to plan for more extensive educational sessions as well as the opportunity to address issues affecting the practice and education of the physical therapist treating foot and ankle disorders. No doubt, the FASIG's primary purpose is to provide educational sessions and workshops covering issues related to the basic science, evaluation and management of problems affecting the foot and ankle. However, as a group, the FASIG has established the following objectives:

1. Foster physical therapy management of foot and ankle disorders based on a scientific foundation.
2. Provide a forum for the discussion of the management of foot and ankle disorders among physical therapists form the Orthopaedic Section, as well as other APTA Sections.
3. Initiate and maintain an on-going dialogue among members to provide: a) suggested standards for entry-level physical therapy education programs in regard to the management of foot and ankle disorders, and b) standards for measurement protocols as well as terminology relative to examination and treatment procedures for the foot and ankle.
4. Provide a forum for interacting with other health care professionals who manage foot and ankle disorders.
5. Provide a network for enhancing communications between clinicians, academicians, and researchers in the physical therapy community interested in the management of foot and ankle dysfunction.

With these objectives in place, I am very excited about the potential impact the FASIG can have on enhancing the clinical practice of the physical therapist. I would like to invite each of you to take part in all of the FASIG activities.

The first official meeting of the FASIG will be held in Reno at the Combined Sections Meeting. We will have a one hour business meeting (Saturday, February 11 from 12:30-1:30 p.m.) followed by three hours of programming. The primary purpose of our business meeting will be to approve the FASIG bylaws and budget, elect officers, and to establish committees to begin working on the above objectives. Our acting nominating committee, consisting of Irene McClay, Michael Mueller, and David Sims, have proposed the following slate of candidates: Chair—Tom McPoil, Secretary/Treasurer—Mark Cornwall, Nominating Committee—Irene McClay (2 yrs), David Sims (2 yrs), Michael Mueller (1 yr) and Jim Birke (1 yr). We will also be taking nominations from the floor, so if you would like to run for one of the above FASIG offices, please attend our business meeting.

The educational portion of our program at CSM in Reno also promises to be stimulating and an excellent opportunity to discuss the various topics to be presented. The invited speakers and their topics include:

1) Jan Bruckner, PhD, PT;
   TOPIC: *Stories Bones Tell—Subtalar Joint Variations*
2) Joe Tamaro, PT, ATC:
   TOPIC: *Orthopaedic Trauma to the Foot and Ankle: Selected Case Studies*
3) David Sims, MS, PT:
   TOPIC: *Issues Related to the Management of the Insensitive Foot*
4) Ted Worrell, EdD, PT, ATC:
   TOPIC: *Review of Foot and Ankle. Research Conducted at the University of Indianapolis.*

The same format as last year will be followed, in which each speaker will have 20 minutes to present on their topic area followed by 25 minutes for

questions and answers from the audience. Mark Cornwall will chair the educational session.

Again, we are all excited to have the Foot and Ankle Special Interest Group of the Orthopaedic Section up and running and are looking forward to our first "official" meeting. The two papers that are included in this issue of *Orthopaedic Practice* are reflective of the clinical discussions that have occurred at previous Foot and Ankle Roundtable sessions. The paper by Jerry LeLeux, PT and Max McLeod, PT addresses the clinical management of ankle sprains. Both Jerry and Max have played important roles in early organization of the FASIG as well as organizing their own foot and ankle study group in Louisiana. The paper by Steve Reischl, PT, OCS and Jean De Bettignies, MS, PT, ATC raises the important issue of motion in the midtarsal joint based on recent research. Steve and Jean have also played important roles in the formation of the FASIG and Steve is currently Acting Vice-Chair of the FASIG. I want to thank each of these individuals for contributing to this special issue of *Orthopaedic Practice* which focuses on the foot and ankle.

The current membership of the FASIG is composed of an outstanding group of clinicians and researchers who have a tremendous interest in the foot and ankle and, most importantly, are willing to share their thoughts and experience on the subject. I cannot begin to thank each of them enough for their continual efforts and support in the establishment of the FASIG! I invite you to consider being a part of the FASIG, and we all look forward to seeing you at the FASIG activities in Reno!

Tom McPoil is Acting Chair of the Foot and Ankle Special Interest Group, and an Associate Professor at Northern Arizona University.

Rehabilitation of Ankle Sprains

By Max McLeod, PT and Jerry LeLeux, PT

Ankle sprains are common lower extremity injuries treated by physical therapists. For any acute soft tissue injury, there is a fine line that separates a progressive rehabilitation program from an overly aggressive one. The successful treatment program must create an environment that allows controlled stress to be applied to healing tissues. In doing so, edema and range of motion are consistently monitored and treated appropriately.

EDEMA

In the acute phase, a soft dressing controls edema. The dressing consists of cast padding covered by an ace wrap. A posterior splint may be necessary to immobilize the foot and ankle, if the sprain is moderate to severe. Apply the cast padding from the MTP line to the middle third of the leg. Place extra layers of padding in the contours of the medial and lateral ankle to ensure that compression will be equal in all parts of the extremity when the ace wrap is applied. The patient *elevates* the extremity and does active toe and ankle range of motion exercises as often as possible. Monitor edema daily by removing the soft dressing. Reapply if necessary. Use a commercial stirrup device when edema decreases to a desirable level.

The residual edema that commonly persists around the lateral malleolus and the anterior-medial ankle may suggest unresolved complications. The edema around the lateral malleolus could be the result of chronic microtrauma to the healing ligaments, a tear of the joint capsule, or a subluxation of the peroneal tendons. Also, mild subluxations of the talocrual joint should be considered. Residual edema along the anteromedial ankle suggests a chondral defect of the talar dome.

LOSS OF MOTION AND FUNCTION

Loss of motion and function result from prolonged immobilization, chronic edema or the lack of use. Immediate attention should be directed to restoring subtalar joint motion and ankle dorsiflexion. These motions are critical for quick progress. Without adequate subtalar motion, the ability to balance is severely limited. The lack of adequate dorsiflexion causes abnormal gait mechanics, and the patient walks with a limp.

Manual Techniques

Manual techniques are used to restore ankle and subtalar joint motion. Passive movement of the tarsals, metatarsals and phalanges in their obligatory motions provides a way to feel the soft tissue restrictions and joint limitations of the foot and ankle. Specific manual techniques can then address specific problems.

With the patient laying supine, one hand holds the heel while the other holds the forefoot across its dorsal surface. While applying a longitudinal traction in line with the long axis of the leg, do passive movements in all planes of motion.

A second technique, this one used to increase ankle dorsiflexion, requires a posterior glide of the talus in the ankle mortise. With the patient in supine and the leg elevated so that the foot is not in contact with the plinth, the heel is held in one hand and the forefoot in the other. Apply a posterior distraction to the heel while the foot is moved into dorsiflexion with the other. When maximum dorsiflexion is achieved, overpressure by the hand holding the forefoot produces a posterior glide of the talus in the ankle mortise. When instructed, the patient assists with the movement by actively dorsiflexing the ankle. Active range of motion exercises maintain or increase motion obtained through the manual techniques.

Aquatic Therapy

Functional exercises in a closed chain environment begin when edema is under control and active motion is adequate. In the early stage of weightbearing, aquatics allow for the unloading of the patient's weight to levels that are comfortable to the patient. Submerging the patient to chin depth reduces body weight by 90%. Fifty percent reduction occurs at waist depth.

Aquatics help in edema control through hydrostatic pressure of the water, the massaging effects of the water and the gentle muscle contractions used to counteract the water resistance. Deep water walking, running, and cross country skiing in nonweightbearing or partial weightbearing positions allow for early range of motion. The patient controls resistance to these movements by controlling the speed of motion and the use of floats. Ultimately, aquatics allow the patient to begin closed chain exercises, normalize gait mechanics and prevent knee and hip problems.

Closed Chain Exercises

If a pool is not available, closed chain exercises begin while sitting. Sliding the foot on a board or a smooth floor improves transverse and sagittal plane motions. Exercise discs and rocking platforms work triplanar motions. Riding a stationary bike improves cardiovascular fitness.

During standing, progressive weightbearing applies controlled stress to the foot and ankle in ways that help stretch soft tissue and restore motion to the involved joints. Foot contact with the ground stimulates sensory and neuromuscular systems to improve proprioception. Assistive devices help with initiating weightbearing. Walkers, canes and crutches allow the patient to stand with control. As the patient's ability to bear full weight improves, the devices are eliminated. Specific exercises and activities include:

1. weight shifting forward, backwards and sideways—stride lengths increase as ankle motion increases,
2. partial squats—excursion is determined by the amount of ankle dorsiflexion,
3. gait—sideways, forward and backwards (*CAUTION* Always look for compensations at the knee and hip for the lack of ankle dorsiflexion),
4. progressive step ups—sideways, forward and backwards (increase the height of the step as ankle dorsiflexion increases),
5. one legged balance (stork exercise)
   a. eyes closed

b. head tilts
c. opposite leg moving in various directions (unweighted and weighted)
d. upper extremities moving in various directions (unweighted and weighted)
e. standing on a mini-trampoline, also doing c. and d.
f. step ups on mini-trampoline—sideways, forward and backwards.

6. full squats,
7. sport or work specific activities.

SUMMARY

Rehabilitation of ankle sprains is a dynamic process. Creating an environment that promotes healing and monitoring the patient's response to that environment are the key factors in this process. One must have a knowledge of tissue healing, understand the biomechanics of the foot and ankle, and know the ultimate effects of treatment in order to successfully rehabilitate ankle sprains. The program that has been presented is only an example of what can be done.

Max McLeod, PT works at McLeod-Trahan Physical Therapy Services in Lafayette, LA and Jerry LeLeux, PT works at Leblanc, Chamberlain, and Martin Physical Therapy Services Inc., Opelousas, LA.

Call for Nominations for Orthopaedic Specialty Council Member

The Orthopaedic Section needs your input for qualified candidates to be appointed as a member of the Orthopaedic Specialty Council. To serve is exciting and an honor! If you would like the opportunity to serve the Section or know of qualified members who would, please fill in the requested information and send or FAX it to the Section office, along with the candidate's curriculum vitae no later than **March 15, 1995.**

Print full name of nominee _____

Address _____

_____

City _____

State _____ Zip _____

Work Telephone (_____) _____

Home Telephone (_____) _____

Qualifications for Specialty Council Member:

_____

_____

_____

_____

1) Must be willing to serve for a four (4) year term beginning July 1, 1995
2) **Must be an Orthopaedic Certified Specialist (OCS)**

PLEASE RETURN BY MARCH 15, 1995 TO:
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FAX NUMBER (608) 784-3350

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THANK YOU!!!

A Different Look at the Midtarsal Joints

By Stephen Reischl, PT, OCS and Jean De Bettignies, MS, PT, ATC

INTRODUCTION

The American Physical Therapy Association states that physical therapists are experts in analyzing movement and movement dysfunction. Recognizing patterns of dysfunction and their impact on all the systems of the body becomes our basis for clinical practice. However, an expectation regarding "the normal" action of a segment may limit the analysis of what is actually happening. A perfect example can be found in the foot during gait. The talonavicular (TNJ) and calcaneocuboid (CCJ) joints, which are often placed together as the midtarsal joints, are said to "lock up" as the subtalar joint supinates, contributing to the stability of the foot in midstance. Clinical experience suggests that this is often not the case. The purpose of this article is to re-examine the above assumption and to propose a different look at the midtarsal joints.

Review of literature concerning function of the foot and the TNJ and CCJ

Many are familiar with the works of Hicks, Manter and Inman. We would like to review more recent literature and share some of the findings on these authors. In 1983, van Langelaan published a paper describing the kinematic analysis of the foot in cadavers with tantalum balls imbedded in the bones of the foot and ankle. (13) With the foot loaded, the foot position was changed in an incremental amount, with a special x-ray taken at each new change. He found there was more movement in the TNJ, CCJ and cuboidnavicular joints than previously reported by Manter and Hicks. There was more movement at the TN joint than at the subtalar joint. The results also showed that there was no single joint axis but described a bundle of axis which best described the movement. A description was given of the anatomic location of the axis of each joint, which corresponded to the more traditional axis. For example, at the calcaneocuboid joint (CCJ) the axis location was the area of the neck shaped region of the CC joint passing anterior medial superior to posterior lateral inferior. This corresponds to the oblique axis. For the talonavicular joint, the axis crosses the foot medial superior to posterior lateral at the central portion of the head of the talus, corresponding to the longitudinal axis. van Langelaan stated that "the rotations of an individual tarsal chain member as well as the intertarsal rotations can considerably exceed the (input) rotation of the tibia."

Benick, in 1985, continued the work of van Langelaan. (1) With the same imbedded balls in the tarsal bones and x-ray measurement, he observed continuous motion of the foot rather than the step wise fashion of van Langelaan. They studied cadavers specimens, freshly amputated specimens and 2 live subjects. This work showed the same responses of the foot and increased motion of the TNJ and CCJ in the 3 types of specimens tested.

Lundberg, in a 3 part series published in 1989, used live subjects with the imbedded balls and x-ray stereophotogrammetry. (4,5,6) In a weightbearing position, the foot and lower leg was moved in 3 different ways: internal/external rotation, dorsiflexion/plantarflexion and supination/pronation. The cuboid was not included in the study arrangement. When the human subjects were moved from pronation to supination, there were larger movements of the talonavicular joints than the subtalar joint, this also varied in the range of the movement measured. Dividing the range of motion into pronation to neutral, then neutral to supination, they found there was more foot/arch movement in the later phase of neutral to supination. When the STJ and TNJ showed supination, the joints proximal and distal to the medial cuneiform showed a pronation pattern, assisting the first MT head in contact with the surface. In part 3 of the presentation (6), they observed movement of internal to external rotation. Foot motion was greater in the movement of neutral to external rotation than internal rotation to neutral.

Ouzonian, in measuring movement of the midfoot in cadavers, found that the TN and CC joints had the most motion followed by the cuboid-5th MT joint. (10) He did not measure the talocalcaneal joint. In another study looking at the effect of arthrodesis of various joints of the foot, Gellman et al, reported that following a tibiotalar arthrodesis 50% of dorsiflexion was maintained, contending that other joints may contribute to the overall motion of the foot. (3) As they restrained motion in various parts of the foot through arthrodesis, the authors calculated the contribution of the midfoot to be 26% dorsiflexion, 19% plantar flexion, 38% inversion and 36% eversion. This does not take into consideration the factors related to periods of immobilization following these types of surgical procedures on patients.

Review of Gait with Considerations of the TNJ and CCJ Normal and Abnormal Conditions

In gait, the requirements of the foot are:

1. a loose adapter for accommodation to uneven terrain at the initiation of stance
2. provide shock attenuation at initial contact loading response
3. a rigid lever for effective propulsion at terminal stance, preswing
4. a mechanism for absorption of rotation of the lower limb during stance phase
   (from McPoil) (7)

The foot is required to move from the loose adapter state to the rigid lever as our body weight passes over the foot in midstance into terminal stance. In gait, one of the requirements of the ankle joint is 10 degrees of dorsiflexion as the foot approaches a neutral position, or a position away from pronation. This exact neutral position concept has been questioned by McPoil, their investigation showing the foot not reaching the subtalar neutral position. (8) The lack of the required talocrual dorsiflexion is common, and a compensation for the restriction is made somewhere in the lower quarter.

There is agreement that foot pronation is a shock absorbing and rotation absorbing mechanism. The movement

of pronation of the entire foot occurs from initial contact to the end of loading response, which is the beginning of single limb stance. In some patients, we can observe the foot continues to pronate beyond the end of loading response. We know that the foot is PRONATED, but we should not be seeing the foot PRONATING as the foot moves to single limb stance. Observation of the medial midfoot at the navicular can show in some patients that the medial longitudinal arch continues to drop when it should not.

It has been described and reported in many texts that as the subtalar joint moves from pronation to supination, the midtarsal joints become more stable and have less available motion. (12) From the studies above, there is evidence that these midtarsal joints have more motion than previously thought, and they may influence the foot function and dysfunction in gait and ADL.

Dysfunction of the TNJ and CCJ

In gait as the body moves over the fixed foot, sagittal plane motion takes place at the talocrual joint. If this is limited, the body still has to move over the foot. The most common compensation is pronation in the phase of gait in which dorsiflexion of the ankle is required. The compensation most commonly seen is abnormal pronation occurring through midstance to terminal stance, depending on the severity of the restriction. Lack of 10 degrees of talocrual dorsiflexion is an endemic problem. Soft tissue restrictions of the gastrocnemius and soleus may contribute to the limitation of motion. Ankle joint dorsiflexion is required after loading response into midstance and terminal stance, just prior to the preswing phase. Depending on the severity of the restriction of dorsiflexion, the foot may compensate by continuing to pronate. It is here where the authors see the effect of the hypermobility of the TNJ and CCJ either individually or together. The effect can be seen in the foot in gait as we observe the pronation of the foot. As the contralateral foot comes off the floor, this is the start of midstance. In a hypermobile TNJ, we can see the navicular bone continue to "drop" in its 3 dimensional pattern as described by Mueller. (9)

Consider the muscular support system of the foot as the navicular stays plantarly displaced. The posterior tibial muscle will be working eccentrically further into the gait cycle at a longer length. If the medial column stays plantarly displaced, the plantarflexion of the first ray cannot be accomplished so we further lose distal medial column stability. The peroneus longus will be at a less than optimal position to function at the first ray. The soleus, functioning eccentrically, assists in controlling the rate of pronation. Often when palpating soft tissue, the medial soleus is tender while the lateral soleus is not. Campbell et al reported differences in the function of lateral vs medial soleus. (2) We picked these muscles to present the changes in function with abnormal foot pronation. Dysfunction in the gait cycle will cause compensating adaptations in the entire lower extremity, pelvis and trunk. Muscle weakness, tightness or increased length will further influence the dysfunction in patients who present abnormal foot pronation.

In the model of normal gait, the foot should have the transition into a rigid segment at terminal stance, prior to preswing. It requires ankle dorsiflexion of 10 degrees. The calcaneocuboid joint axis is most similar to the talocrual axis that can give the foot the dorsiflexion it requires in this phase of gait. In patients who pronate in terminal stance, we see an abduction type movement of the calcaneus. Tiberio discussed how pronation occurring later in stance phase can have a more detrimental effect than excessive pronation at loading response. (11) If pronation is occurring at the wrong phase of gait, the abnormal internal rotation of the lower extremity can cause changes in the lower quarter, with examples of pain and malalignment of patellofemoral joint and the lumbopelvic region.

SUMMARY

In summary, we propose that the talonavicular and calcaneocuboid joints are common sites of dysfunction within the gait cycle. Review of the literature indicates that there is more movement in these joints than previously considered. Maintaining normal flexibility and strength are significant considerations to normal "midfoot" function and normal lower extremity biomechanics.

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Stephen Reischl owns Reischl Physical Therapy in Long Beach, California. Jean DeBettignies works at Precision Biomechanics, Inc. in Santa Barbara, California.

The Need for Case Studies in the Orthopaedic Physical Therapy Literature

By Phil McClure, MS, PT, OCS

Case studies are perhaps the most practical way for all those who treat patients to contribute to our professional literature. Case studies promote scientifically based clinical practice in several ways. They provide a mechanism for bridging the gap between theory and practice, promote professional discussion and guide future research efforts.

The need to integrate theory with practice is constantly evident in both clinical and academic teaching environments. When asked to write on the need for case studies, I began to reflect on how ideas and knowledge are transferred to students and colleagues so as to effect clinical practice. I have had the opportunity of teaching orthopaedic physical therapy to students and colleagues in both clinical and academic environments. I believe one of the greatest challenges to effective classroom teaching is the problem of making a general concept or theory clinically relevant and applicable. Case studies provide a powerful way for all of us who treat patients to share how we integrate theory into practice. This is perhaps what makes clinical teaching so effective because all teaching is done in the context of a specific patient problem. Writing a case study also forces the development and refinement of theory because it compels us to think through and justify our clinical decisions.

Well written case studies provide an excellent starting point for meaningful professional discussion relating to clinical practice. I often observe at continuing education courses that the most useful dialogue and learning seems to happen between participants discussing specific patients during breaks, particularly when the speaker has provided some interesting or controversial material as a starting point for discussion. This same phenomenon occurs when a case study is shared through the professional literature. I have been very gratified by letters of inquiry and discussion received following publication of case studies dealing with the common problem of shoulder stiffness. I know other authors of case studies who have had similar experiences.

Case studies seem to sometimes be reserved for the more rare and exotic patient problems. While these have their place, there is an urgent need for us to simply describe and document how we manage patients with more common pathologies. Without these types of case studies, there is no way of knowing how we routinely treat patients and make clinical decisions. Consider for example, management of a patient with low back pain or a patient with anterior knee pain. How do we decide what evaluation procedures to use? How does the evaluation guide the specifics of treatment such as the type of treatment, the frequency of visits and the end point of treatment? Despite the common nature of these problems we appear to be a long way from a consensus on these issues. Case reports might allow us to gauge how close we are to consensus and also raise critical issues that need to be addressed to gain consensus.

Case studies can also provide the impetus for future experimental research. Our profession is making strides toward scientifically based practice yet many gaps exist in our knowledge. Consequently we are forced to approach many patient problems based soley on a theoretical framework, without hard data to support the efficacy of a particular approach. Papers that carefully describe patient treatment based on sound theory and use reliable and valid outcome measures are extremely useful because they can form a foundation or stepping stone for more extensive experimental research studies. In a general sense, a case study helps to determine what is worthy of further study. A case study may help to define a specific treatment so we know how to apply it in a controlled study. Case studies help to identify appropriate patient populations and important variables that may need to be controlled or manipulated. They may also help to identify the most appropriate and sensitive measures of outcomes. To those who are intimidated by experimental research and who shudder at the thought of statistics, case reports provide an excellent mechanism to share experiences and professional knowledge.

The basic ingredients of a good case study are similar to those in true experimental research. The measurements used for evaluation and to document outcome must be reliable and valid. The treatment must be thoroughly described and there should be a sound theoretical basis for the treatment and clinical decisions made during a course of treatment. Results of a case study are not as generalizable and conclusive as true experimental research due to inadequate numbers of patients and the lack of controls that allow a researcher to attribute a treatment effect to a specific intervention. However, a case study should raise the possibility of a particular treatment effect or mechanism that can be more rigorously tested with experimental research.

Perhaps one barrier to writing case studies is the rigor of peer review. To have other professionals scrutinize your practice as well as your writing can, at times, be almost painful. Yet clearly there is a need for peer review in order to refine ideas and maintain a high quality of written reports. One would not have to look very far to find misinformation being passed along in a published form due to a lack of professional peer review. Peer review represents a rich opportunity for help and refinement of our work. Clinicians who feel they have important experiences to share but are intimidated by the process of writing for publication should seek help from others who have been through the process. Dr. Rothstein, as editor of *Physical Therapy*, has clearly invited submission of case reports. (1)

A consistent theme among clinicians is the disdain for a "cookbook approach" to clinical management of patients. However, aimless application of the latest fads in treatment without regard to a solid theoretical basis and

(continued on page 17)

A Winner Has Been Chosen for the 1995 Student Guest Program

By Karen Piegorsch, MS, PT, OCS, MSIE

The winner of the second annual Student Guest Program was drawn from a pool of 49 students whose names were submitted by their schools. The winner, *Dana Ehlenfeldt*, is a physical therapy student at Finch University of Health Sciences, Chicago Medical School.

Please join the Section in welcoming Dana Ehlenfeldt at CSM in Reno.

The Student Guest Program presents an excellent opportunity to foster the interest of a promising physical therapy student in the field of orthopaedics.

This program, sponsored by the Orthopaedic Section, is open to all accredited entry-level physical therapy schools in the United States and Puerto Rico. Each eligible school is invited to submit the name of one student for inclusion in a random drawing that will be held at the Section office. The winner of the drawing will receive funding from the Orthopaedic Section to attend the 1995 Combined Sections Meeting (CSM).

Eligible students are those members of the senior class who have demonstrated an interest in orthopaedic physical therapy, who exhibit professionalism, and who are able to attend the entire conference.

The winner of the drawing is expected to attend the Orthopaedic Section Business Meeting and Issues Forum during CSM, assist with audiovisuals at an orthopaedic research session during CSM, and make an oral presentation to his/her class upon returning from CSM.

The following is an alphabetical list of the students whose names were submitted for this year's drawing:

Leo Albano, Medical University of South Carolina, Charleston, SC
Mike Bailey, Idaho State University, Pocatello, ID
Scott Bankard, California State University-Fresno, Fresno, CA
Dana Beck, University of Montana, Missoula, MT
Rhonda Delong, Grand Valley State University, Allendale, MI
Elizabeth Bishop, The College of St. Scholastica, Duluth, MN
Mitchell Bland, University of Connecticut, Storrs, CT
Jennifer Bloom, University of Colorado, Denver, CO
Shelly Cameron, US Army-Baylor Unveristy, Fort Sam Houston, TX
Amy Campbell, University of Alabama at Birmingham, Birmingham, AL
Doug Dunn, Wichita State University, Wichita, KS
Jay Estes, University of Texas Southwestern Medical Center at Dallas, Dallas, TX
Sandra Furker, Boston University, Boston, MA
Kerry Gale, Springfield College, Springfield, MA
Katie Grant, University of Wisconsin, Madison, WI
Shari Hariton, State University of New York at Buffalo, Buffalo, NY
Leatha Hawbaker, University of North Dakota, Grand Forks, ND
Hidde Hendriks, Stockton State College, Pomona, NJ
Shuriz Hishmeh, New York University, New York, NY
Liberty Kauders, Medical College of Virginia, Richmond, VA
Helene Kraeutler, Philadelphia College of Pharmacy and Science, Philadelphia, PA
Mike La Rosa, D'Youville College, Buffalo, NY
Paul LeBas, Louisiana State University Medical Center, Shreveport, LA
Doug Longmore, Slippery Rock University, Slippery Rock, PA
Carlos Martinez, Howard University, Washington, DC
Ray McKenna, Texas Women's University-Houston, Houston, TX
Ken Miller, Touro College, Dix Hills, NY
Karla Morgan, Thomas Jefferson University, Philadelphia, PA
Marianne Nazirides, Long Island University, Brooklyn, NY
Kim Olech, Medical College of Ohio, Toledo, OH
Alla Onitskansky, Cleveland State University, Cleveland, OH
Gregory Parry, Duke University, Durham, NC
Pete Phillips, Quinnipiac College, Hamden, CT
Vincent Puccio, University of Medicine and Dentistry of New Jersey, Newark, NJ
Chris Puzey, University of the Pacific, Stockton, CA
Debbie Reeves, California State University-Northridge, Northridge, CA
Jeanne Schneyer, University of Osteopathic Medicine and Health Sciences, Des Moines, IA
Cynthia Schwieder, Saint Louis University, St. Louis, MO
Chris Seagrave, University of New England, Biddeford, ME
Wendy Skinner, Florida International University, Miami, FL
Steve Super, Hahnemann University, Philadelphia, PA
Sue Thome-Barrett, University of Florida, Gainesville, FL
Mark Thompson, University of California-San Francisco, San Francisco, CA
Stuart Vestergaard, The University of Oklahoma, Oklahoma City, OK
Shawnalyn Weigel, University of Southern California, Los Angeles, CA
Kelley Wiedmeyer, Washington University, St. Louis, MO
Fred Wilson, Rockhurst College, Kansas City, MO
Juli Yonkus, Oakland University, Rochester, MI

Section News

NOMINATING COMMITTEE REPORT

At the Fall business meeting in Phoenix, the section Board of Directors approved revisions to the current section elections process. The intent of this revision was to announce the election of officers at the Section's annual meeting held during APTA's Combined Sections Meeting.

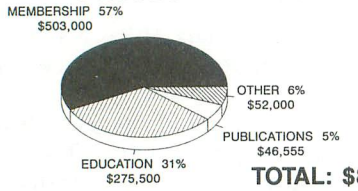
The revised nomination and election schedule follows:

March 1	Contact nominating committee members and inform them of their duties Submit call for Section nominations to *Orthopaedic Practice* for publication in the issue
April 15	Call incumbent officers to determine if they wish to be renominated
APTA Annual Mtg, June	Call for nominations for APTA offices, awards and scholarships
July 1 - September 15	Solicit consent to run, candidate profiles, statements, curriculum vitae and photographs from candidates
October 1	Slate finalized and submitted to Orthopaedic Section office
November 15	Ballots mailed to Orthopaedic Section members
December 30	Deadline for return of ballots
CSM, February	Results of election announced

Michael J. Wooden, MS, PT, OCS
Chair, Nominating Committee

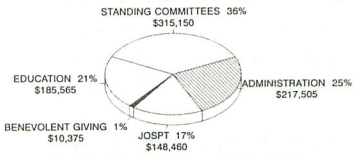
FINANCIAL REPORT

1995 STRATEGIC PLAN
PROJECTED INCOME



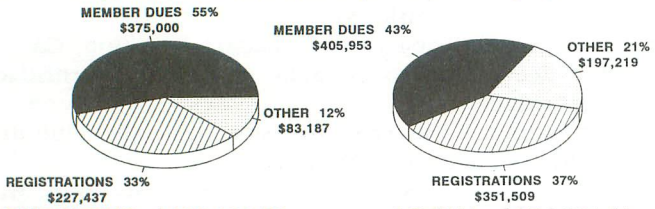
TOTAL: $877,055

1995 STRATEGIC PLAN
PROJECTED EXPENSES



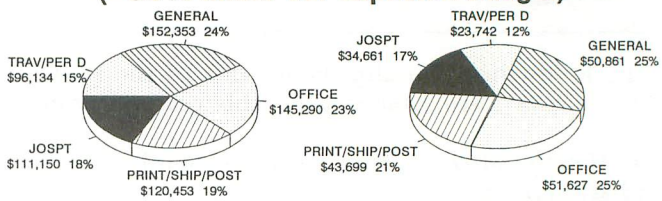
PROJECTED: $877,055

1994 BUDGET TO ACTUAL
INCOME: BREAKDOWN - September 30, 1994
(+39.2% over our expected budget)



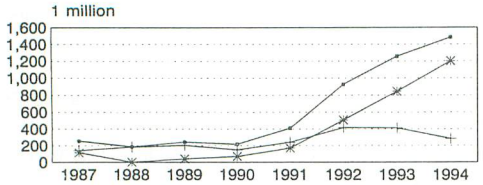
BUDGETED: $685,623.78 **ACTUAL: $954,681.41**

1994 YTD BUDGET TO ACTUAL
EXPENSE: BREAKDOWN - September 30, 1994
(–5.9% under our expected budget)



BUDGETED: $625,380.93 **ACTUAL: $588,467.35**

YEAR END FISCAL TRENDS
1987-1994 (1994 data is as of September 30, 1994)

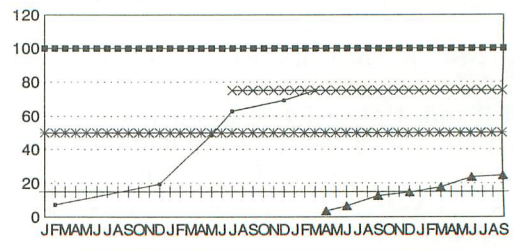


	1987	1988	1989	1990	1991	1992	1993	1994
ASSETS	255	185	243	217	410	925	1,257	1,484
LIABILITIES	141	183	203	148	240	417	413	283
EQUITY	114	2	40	69	170	508	844	1,201

ASSETS LIABILITIES EQUITY

To nearest thousand

RESERVE FUND
January 1, 1991 to September 30, 1994



Meeting Minutes

FALL BOARD OF DIRECTORS MEETING
SEPTEMBER 29-OCTOBER 2, 1994
SCOTTSDALE, ARIZONA

MARRIOTT MOUNTAIN SHADOWS RESORT
5611 E. LINCOLN DRIVE
SCOTTSDALE, ARIZONA

The Fall Board of Directors Meeting was called to order in Scottsdale, Arizona at 1:00 PM on Thursday, September 29, 1994 by President, Annette Iglarsh.

ROLL CALL:
Present—Annette Iglarsh, President; John Medeiros, Vice President; Dorothy Santi, Treasurer; Michael Cibulka, Director; Elaine Rosen, Director; Nancy White, Education Co-Chair; Lola Rosenbaum, Education Co-Chair; Dan Riddle, Research Chair; Terri Pericak, Executive Director; Jonathan Cooperman, *OP* Editor; Joe Godges, Specialty Council Member; Don Lloyd, Finance Committee Member; Scott Stephens, Practice Chair; Karen Piegorsch, Public Relations Chair; Michael Wooden, Nominating Committee Chair; Dennis Isernhagen, OHSIG President; Sam Brown, APTA Board Liaison
Absent:—Mary Ann Sweeney, Specialty Council Chair

MEETING SUMMARY:
The minutes from the June 3, 1994, Board of Directors meeting in Toronto, Canada, were approved by the Board as printed.

=MOTION 1= The Section Bylaws may be amended in whole or in part by an affirmative vote of two-thirds (2/3) of the respondents of a mailed ballot. The proposed amendment(s) shall be referred to the Board of Directors at least thirty (30) days prior to being discussed by the membership at the annual Section business meeting. Following the annual Section business meeting the proposed amendment(s) shall be published in *OP* or in a separate mailing and shall be sent to all members at least thirty (30) days prior to the ballet deadline. The amendments shall be in effect only after approval by the Board of Directors of the Association. =PASSED=

=MOTION 2= That Don Lloyd be appointed, to replace Jay Kauffman, as a one person task force to oversee the financial operations of the *JOSPT* and serve as a consultant to the Board of Directors with the first report due at the 1994 Fall Meeting. =PASSED=

=MOTION 3= That the Section staff its booth on an annual basis at the Student Conclave meeting beginning in the Fall of 1994. =PASSED=

=MOTION 4= The minutes of the August Finance Committee meeting be accepted as revised by the members in attendance at the Fall Board of Directors meeting and follow up on recommendations to be done by CSM 1995. =PASSED=

=MOTION 5= The Orthopaedic Section Board of Directors request that the APTA-Board of Directors expand the charge of IRAC to include the development of "Acute Industrial Physical Therapy Guidelines". =PASSED=

=MOTION 6= The Orthopaedic Board of Directors request the APTA appoint the OHPTSIG as an advisory group to the APTA's staff person(s) on issues relating to worker's compensation or other issues affecting therapists working in occupational health. In addition, all pertinent information and documents produced or received by the APTA on topics relating to the practice, reimbursement and legislative issues of occupational health physical therapy should be forwarded to the OHPTSIG for input. Appointments by the APTA to internal and external committees and/or task forces on subjects relating to occupational health include input/recommendation by the OHPTSIG. =PASSED=

=MOTION 7= That the Section's committees on Education, Research, Public Relations, Publications and Practice include liaisons from the OHPTSIG. =PASSED=

=MOTION 8= The Orthopaedic Section add reimbursement for one CSM registration for a member of the Program Committee in the 1995 budget. =PASSED=

Fiscal Implication: Less than $300.

=MOTION 9= That the Section budget a free standing meeting of three (3) persons to develop an item review committee to help develop items for the OSC exam in 1995. =PASSED=

=MOTION 10= The following be added to the 1995 proposed annual budget for Specialization:

3 persons x 2 days at CSM	$2,580
3 persons x 2 days at ASI	2,580
Administrative expenses	1,500
Telephone, FAX, etc.	500
TOTAL	$7,160

3 persons X 2 days for item review committee	$2,580
GRAND TOTAL	$9,740

=MOTION 11= That the budget for copywriting the second set of brochure inserts be increased to $840 and that the Section contract with Paula Ashely of Next Years News for this service. =PASSED=

Fiscal Implication: Increase of $140 to come out of the 1994 Miscellaneous Fund. (The original motion was made at CSM in 1994)

=MOTION 12= That we do a mailing to all PT and PTA programs regarding information on awards. =PASSED=

Fiscal Implication: Cost of postage and stationery. Increase to be added to DPD i.

=MOTION 13= The Section reimburse airfare to the full amount of the actual ticket provided reservations are made through Goli's, the Section's travel agent. =PASSED=

=MOTION 14= That the Orthopaedic Section Board of Directors recommend to the APTA Board of Directors the inclusion of a staff member to focus on worker's compensation issues in the 1995 APTA budget. It is further recommended that this person be placed in the Department of Reimbursement. =PASSED=

Rationale: Reimbursement in the worker's compensation area is of vital importance in all areas of practice during this time of health care reform in most states. The Occupational Health PTSIG of the Orthopaedic Section is willing to function in an advisory position for this staff person. The Orthopaedic Section is willing to provide other support as deemed necessary.

=MOTION 15= That the Orthopaedic Section accept the Therasys, Inc. proposal to customize, install and train Orthopaedic Section personnel in the operation and maintenance of the proposed computer network. =PASSED PENDING A RE-VOTE IN 30 DAYS AFTER THE TWO NEW BOARD MEMBERS HAVE HAD A CHANCE TO LOOK AT THE SYSTEM=

Fiscal Implication: $100,000 to come out of the reserve fund.

=MOTION 16= The 1995 Strategic Plan and Budget be approved as presented. =PASSED=

GOALS FOR THE ORTHOPAEDIC SECTION

1) GOVERNMENT
   * SIG motion on worker's compensation
   * Compilation of state boards
   * Workers Comp Focus Group
   * willing providers
   * APT-CAC
   * Re-look at Association Governance

2) SPECIALIZATION
   * ACE (motion passed to create an item writing committee)
   * Task Force information on residencies

3) PTA INVOLVEMENT
   * Education Program Committee to put a PTA on their committee
   * Investigate PTA recruitment dollars to the assembly
   * Have Section booth at Student Conclave in October each year
   * Student member (PT/PTA) on Board of Directors

4) PRACTICE VALIDATION
   * Form a committee to come up with an approach and present the preliminary report at CSM.

1995 FALL BOARD OF DIRECTORS MEETING

The dates of the Fall Board meeting are September 28-October 1.

Adjournment

The Need for Case Studies

(continued from page 13)

careful measurements of outcome is just as irresponsible as blind application of protocols. Clinicians who take pride in the thoughtful evaluation and treatment of their patients have a responsibility to share their expertise with others. Case studies provide an excellent mechanism for doing just that.

1. Rothstein JM. Editor's Note: The case for case reports. *Physical Therapy.* 1993;73:492-493.

Phil McClure is an Assistant Professor at Hahnemann University. He is also a member of the Research Committee for the Orthopaedic Section, APTA.

PRACTICE PROBLEMS??

The Practice Committee of the **Orthopaedic Section** needs to know your problems! Your input will define practice issues of importance to you as physical therapists in the area of orthopaedic physical therapy.

Please write, call or fax the issues you need to have addressed and resolved. Spending a few moments to share your problems may well be one of the better uses of your time today! Your voice will be heard only if you speak up.

Telephone: 800-444-3982
FAX: 608-784-3350

Scott Stephens, MS, PT
Orthopaedic Section, APTA, Inc.
Practice Committee
505 King Street, Suite 103
La Crosse, WI 54601

Name: _____

Address: _____

City: _____

State: _____ Zip: _____

Daytime Telephone #: (_____) _____

In my practice, I'm having trouble with _____

_____

Please get in touch with me to discuss _____

_____

_____

Avoiding Common Investment Mistakes Throughout Your Life Stages

By Larry Boatman

20s and 30s

Getting in too deep with credit card debt seems to be one of the most common mistakes of those in their 20s and 30s. Many recent college graduates see credit cards as a means to instant gratification, to reattaining the lifestyle they left behind when they left their parents, even if it means "maxing out" those cards. During these years, one of the biggest favors you can do yourself is to pay off credit card debts in their entirety every month.

Many also make the mistake of not taking advantage of their employer's tax deferred retirement investment or savings plans such as a 401k. Money contributed to these programs lowers taxable income while beginning retirement savings, a two-step combination.

Unfortunately, an overwhelming number of individuals in this age group feel that they just can't afford to start saving for retirement, or that retirement is so far off they have plenty of time to start saving. What they don't realize is that because of the effects compounding interest can have on an investment plan, they can hardly afford not to get started.

40s and 50s

An established career, home ownership, grown children, saving for retirement. While these seem to be common descriptions of this age group, growing numbers are not fitting into this category. Many among this so called "sandwich" generation feel pressure from both their childrens' college bills as well as their own aging parents' personal and medical expenses.

During your 40s and 50s, it is especially important to have retirement savings and investment plans in place so that childrens' college and parents' medical bills don't infringe on your retirement savings.

Another common mistake made during these years is pulling money out of 401k plans and individual retirement accounts before reaching age 59½. Those who do so will pay as much as 40 percent in federal, state and local taxes, plus a 1 percent penalty for taking the money out early, ultimately losing *half* of their 401k nest egg.

It's important to contribute the maximum to your 401k or 403b program during these years and to leave that money in the account until you can legitimately withdraw it without the burden of extra taxes or penalties.

60s and 70s

Once you've reached your golden years, there are still some important steps to take to make your money last as long as you do and to pass it along to your heirs. One of these steps is to make sure your estate is in order to cut down on the estate taxes that will be paid by your heirs. Too many neglect estate planning, creating an unnecessary burden on those they leave behind.

Another mistake is putting too much money in what appear to be safe investments, such as CDs and municipal bonds. While these conservative investments should make up the majority of your portfolio during these years, you should still keep some of your money invested for total return, to help make it last as long as you do. (Please remember that CDs are federally insured and offer a fixed rate of return whereas both the principal and yield of investment securities will fluctuate with changes in market conditions.)

No matter what state of life you're in, take steps to avoid common investment mistakes, and put yourself on the path toward financial security. Working with a trusted investment professional is the best "first step" you can take.

Larry Boatman is an Investment Executive who provides investment advice to the Orthopaedic Section, APTA.

If you would like additional information, please contact Larry through the Orthopaedic Section office.

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:

John Adam
Patrick Adamek
Paula Adkins
Ronald Agostini
Foley Aileen
Lawrence Ajayi
Jennifer Alexander
Alkis Alexiadis
Brian Almanti
Mario Alvarado
James Androsik
J Anglada
Bessie Antonopoulos
Amy Arends
Karlan Armstrong
Andrea Aronheim
Michael Bagnoli
Candace Bailey
Denise Bailey
Robyn Baker
Christine Banta
John Barnhill
Nancy Barr
Kristi Barrett
Kelli Barry
Jennifer Bartholomew
Danielle Barzoloski
Nancy Basile
Michael Baskin
Charulata Basole
Barbara Bauman
Jeffrey Bayona
Sonya Beattie
Karen Beauieu
Amy Beets
Patriicia Begeman
Ronald Behnke
Tracy Beland
Julie Belcher
Linda Belcher
Chris Benn
Sylvia Bennett
Kimberly Bennett
Cynthia Bentsen
Annette Bergeron
Leah Bergland
Karen Bexfield
Patrick Blair
Raymond Blakely
Maureen Blanchfield
Heidi Bockelkamp
Craig Bolles
Barbara Bolton
Antonino Borremeo
Linda Botos
Robert Bowman
Lynnae Brady
Laura Brady
Teresa Bragg
Amy Bratta
John Braun
Cody Brazos
Kevin Bresnahan

Patrick Brody
Allison Brookes
Donald Brown
Samuel Brown
Ruth Brown
Gerald Browning
Tad Buckmiller
Stacy Buff
Christine Burke
James Burns
Kandice Butcher-Foster
Maria Camacho
Michael Candito
Howard Cantor
Claudia Capelle-Gazsi
Joe Carpenter
Carla Carpenter
Elena Carpenter
Emery Carper
Mary Carruth
Richard Cearley
Robert Cecil
Jodi Cesaratto
Martin Chadwick
Danielle Chams
Amy Chill
Alice Chiu
Laura Christianson
Bernadette Chua
Jennifer Ciesco
Chad Clark
James Clinkeingbeard
Heidi Clonts
Shanna Colligan
Nicole Collins
Elaine Conner
Lucretia Cook
Kevin Cook
Charmaine Cooper
Lisa Coraci
Mia Corley
Cristen Cote
Brian Couch
Jennifer Crocker
Mary Crosswell
Kristina Crowell-Massey
Stephanie Cue
David Cunningham
Alisa Curry
Agatha Czarska
Robert Damm
Michelle Dancheck
Dana Daniels
Kerensa Davey
Judith David
Laura Davis
Nicceta Davis
Lashwn Davis
Ge''Onna Deck
Lynn Decker
Tara Defibaugh
Susan Dembowski
Michael Deprimo

Gina Diaz
Geoffrey Dick
Carla Difelice
Nancy Dilello
Candace Doerfler
Deborah Doerfler
Alice Donlan
Louis Dorrett
Dennis Doty
Douphrate David
Linda Downs
Steven Downs
Michele Drury
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Kenneth Edelson
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Mary Enerson
Amanda Enlow
Lori Eppich
Kendra Ervin
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Nicholas Espanet
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Leanne Farley
Rick Farley
Kathlene Farnsworth
Allen Farrar
Thomas Farrell
Katherine Fazio
Yvonne Feraru
John Fernandez
Shaon Fey
Jacqueline Fidge
Michael Fiedler
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Frank Fogal
Joel Follmer
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Lori Halper
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Veronica Kramer
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Irene Uy-Hujsa
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Marie Vennett-White
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Raymond Visconti
Maria Vital
Joelle Vrancken
Linda Waak
Ann Wade
Carla Wade
Alison Wahl
Eric Wahlen
Doria Waldbillig
Nancy Walker
John Ward
Patricia Wat
Therese Watson
Melanie Watson
Morgan Watts
Kimberly Weinerth
Andrew Weismer
Colleen Welling
Robert Wessell

Michael Wetula
Corey Weydert
Nicole Wilkes
Kristine Willenecker
Teresa Williams
James Williams
Kerri Williams
Damita Williams-Swanson
Laura Williams-Thomas
Dana Wills
Theresa Wilson
Cindy Wilson
David Wilson
Bradley Webb
Scott Wise
Winston Witherell
Annette Withington
James Wold
Diana Wolff
Michele Wong
Jeff Wood
Jane Wright
Sandra Wright
Barbara Wrobel
Deborah Yates
Laura Zavagnin
Michelle Ziegler
Ritchie Zipse

Orthopaedic Study Groups

In an attempt to identify for section members study groups which are functioning in their area, the following list of persons concerned with study groups is published. It is our hope to develop a network of study groups to facilitate acquisition of the vast amount of knowledge encompassed in the area of orthopaedics.

ALABAMA

Tuscaloosa Area Orthopaedic Study Group
James A. Korte, Coordinator
c/o Department of Rehabilitation
DCH Regional Medical Center
809 University Boulevard E
Tuscaloosa, AL 35403
(205) 759-7157

ARIZONA

The Phoenix Manual Therapy Study Group
c/o Arizona Physical Therapy Professionals
Timothy O. Fearon
6135 North Seventh Street
Phoenix, AZ 85014
(602) 230-9871

Southern District Orthopaedic Physical Therapy Study Group
Christina Kiefer
1701 W. St. Mary's Rd, Ste. C101
Tucson, AZ 85745
(602) 791-2748

CALIFORNIA

Los Angeles Orthopaedic Study Group
Lyman Kennedy, Chairman
4144 North Gayle Street
Orange, CA 92665
(714) 638-9309 (Home)
(714) 847-1367 (Work)

Manual Therapy Study Group
Alice L. McCleary
1321 Cary Way
San Diego, CA 92109
(619) 488-6130

Northern California Orthopaedic Study Group
Richard Fike, MS, PT
4737 El Camino Avenue
Carmichael, CA 95608
(916) 487-3473

San Luis Obispo Orthopaedic Study Group
Ross Dover
6854 Morro Avenue
Morro Bay, CA 93442

Southern California TMJ Study Group
Joan Schmidt, P.T.
10921 Wilshire, Suite 704
Los Angeles, CA 90024
(213) 208-3316

Bay Area Orthopaedic Study Group
Daniel L. James, PT
1716 Ocean Avenue, #196
San Francisco, CA 94112-1792

CONNECTICUT

Regional Physical Therapy
Sharon Weiselfish, MA, PT
Crossroads Plaza
740 North Main Street, Suite 2-G
West Hartford, CT 06117
(203) 523- 5487

FLORIDA

East Central Florida Orthopaedic Study Group
John C. Trittschuh
119 West Plymouth Avenue
Deland, FL 32720
(904) 738-3456

Manual Therapy Interest Group
Adam Geril, MS, PT, Chairman
Shands Hospital at the University of Florida
P. O. Box J-341
Gainesville, FL 32611
(904) 395-0295

Jacksonville Area Orthopaedic Physical Therapy Study Group
Don J. Hunter, MS, PT
4171 Roosevelt Blvd.
Jacksonville, FL 32210
(904) 384-8798

Southeastern District Orthopaedic Study Group
Bruce R. Wilk, PT, OCS
8780 SW 92 St. #206
Miami, FL 33176
(305) 595-9425

ILLINOIS

Chicagoland Orthopaedic Physical Therapy
Elena Kurth, Vice-President
P.O. Box 4861
Oak Brook, IL 60522
(312) 525-7868

IOWA

Southeast Iowa Orthopaedic Study Group
Karl Uhlenhopp
Mercy Medical Center
701 10th St SE
Cedar Rapids, IA 52403

Mid Iowa Orthopaedic Study Group
Jim Nespor, PT, ATC
Sports Medicine & Physical Therapy Center
132 Recreation/Athletic Facility
Ames, IA 50011
(515) 294-2626

KENTUCKY

Louisville Sports-Orthopaedic Study Group
Larry Benz, PT, Chairman
134 Heartland Drive
Elizabethtown, KY 42701
1-800-248-8262

LOUISIANA

New Orleans Orthopaedic Study Group
Rebecca Devoe
136 Rosewood
Metairie, LA 70005
(504) 831-4285

Bayou Orthopaedic Study Group
John Schmidt
1329 Englewood Drive
Slidell, LA 70458
(504) 649-5311

MARYLAND

Orthopaedic Study Group of Southern Maryland
Bob Grossman, Chairman
2415 Musgrove Rd.
Silver Spring, MD 20904
(301) 989-9040

MASSACHUSETTS

Southeastern Massachusetts Orthopaedic Study Group
Nanci Machnik, P.T.,Chairman
Box 12-A, 3 Village Way
Brockton, MA 02401
(617) 587-5367

MICHIGAN

Grand Rapids Area Orthopaedic Study Group
Joe Witte
355 Carlton, S.E.
Grand Rapids, MI 49506
(616) 458-6198

Southeastern Michigan Orthopedic Study Group
Frank Kava, P.T
Oakland Physical Therapy, P.C.
39555 West Ten Mile Road, Suite 301
Novi, MI 48375
(313) 478-6140 FAX (313) 478-6167

MINNESOTA

Minnesota Orthopaedic Study Group
Dennis Cramblit
The Orthopaedic and Fracture Clinic Physical Therapy-Sports Medicine Center
309 Holly Lane
Mankato, MN 56001
(507) 387-3444

Minnesota Orthopaedic Study Group
Jane Tadsen
501 South Maple Street
Waconia, MN 55387
(612) 442-2191 ext. 632

Central Minnesota Orthopaedic Study Group
K.C. Bennink
Abbott Northwestern Hospital
Physical Therapy Department
800 E. 28th Street
Minneapolis, MN 55407
(612) 863-4446

MISSOURI

St. Louis Orthopaedic Study Group
William L. Franzen, PT
803 Clark Avenue
Webster Groves, MO 63119

NEW JERSEY

NENJOSG
Daniel J. Dussman, PT
584 32nd Street
Union City, NJ 07087
(201) 601-0303

NEW HAMPSHIRE
Southern New Hampshire Study Group
Michele McKlean
OPT: Orthopaedic Physical Therapy Assoc.
155 Main Dunstable Rd., Suite 155
Nashua, NH 03060
603/881-5554

NORTH CAROLINA

Triangle Orthopaedic Study Group
Stephanie Maw, PT
2609 N. Duke St., Bldg 900
Durham, NC 27706
(919) 220-5077

OHIO

Northeast Ohio Orthopaedic Study Group
Edie Knowlton Benner
Ron Kleinman
P.O. Box 17
Mantua, OH 44255
(216) 274-3148

Youngstown Orthopedic Study Group
Michael R. Napierala, PT, Coordinator
Advanced Physical Therapy
914 Trailwood Drive
Boardman, OH 44512
216/758-2600

OKLAHOMA

Northeast Oklahoma Orthopaedic & Sports Physical Therapy Study Group
martha Lindley-Woodward, Chairman
Physical Therapy Consultants
4157 S. Harvard, Suite 111
Tulsa, OK 74135
(918) 743-2988

OREGON

Oregon Orthopedic Physical Therapy Study Group
Tami Nicholson, Secretary
9240 SW 18th Place
Portland, OR 97219
(503) 768-4110

PENNSYLVANIA

South Central Pennsylvania Orthopaedic Study Group
Ted C. Pedergnana
P.O. Box 190
Shermans Dale, PA 17090
(717) 582-7172

RHODE ISLAND

Orthopaedic Study Group of Rhode Island
Alan N. Silk, P.T.
Occupational Orthopaedic Center, Inc.
590 Pawtucket Avenue
Pawtucket, RI 02860
(401) 722-8880

TENNESSEE

Tennessee Orthopaedic Study Group
Greg Cross, PT
The Sullivan Center
433 West Sullivan Street
Kingsport, TN 37660
(615) 229-7958

WASHINGTON

Washington Orthopaedic Special Interest Group
Gerry Chanbers
9251 39th Avenue, South
Seattle, WA 98118
and
Brenda Matter
3953 South Ferdinand
Seattle, WA 98118

THE ORTHOPAEDIC SECTION, APTA, INC.

presents

"1995 REVIEW FOR ADVANCED ORTHOPAEDIC COMPETENCIES" COURSE

Albuquerque Hilton Hotel
Albuquerque, New Mexico
July 16 - 22, 1995

MEETING A: July 16 - 18, 1995
The Cervical Spine
The Shoulder & Elbow
The Wrist & Hand

MEETING B: July 19 - 22, 1995
The Knee
The Foot
Low Back/SI Joint/Hip

TUITION: Before June 10, 1995		After June 10, 1995
Meeting A:	$300 Orthopaedic Section Members	$350
	$350 APTA Members	$400
	$450 Non-APTA Members	$500
Meeting B:	$350 Orthopaedic Section Members	$400
	$400 APTA Members	$450
	$500 Non-APTA Members	$550
Meetings A & B:	$550 Orthopaedic Section Members	$600
	$650 APTA Members	$700
	$800 Non-APTA Members	$850

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 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.

Join the Section and take advantage of the discounted registration rate immediately!

For More Information, complete the form below, detach and mail to:
Orthopaedic Section, APTA, 505 King Street, Suite 103, La Crosse, WI 54601 *(800)444-3982

REVIEW FOR ADVANCED ORTHOPAEDIC COMPETENCIES * JULY 16-22, 1995

Name: _____ Day-Time Phone No. ( ) _____
Address: _____ City: _____
State: _____ Zip: _____ APTA ID #: _____

Check: **Please register me for the following course(s): July 16-22, 1995: Mtg A: ____ Mtg B: ____ Mtgs A & B: ____**
Enclosed is my registration fee in the amount of $ _____. Ortho Sec. Mbr. ____ APTA Mbr. ____ Non-Member ____
Yes. I want to take advantage of the member rate immediately. *(Please add $50 to your member rate fee). ____

Make checks payable to the Orthopaedic Section

____ Check here if you have special needs that are regulated by the Americans With Disabilities Act

Occupational Health Physical Therapists
Special Interest Group
Orthopaedic Section, APTA, Inc.

Newsletter

FALL 1994 VOLUME 2, NUMBER 2

OHPTSIG PRESIDENT'S MESSAGE

During the past several years, legislators, third party payors and employers have identified one of the primary problems for their ever increasing workers' compensation cost is an excessive amount of rehabilitation services (physical therapy). Many therapists have been offended by this view of our profession. The traditional ways that we have provided our services have served us and our patients well in the past. Why should we need to change?

The choice to change or not to change is no longer an option. We must change in order to survive. Change should not always be looked at in a negative way. It can actually be healthy for our practices and for our profession to go through a change. Usually with change comes new opportunities. It requires us to become creative and challenges us to look at ourselves, the services that we are delivering and how they are being delivered.

Today's workers' compensation payors are attempting to control costs by cutting fees for services rendered and by limiting the length of time that services can be provided. Therapists need to learn as much as they can about payors and managed care, how they work, who are the players, and what are their expectations from physical therapy. We need to look at the world through the payor's eyes and not soley through ours. The knee jerk reaction that we normally have is, how can they cut our fees or limit the visits that we have traditionally needed to achieve a good outcome with my patients. It becomes a "we against they" scenario.

The challenge is how can we deliver a high quality physical therapy service in today's and tomorrow's market place without compromising our high values and standards? How can we streamline the way we deliver our services so that we can deliver them in a more fiscally efficient manner?

I am confident that the physical therapy community can rise to these challenges and become better and stronger because of it. It will however, require some of us to take off our blinders, pull our heads out of the sand, become creative and not only follow traditional ways. The opportunities are there. We just need to be able to recognize them and then do something about it. Being a passive participant in our business will no longer cut it.

Dennis D. Isernhagen, PT

INTERVIEW: MANAGED CARE IN WORKERS' COMPENSATION

Editor's Note: Each passing day sees managed care making greater inroads into workers compensation systems throughout the country. States such as Montana, Florida, Nevada, California and Oregon (among others) have begun to legislate the use of managed care organizations for some, if not all, of the care of the employees who suffer from work injuries. Because many physical therapists see workers' compensation as the last bastion of fee for service medicine, they find the infiltration of managed care into this portion of their practice particularly unsettling. Recently I interviewed Vicki Merrill, the President of COMPREMIER, a workers' compensation managed care organization, to discover what she believes managed care in the workers' compensation arena really means to physical therapists and to their future pattern of practice. Following is a summation of my interview with her: S.A.

How do you see managed care in workers' compensation affecting physical therapists?

I believe that managed care is going to help them tremendously. In general, managed care is looking for aggressive medical management of each case, and most physical therapists have always done that. However, it will require them to make some changes.

As you know, at risk plans (such as HMOs) usually contract with large

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multi-specialty medical groups to provide all types of care, including physical therapy. These multi-specialty groups are, therefore, usually at risk for PT. Who better to assist them in managing this risk than physical therapists. Because of this, it is my opinion that in the future independent physical therapy practitioners will need to more closely align with these multi-specialty groups and with primary care providers (PCPs). They may also need to offer expertise at multiple locations close the multi-specialty providers' sites to help them in managing this care. Such alignments may also be appropriate with skilled nursing facilities, home health agencies, durable medical equipment providers, and even directly with HMOs and other health plans. Along with this comes the need for accepting alternative reimbursement models, such as capitation, case rate programs, etc., each of which require different quantifications of treatment patterns.

However, managed care will also promote something physical therapists have supported for years—active rather than passive modalities that demonstrate positive outcomes. In general, managed care is looking for aggressive medical management of each case. When a provider takes a sports medicine like approach to a patient, that's exactly the approach that most managed care organizations want to see and are actively promoting. Because of this, I would say that managed care—especially in workers' compensation—is a definite plus to the physical therapist. Physical therapy will be challenged, however, to demonstrate the cost benefit of any treatment as it relates to early return to work and longevity of service. Such outcome studies are difficult to quantify but are essential in a managed care environment.

Physical therapists are also in an excellent position to work directly with the payor (carrier and/or employer) to provide injury prevention programs (ie., muscle strengthening for potential back injuries, ergonomic analysis/redesign of proven high risk tasks, etc.) Prevention is the ultimate solution to the workers' comp problem, and who is better prepared to offer that solution aggressively?

A number of products are coming on line that purport to provide 24 hour coverage. (see sidebar) Do you see a similar effect on physical therapists when an organization offers or is covered by this type of coverage?

To me twenty four hour coverage means providing a single policy for both group health and workers' compensation. Frankly, I don't see that coming anytime soon due to a lack of indemnity (lost time) exposure on the group health side and a lack of employee cost sharing on the workers' compensation side. What I do see is organizations like mine pursuing more coordination of services—a more synergistic approach to cases. Our industry has applied our disciplined medical management very well on the group health side. But, as an industry, we are not currently managing the return to work process after a major medical procedure on the group side as well as it is has been routinely been done on the workers' compensation side. We need to apply return to work approaches, and in so doing need to apply a more coordinated approach to the management of disability on both sides. Physical therapists have a tremendous expertise in return to work techniques which should be of great value as managed care organizations move forward—not only in managing the workers' comp medical care but also in managing group health disabilities.

That is good news! In the profession of physical therapy, we have had a number of naysayers. These individuals predict that managed care is moving the profession to the ICU and is the beginning of the end for private practitioners. Do you have any comments?

As I mentioned before, I believe that managed care can have a very positive impact on the profession of physical therapy. However, I must agree with your supposed naysayers that private practice as we now know it is a thing of the past and say again that I truly believe that private practitioners will need to affiliate with health plans or with larger group practices. A Managed Care Organization (MCO) does not have time to affiliate with a myriad of individual practices. So, it would be my recommendation for those currently in practice to begin taking steps to become part of something larger which will be actively affiliating with MCOs.

How does a physical therapist know which health plans or medical group to affiliate with?

I don't envy them. Each health plan and medical group is different. Each is financed differently. If you are going to affiliate, you must do your homework. You should only affiliate or partner with a health plan or medical group that matches your values and vision for the future. You can only find out about that through networking, affiliating with people in trade organizations, and talking directly with a targeted partners.

You mentioned networking. Which groups would you recommend networking with?

Across the country, there are a number of regional yet broad based coalitions. These coalitions frequently

Membership in the Occupational Health SIG is open to any member of the Orthopaedic Section. To join, simply contact Tara Fredrickson at the Section office, 1-800-444-3982.

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involve employers, payors, providers, brokers and consultants. Most, but not all, focus the attention of these divergent groups on a common interest, such as managed disability or managing medical costs in a community. Such coalitions become part of the payor's solution to a shared problem. Most major metropolitan areas have such coalitions. Cleveland has one. Puget Sound has one. Houston and New Orleans each have one. To determine if your area has such a coalition, talk with employers and payors in your area, read the business or insurance section of your local paper or call the department of insurance in your state.

Secondarily, I would recommend attending some of the many conferences sponsored by the payor and employer community with focus on such issues as medical management, disability management, case management and integrated delivery system which are well attended by both payors and large providers. Physical therapists could gain great insight and exposure by attending such conferences.

The third thing I would recommend is to sponsor focus groups of rehab customers. Ask questions about what each wants, what are they interested in, what business they are in and how physical therapy saves them money and increases productivity. Follow the money and then plan how you can best meet their needs.

Many experts in the insurance and payer community are talking about 24 hour coverage as a possible solution to the problems associated with workers' compensation coverage and costs. Unfortunately, however, one of the difficulties in proceeding with the discussion of this solution is the lack of a common definition.

Is it:

- an emerging idea for providing broad based medical and disability based benefits to workers' regardless of how a disability arises or,
- a way to significantly reduce litigation and administrative costs in workers' compensation or,
- the demise of workers' compensation in favor of a tort remedy or,
- an extraordinarily costly program for mandating universal medical and disability benefits or,
- the solution to medical cost containment in workers' compensation

No matter which bullet you selected as the true essence of 24 hour coverage, you could find an expert in the workers' compensation arena who agrees with you. So what is it really?

The Workers' Compensation Research Institute (WCRI) in their publication *Twenty Four Hour Coverage* (1), state that in general all 24 hour coverage proposals or plans attempt to dissolve the boundary between occupational and nonoccupational accidents and diseases. In order to do this effectively, they contend that a proposal or plan would have to harmonize the disparate features of workers' compensation and employees benefits' programs. This is not easily done. Another definition is offered by Roger Thompson, the Assistant Director of Workers' Compensation at the Travelers Insurance Co. (2) He contends that:

"in the broadest terms, 24 hour coverage is a program of economic security, furnishing a uniform level of medical care and income protection, including death benefits, to covered workers for economic consequences of injury or illness from occupational or nonoccupational causes."

Under this definition, he believes that 24 hour coverage is an integration of workers' compensation and employer sponsored health and disability coverage.

1. Richard A. Victor, Editor. *Twenty Four Hour Coverage*. Workers' Compensation Research Institute. Cambridge, MA. June 1991.
2. Roger Thompson. "Time to put up or shut up—States must issue detailed guidelines before 24 hour coverage is a reality." *Business Insurance*. Crains Communication. Chicago, IL 6/29/92.

CANDIDATES FOR OFFICE

Dennis Driscoll, Chair of the Nominating Committee, and other Nominating Committee members are proud to put forth the following candidates for 1995 SIG office. The candidates listed are those that have agreed to run as of the deadline for publication of this newsletter. All were asked to submit a candidate profile communicating their professional status and achievements as well as a candidate statement reflecting their views on the SIGs functions and future directions. To assist the membership in the selection process this newsletter has included each of the candidates statements received by the due date.

The following individual agreed to run for SIG President:
Dennis Isernhagen, Minnesota

CANDIDATE PROFILE:

Dennis Isernhagen is vice president of Isernhagen Work Systems of Duluth, Minnesota, an internationally recognized training and consulting firm in work injury prevention, rehabilitation and return to work programs. He has served for the past three years as President of the Occupational Health Physical Therapist Special Interest Group. He has worked with members of the Orthopaedic Section, Private Practice Section and the APTA Board of Directors in developing the Workers' Compensation Focus Group. This group is attempting to identify the critical issues facing the physical therapy profession in workers' compensation and developing strategies to address these issues.

Dennis has served in numerous capacities within the APTA that have included elected and appointed positions. Some of these have included serving as Minnesota Chapter President (2 terms), Delegate and Chief Delegate of the APTA House of Delegates, APTA Nominating Committee and various committees and taskforces. He received the Minnesota Chapter's Outstanding Service Award on two different occasions (1980 & 1993).

He has written articles/chapters, lectured and consulted with health care providers, payor groups and business/industry throughout the United States, Canada, Australia and Europe on topics relating to work injury prevention, rehabilitation and management.

CANDIDATE STATEMENT:

I have been very fortunate to have

served as the President of the Occupational Health Physical Therapist-SIG for the past three years. During this period of time I have had the good fortune to work with some excellent elected officers, appointed chairpersons and most of all a very dynamic, enthusiastic and dedicated membership. We, as a united group, have made major headway in confronting the issues facing our specialty area. The issues that we face are reflective of the changes that are going on in health care today. These changes are setting a precedence for all of physical therapy in the future.

Some of the more pressing issues that the SIG needs to continue to address include:

- Development and implementation of a mechanism to gather and disseminate information to members relating to workers' compensation and other issues impacting the practice of occupational health physical therapy.
- Development and implementation of methods to assist State Physical Therapy Associations in developing strategies to deal with legislative issues facing the practice of occupational health physical therapy.
- Develop relationships with third party payors that will result in a better understanding by the payors of the benefits of physical therapy, and a better understanding by physical therapists of the needs of the third party payor.
- Work cooperatively with other APTA groups to coordinate resources and efforts on issues relating to occupational health physical therapy (APTA Board of Directors, Private Practice Section, APTA staff, etc.)

There are many more issues that need to be addressed. It is important that the elected and appointed members of the SIG be responsive to the membership and keep the membership up to date on the ever changing issues. I look forward to the potential opportunity of representing the SIG as its President.

The following individuals agreed to run for SIG Treasurer: Michael Burke and Mary Mohr

Michael Burke, California

CANDIDATE PROFILE

Mike Burke came to the field of physical therapy following a vast array of jobs. These include railroad brakeman, New York City taxi driver, industrial filmmaker, short order cook, bicycle messenger, fast food restaurant manager, veterinary assistant, park attendant, day laborer, body guard, and several more. This diverse background provides him with a unique perspective to identify opportunities for growth and the confidence to act in a way that compels change and improvement.

Before becoming a full time ergonomic consultant in 1988, he ran an outpatient orthopaedic physical therapy clinic expanding to work hardening and industrial injury prevention services. Two years ago, Mike started his own ergonomic consulting and training business in Lake Zurich, Illinois. He has close ties with several industrial affiliations such as American Industrial Hygiene Association, National Safety Council, American Society of Safety Engineers, American Occupational Health Nurses Association and the Ergonomics and Human Factors Society. He holds degrees in physical therapy from Northwestern University Medical School and Cinema from the University of Southern California.

He is the author of *Applied Ergonomics Handbook* and creator and designer of Ergonomic Analysis and Problem Solving Software. He has developed several unique ergonomics educational programs and tools such as the ERGONOMIX TOOL KIT™ to help instruct persons at various levels in the basic and simple application of ergonomic principles. He has performed presentations and workshops at many national professional meetings such as the APTA Annual Conference, Combined Sections Meeting, American Occupational Health Conference and the Human Factors Society Annual Conference.

CANDIDATE STATEMENT:

I believe that the role of the physical therapist in an industrial setting is at a critical point. Huge opportunities to expand the services of PTs in occupational health evolve daily. This requires increased exposure to demonstrate the validity of therapists working in industrial rehabilitation, injury prevention, workers compensation cost control and regulatory compliance.

Physical therapists in the area of industrial rehabilitation and occupational health should interact more with occupational health disciplines such as safety, industrial hygiene, facilities engineering, quality assurance and risk management. Professionals in these areas of unaware of the unique talents and capabilities of physical therapists to help them achieve their goals.

As PT's rush forward to embrace the emerging opportunities in occupational health, the need for self assessment of personal capabilities and motives becomes apparent. Substandard provision of services by a PT damages the overall professional image and creates unfair barriers to other therapists. Ethical guidelines and self assessment tools can help individuals to more accurately determine their capabilities.

I believe that physical therapists have demonstrated the observational and analytical skills to enhance the effectiveness of industrial and office work environments. The SIG can help increase the visibility of qualified PTs to insure that the profession is included in the ongoing evolution of occupational health opportunities. While functioning as treasurer, Burke will do everything possible to substantiate the role of PTs in industrial rehabilitation and promote acceptance of physical therapists as ergonomic, injury prevention and workers compensation cost management consultants.

The following individuals agreed to run for Nominating Committee: Roberta Kayser and Rick Shutes

Roberta Kayser, Kentucky

CANDIDATE PROFILE:

Roberta L. Kayser, PT received a BS in physical therapy from the University of Wisconsin-La Crosse in 1979. She is currently the Director of ERGOPLEX by Physiotherapy Associates, a free standing CARF accredited industrial rehabilitation facility. Ms. Kayser has attended numerous post graduate courses in therapeutic techniques, clinical administrations, and occupational health and safety. Active memberships include APTA since 1977, KPTA 1985, Orthopaedic Section 1979 and its Occupational Health Physical Therapists Special Interest Groups since its inception, ASSE, NARPPS and Safety Network. In addition, Ms. Kayser is a CARF Surveyor, clinical faculty member of the University of Louisville P.T. program, a member of the KPTA Socioeconomic committee and participant of the APTA National Worker's Compensation Focus Group. A co-author of Compensation in Kentucky, Ms. Kayser speaks frequently to professional groups and in industry on work rehabilitation, injury prevention and on-site

provision of industrial rehabilitation service. Seven years of experience in industrial rehabilitation is combined with 15 years as a licensed physical therapist and 12 years as an administrator.

CANDIDATE STATEMENT:

I feel that serving on the OHPTSIG Nominating Committee would be a great privilege and opportunity to become more involved in the section and association levels. My initial involvement with the SIG was to assist with the initial draft of the bylaws. Issues of concern include changing health care delivery and reimbursement, the impact of on-site industrial rehabilitation services on health care costs, and outcomes based research to document the importance of physical therapists in the industrial setting. All professionals should, in some way, take an active part in their national and state associations to further these organizations goals and positively affect our future healthcare environment. As an elected officer on the nominating committee, I feel strongly that I can impact the profession through guiding others toward involvement and making a difference. Increased membership involvement will undoubtedly facilitate the growth of the physical therapy profession in the occupational health arena.

LEGAL BEAGLE

By Kathy Lewis, JD, MAPT

ILLEGAL CONTRACTS NOT ENFORCEABLE, IN WHOLE OR IN PART:

CASE LAW: A public relations and consulting firm (PR) entered a contractual relationship with a durable medical equipment company (DME). DME agreed to pay PR 30% of gross earnings for PR's efforts in obtaining new accounts for DME. After entering into the agreement, DME was advised by two separate law firms that the contract violated the Federal Anti-Kickback Statute.

Subsequently, DME terminated the agreement. PR (plaintiff) filed suit against DME (defendant) for breach of contract. DME contended that the contract was a violation of federal criminal law; therefore void and unenforceable. PR argued that it was not a health care provider; therefore had no direct contact for referral of patients and could not violate Anti-Kickback law. Also, PR contended that compensation was due for those services rendered which were not related to Medicare. DME countered that the agreement did not have a severable compensation scheme; therefore was not liable for any compensation.

The court ruled in favor of DME (defendant), stating that the contract was illegal a matter of law.

Application to physical therapy: Although the subject matter of the agreement in this case was violation of Anti-Kickback law, there are numerous other state and federal laws that could be violated. Signing a contract that is in violation of the law is done at your own peril. Courts will not enforce such agreements. Contractual terms that violate a law are not always easily recognized.

Therapists can protect their rights to receive compensation for services rendered.

- Seek legal counsel before signing contracts.
- Many laws are changing. Obtain counsel's review of previously signed contracts.
- Request that your attorney draft a "severability clause" in your contracts. Such a clause identifies that the parties intended to have a valid contract even though some provisions may be invalid or unenforceable. With a "severability clause," the court will most likely enforce any parts of the contract that are not illegal and void only those terms that are illegal. A basic example of a severability clause is: *"The invalidity or unenforceability of any provision hereof shall in no way affect the validity or enforceability of any other provision of this Agreement."*

COMPUTER TECHNOLOGY FOR PATIENT RECORDS. *WILL THESE RECORDS STAND UP IN COURT?* Whether record keeping methods are traditional, manual systems or computer technology systems, the issues (eg. authenticity, confidentiality, and accuracy) are similar. Procedures to manage these issues are significantly different between these two record keeping methods. In recognition of these differences, statutes and regulations are being passed.

Even though certain physical therapy centers may not be included in these new laws, therapists would be wise to institute some of the required procedures. One such statute (Illinois amendment to its Hospital License Requirements—Title 77 of the Illinois Administrative Code, Part 250) represents requirements that are worth considering. Some suggestions are:

- If electronic signatures are legally acceptable in your jurisdiction, adopt a departmental policy recognizing such use.
- Establish requirements for those who will be given authorization to access departmental records.
- Establish procedures to assure confidentiality, eg. unique identifiers for authorized users and use programs that include security mechanisms.
- Institute a verification process to ensure that records are accurate.
- Periodically review random samples of records to verify integrity of the computer system.
- Incorporate staff training on the use of your particular computer program. It is risky to assume that computer literacy equates to effective use of all computer programs.

In the event that a malpractice claim or some other legal cause of action is filed, such procedures will provide greater assurance that therapy records will be legally recognized as authentic, accurate and confidential.

REFERENCES

1. Imperator GL. Florida Court Invalidates Contract Between DME Supplier and PR Firm for Violating the Federal Anti-Kickback Law. Health Law Digest. 1994;22:31-32.
2. Meier HN. Illinois Health Agency Amends Hospital Licensing Requirements on Medical Records. Health Law Digest. 1994;22:41-42.

The OHPTSIG welcomes any comments and ideas for submission in the newsletter. Inquiries can be directed to: Susan H. Abeln, PT, ARM, OHPTSIG Newsletter Editor, 870 Calle Vallarta, San Clemente, CA 92673-3524, 714-361-1306.

ORTHOPAEDIC PHYSICAL THERAPY HOME STUDY COURSE 95-1

TOPIC: THE FOOT AND ANKLE

COURSE LENGTH: 6 SESSIONS JANUARY-JUNE 1995

Proposed Authors and Topics:

- *Damien Howell, MS, PT*
  Treatment Approaches to Foot & Ankle Disorders using Exercise & Orthotic Devices
- *Jeff Kloer, PT*
  Traumatic Disorders of the Foot & Ankle
- *Tom Mayhew, PhD, PT*
  Anatomy of the Foot & Ankle
- *Mike Mueller, PhD, PT*
  Systemic Diseases which Affect the Foot
- *David Tiberio, MS, PT*
  Biomechanics of the Foot & Ankle
- *Michael Wooden, MS, PT*
  Overuse Syndrome of the Foot & Ankle

Contained within this course is information relating to:
• BASIC SCIENCE • PATHOLOGY •
• ISSUES OF CLINICAL DECISION MAKING •
• CASE STUDIES •

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1995 CSM PROGRAM

WEDNESDAY, FEBRUARY 8
8:00 AM—4:30 PM
Pre-Instructional Course
"Performance Based Documentation"
Speakers: Gary Smith, EdD, PT, OCS
Donna El Din, PhD, PT

THURSDAY, FEBRUARY 9
7:30 AM—4:30 PM
Council of Executive Personnel Meeting

8:00 AM—Noon
=JOINT PROGRAM=
"Emerging Trends in the Delivery of Care"
Speakers: Connie Burgess, MS, RN
Michael Burcham, MBA, PT
Patricia Montgomery, PhD, PT
Stuart Norris, PT
Kathy Sullivan, PT

1:00—3:00 PM
=CHRONIC PAIN ROUNDTABLE=
"Reflex Sympathetic Dystrophy"
Speaker: Kenneth Oswalt, MD

2:30—4:30 PM
=MANUAL THERAPY ROUNDTABLE

2:30—3:30 PM
"Specific Tissue Regeneration by Virtue of Biomechanical and Nutritional Energy"
Speaker: Ola Grimsby, PT, MNFF, MNSMT

3:30—4:30 PM
"Manual Therapy Research in the Clinical Setting"
Speaker: Richard Erhard, PT, DC

FRIDAY, FEBRUARY 10
8:00 AM—Noon
"Pharmacology for Physical Therapists"
Speaker: Richard Brown, PhD

8:00 AM—Noon
Research Platform Presentations A

8:00 AM—Noon
Research Platform Presentations B

8:00—10:00 AM
=JOINT PROGRAM=
Catherine Worthingham Fellows Forum
"Education for Physical Therapy: What Represents Responsible Development of New Educational Programs?

8:00 AM—5:00 PM
Orthopaedic Section Board of Directors Meeting

12:30—2:00 PM
JOSPT Advisory Council Meeting

12:30—2:30 PM
=JOINT PROGRAM=
Research Issues Forum: Occupational Health
"Physical Measures in Occupational Health Physical Therapy"
Speaker: Michelle Crites Battie, PhD, PT

"Psychosocial Measures in Occupational Health Physical Therapy"
Speaker: Micheal Fruerstein, PhD

1:00—2:30 PM
3:30—5:00 PM
"Exercise and Taping for Muscle Imbalances and Pain Syndromes of the Hip: An Integrated Approach"
Speaker: Carrie Hall, MHS, PT

1:30—2:30 PM
Head and Neck Business Meeting

1:30—2:30 PM
Performing Arts Physical Therapy Business Meeting

3:30—5:30 PM
Performing Arts Physical Therapy

3:30—4:00 PM
"Common Injuries in Sitting Musician"
Speaker: Sean Gallagher, PT

4:00—4:30 PM
"Lifting Injuries in the Dancer"
Speaker: Lori Coleman, PT

4:30—5:00 PM
"Treatment and Care of the Broadway Show Performer"
Speaker: Mindy Boehnert, PT

5:00—5:30 PM
Panel

3:30—5:30 PM
"Case Studies in Craniofacial Treatment"
Speaker: Lauri Lazarus, PT

SATURDAY, FEBRUARY 11
8:00—10:00 AM
Orthopaedic Section Business Meeting/Forum

11:00 AM—Noon
"The Mentorship Program in the Orthopaedic Section"
Speakers: Leza Hatch, MA, PT
William H. O'Grady, MA, PT, OCS, MTC
Rick Ritter, MA, PT

11:00 AM—Noon
Chronic Pain Business Meeting

11:00 AM—12:30 PM
Occupational Health SIG Business Meeting

12:30—1:30 PM
Foot and Ankle Business Meeting

1:00—2:00 PM
Manual Therapy Business Meeting

1:00—2:30 PM
Occupational Health SIG Hot Topics Forum
"Are You Caught in the Workers Comp/ADA Trap?"
Speakers: Susan Isernhagen, PT
Glenda Key, PT
John DeGraff, Attorney-at-Law
DeGraff, Salerno, McCarty & Ryan
Carson City and Las Vegas, NV

1:30—2:30 PM
Foot and Ankle SIG
"Orthopaedic Trauma to the Foot and Ankle: Selected Case Studies
Speaker: Joe Tomaro, MS, PT, ATC

1:30—5:30 PM
Research Platform Presentations A

1:30—5:30 PM
Research Platform Presentations B

3:30-5:30 PM
=JOINT PROGRAM WITH ONCOLOGY=
"Oncology and the Orthopaedic Patient"
Speakers: Lola Rosenbaum, PT, OCS
Charles McGarvey, MS, PT
Donald Rosenbaum, DO

3:30—5:30 PM
=JOINT PROGRAM=
"Health Benefits of Exercise for Women'
Moderator:
Ellen Hillegass MMSc, PT, CCS
Speakers: Judy Mahle Lutter, MA
Fredric Pashkow, MD
Barbara Drinkwater, PhD
Kathy Berra, RN, BSN

3:30—5:30 PM
Foot and Ankle SIG

3:30—4:10 PM "Review of Foot and Ankle Clinical Research Conducted at the University of Indianapolis"
Speaker: Ted Warrell, EdD, PT, ATC

4:10—4:50 PM
"Stories Bones Tell—Subtalar Joint Variations"
Speaker: Jan Bruckner, PhD, PT

4:50—5:30 PM
"Issues Related to the Management of the Insensitive Foot"
Speaker: David Sims, MS, PT

6:00—7:00 PM
Paris Distinguished Service Award Lecture
Speaker: Joe Farrell, MS, PT

7:00—10:00 PM
Black Tie and Roses Reception

SUNDAY, FEBRUARY 12
8:00 AM—Noon
=JOINT PROGRAM=
"Special Topics in Pediatric Orthopaedics'
Speaker: George Thabit, MD

Orthopaedic Physical Therapy Practice
American Physical Therapy Association
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The Orthopaedic Section of APTA presents

1995 REVIEW FOR ADVANCED ORTHOPAEDIC COMPETENCIES

ALBUQUERQUE, NEW MEXICO
Albuquerque Hilton
July 16-22, 1995

The purpose of the "Review for Advanced Orthopaedic Competencies" is to provide the 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 page 23 for further details.