ORTHOPAEDIC PHYSICAL THERAPY PRACTICE

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ORTHOPAEDIC SECTION • AMERICAN PHYSICAL THERAPY ASSOCIATION •

APTA
American Physical Therapy Association

Current Concepts of Orthopedic Physical Therapy

Home Study Course 11.2
August–December 2001

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Topics & Authors

11.2.1 Connective Tissue Response to Injury, Immoblization, and Mobilization—*Varick L. Olson, PT, PhD*

11.2.2 Patient Examination—*Deborah Stetts, MPT, OCS*

11.2.3-4 Lumbopelvic Region (2 monographs)—*Peter Huijbregts, PT, MS, MHS, OCS, FAAOMPT*

11.2.5 Thoracic Spine and Ribcage—*Timothy W. Flynn, PT, PhD*

11.2.6 Shoulder—*Lori Thein Brody, PT, MS, SCS, ATC*

11.2.7 Elbow—*Jeff Ryan, PT, ATC*

11.2.8 Wrist & Hand—*Carolyn Wadsworth, PT, MS, OCS, CHT*

11.2.9 Cervical Spine—*Richard Walsh, PT, DHSc, OCS and Arthur Nitz, PT, PhD*

11.2.10 Hip—*Tim Fagerson, PT, MS*

11.2.11 Knee—*Bruce Greenfield, PT, MMSc, OCS; Brian Tovin, PT, MMSc, SCS, ATC, FAAOMPT; and Greg Bennett, PT, MS*

11.2.12 Foot & Ankle—*Susan Appling, PT, MS, OCS and Richard H. Kasser, PT, PhD*

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11.2 Current Concepts of Orthopedic Physical Therapy

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This award is given to recognize and support excellence in instructing OPT principles and techniques through the acknowledgement of an individual with exemplary teaching skills. The instructor nominated for this award must devote the majority of his/her professional career to student education, serving as a mentor and role model with evidence of strong student rapport. The instructor's techniques must be intellectually challenging and promote necessary knowledge and skills.

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This award is given to acknowledge and honor a most outstanding Orthopaedic Section member whose contributions to the Section are of exceptional and enduring value. The nominee shall have made substantial contributions to the Section in areas such as: professional recognition and respect for the Section's achievements, and advanced public awareness of orthopaedic physical therapy.

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Submission deadline: September 1, 2001

The purpose of this award is to recognize and reward a physical therapist who has made a significant contribution to the literature dealing with the science, theory, or practice of orthopaedic physical therapy. The submitted article must be a report of research but may deal with basic sciences, applied science, or clinical research.

Contact the Orthopaedic Section office for more information pertaining to the above mentioned awards, as well as the other benefits and services offered to Orthopaedic Section members!

Orthopaedic Section, APTA, Inc.
2920 East Ave. South, Suite 200
La Crosse, WI 54601
ATTN: Stefanie Snyder
800/444-3982 * 608/788-3965 (FAX)
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ORTHOPAEDIC PHYSICAL THERAPY PRACTICE

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The mission of Orthopaedic Section of the American Physical Therapy Association is to be the leading advocate and resource for the practice of orthopaedic physical therapy. The Section will serve its members by fostering high quality patient care and promoting professional growth through:

- Advancement of education and clinical practice,
- Facilitation of quality research, and
- Professional development of members.

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Orthopaedic Section Directory
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■ ELECTED OFFICERS

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■ COMMITTEE CHAIRS

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Michael Wooden, PT, MS, OCS
4770 Forestglade Court
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(770) 496-1693 (Office/FAX)
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Heartland Physical Therapy
3705 River Ridge Dr. NE
Cedar Rapids, IA 52402
(319) 393-9358 (Office)
(319) 362-7858 (FAX)
carolynwz@aol.com

Home Study Course Coordinator:
Kathy Olson
kmolson@centurytel.net
(See Section Office)

ORTHOPAEDIC PRACTICE
Editor:
Susan A. Appling, PT, MS, OCS
University of Tennessee
822 Beale St., Ste. 337
Memphis, TN 38163
(901) 448-5888
(901) 448-7545 (FAX)
sappling@utmem.edu

Managing Editor: Sharon Klinski
sklinski@centurytel.net
(See Section Office)

RESEARCH
Chair:
Philip McClure, PT, PhD
Beaver College, PT Dept.
450 S. Easton Rd.
Glenside, PA 19038
(215) 572-2863
(215) 572-2157 (FAX)
mcclure@beaver.edu

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scfm@mcdavittpt.com

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353 Bogle St.
Somerset, KY 42503
(606) 679-6454 (Home)
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JOSPT
Editor:
Richard P. DiFabio, PT, PhD
2920 East Ave. South, Ste. 100
La Crosse, WI 54601
(608) 788-2554
(608) 788-4878 (FAX)
Editor-JOSPT@centurytel.net

Production Editor: *Emily Petty*
JOSPT@centurytel.net

NOMINATIONS
Chair:
Mary K. Milidonis, PT, MMSc, OCS
Cleveland State University
1983 East 24th Street
Cleveland, Ohio 44115-2440
(216) 687-2447
(216) 687-9316 (FAX)
m.milidonis@csuohio.edu

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■ SECTION OFFICE PERSONNEL

Orthopaedic Section, APTA, Inc., 2920 East Avenue South, Ste. 200, La Crosse, WI 54601-7202, (800) 444-3982 (Office), (608) 788-3965 (FAX)

Terri DeFlorian, Executive Director	*x 204*	*tdeflorian@centurytel.net*	*Stefanie Snyder, Program Coordinator*	*x 205*	*ssnyder@centurytel.net*
Tara Fredrickson, Executive Assistant	*x 203*	*tfred@centurytel.net*	*Linda Calkins, Project Assistant*	*x 215*	*lcalkins@centurytel.net*
Sharon Klinski, Managing Editor	*x 202*	*sklinski@centurytel.net*	*Jessica Gandy, Receptionist*	*x 201*	*jgandy@centurytel.net*
Kathy Olson, HSC Coordinator	*x 213*	*kmolson@centurytel.net*	*Darlene Aberg, HSC Registration Coord.*	*x 216*	*daberg@centurytel.net*
			April Carlson, Executive Secretary Asst.	*x 214*	*apcarlson@centurytel.net*

Editor's Message

Occupational Health Physical Therapy

The topics of occupational health and prevention of repetitive motion injuries have been quite popular recently. This is in part due to the Ergonomics Standard, which was endorsed by President Clinton in November 2000. This rule was the result of a 10-year effort to protect workers from painful, disabling injuries. Business and industry lobbied the legislature hard and were successful in killing the ergonomics rule in the House and Senate, much to the dismay of organized labor. Regardless of the arguments from either side, the rule is now dead. However, there is certainly increased awareness of the intent of the rule, and hopefully, there will be some carryover effect to decrease risks to workers—particularly related to repetitive motion injuries.

The federal Occupational Safety and Health Administration estimate that 800,000 workers a year suffer from musculoskeletal problems related to repetitive work. OSHA also reports that while the overall rate of workplace accidents has decreased, repetitive motion injuries are declining at a much slower rate and account for a larger percentage of injuries. Overall, workplace injuries declined by 26% between 1992 and 1998, from 2.3 to 1.7 million. Repetitive motion injuries declined by only 12% from 1993 to 1999, from 650,000 to 570,000.

Over the past year, I have had the opportunity to work with a local distribution facility and to provide educational seminars and one-on-one consults with the employees in an effort to decrease workplace injuries—particularly repetitive motion injuries. Last week, I met with the corporate risk management officer and was informed that the local facility's workers' compensation costs decreased 50% since we began our program. While I am sure other factors may have also contributed to this decrease in claims, the company (and I) believed that our program was responsible for a large percentage of the change. In addition, that risk management officer was supportive of prevention programs and stated she believed that the program should be in place not to meet some ergonomic rule established by OSHA, but to protect the worker. "It is the right thing to do." She was pleased with the results of our program, and now wants to implement the program at 3 other of their facilities.

This experience has taught me several lessons, in particular, to know what you are getting into before you begin a program. Luckily, I contacted Deborah Lechner, President of the Occupational Health SIG, for some assistance before beginning this adventure. She was quite helpful in providing suggestions and directing me to available resources. At that time, I began to realize there was a need to share information related to Occupational Health Physical Therapy and thought *OP* would be a great medium. So, you have a special issue of *Orthopaedic Physical Therapy Practice* focused on that topic. My thanks go to Deborah Lechner for her assistance with getting this issue together, and to all the authors for their contributions.

The articles in this issue are focused on different aspects of Occupational Health Physical Therapy. The intent of the articles is to provide information for the physical therapist interested in working in the occupational health setting, but the concepts and suggestions can be used across many aspects of specialty practice. The articles are written from the perspectives of the authors in their own clinical practice, with helpful suggestions for those of you just entering occupational health PT, or for those of you already in this area of practice.

Diane Kolarczyk presents a most helpful article on onsite therapy and outcomes in occupational health PT. Deborah Lechner discusses prework screen and provides important insight on both the practical and legal aspects of this service. Marnie Myhre informs us about the importance of employee education and ergonomic workstations evaluation. John Ritch provides a very informative article on marketing your physical therapy practice to employers. However, the marketing principles John's template provides can be used across a wide range of practice areas.

In addition, in this issue of *OP*, we have the ever-popular SIG newsletters. They are full of useful information, including calls for nominations for officers for several SIGs, calls for submissions for presentation at CSM in Boston, as well as updates on strategic plans. Both the Foot and Ankle SIG and the Performing Arts SIG have surveys for you to complete as well.

I hope you enjoy this issue of *OP* and find it useful in your daily practice.

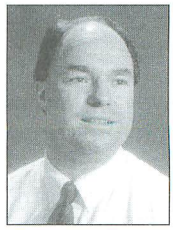
Susan A. Appling, PT,MS,OCS
Editor, OP

President's Message

As a physical therapist and owner of a small outpatient private practice I sometimes wonder how my practice compares with others. Am I outside, inside, or along the mainstream of therapists out there when it comes to staying up with the new trends in evaluation and treatment of my patient's problems/conditions? I, like many other evidenced-based physical therapists, try to keep up by reading the physical therapy journals as well as some specialty-related journal—like in my case, the journal *Spine*. In fact I just got my renewal from *Spine* in the mail today; the price was $397.10. Now I know that our journal, the *Journal of Orthopaedic & Sports Physical Therapy (JOSPT)* may not yet be in the same class as *Spine*; however, our journal continues to improve. *JOSPT* has the single highest number of clinical articles about orthopaedic and sports physical therapy of any publication in the world. Furthermore, the *Journal* continues to improve its scientific ranking as one of the top rehabilitation journals in the world. I would therefore argue that the biggest difference is not in the quality, but the asking price. For $50.00, the cost of membership in the Orthopaedic Section, members not only receive the *Journal,* but also receive all kinds of other member benefits including: as a member you can have a voice in what we do; an 1-800-number where you can almost 99% of the time talk to someone about orthopaedic physical therapy; get *Orthopaedic Physical Therapy Practice*; have access to our Web site's discussion board (orthopt.org) and discuss any topic you want; receive discounts on Home Study Courses; attend great courses at CSM including Special Interest Group programming; go to the Rose Award ceremony and celebration (always great food and drink, music, and dialogue); and many, many other benefits. Also, the Orthopaedic Section is the leading Section when it comes to donating money to the great causes of the American Physical Therapy Association including, but not limited to, the Foundation for Physical Therapy and Diversity 2000. We are truly a benevolent Section that deeply cares for our members, as well as their causes and concerns. Again just think of what you get for your money. When you look just at the cost of the *Journal* and then look at the cost of *Spine* ($50.00 versus $397.10), we as a Section are underselling and undervaluing ourselves greatly. The same can be said when considering our APTA dues, which also includes receiving our peer reviewed journal, *Physical Therapy,* among the many other benefits. Again, considering the cost of *Spine* as just one example, APTA due's are also a relative bargain. The cost of the *Journal* to physical therapists outside the US is about $93.00, which is still cheap if you compare costs with other similarly targeted journals. I am amazed that we don't have 2 to 3 times as many members after just comparing the *Journal* subscription rate prices. If therapists don't receive either *Physical Therapy* or *JOSPT*, how do they keep up with the continuous changes in practice? I believe that evidenced-based physical therapy will mandate, out of clinical necessity, required reading of clinically relevant journals. I know that some nay sayers suggest that our journals don't yet have the evidence that they need to practice, I however disagree. We may not be perfect but I believe we are on the right track.

A major reason why *JOSPT* remains inexpensive is that it is underwritten by the Orthopaedic and Sports Sections. The Editor-in-Chief, the Editorial Board Members, and the Manuscript Reviewers work long, often thankless hours in trying to make the *Journal* the best. As I continue to see the metamorphosis of the *Journal*, I hope others will finally realize the value of belonging and join our Section. I am saddened to note that our Editor-in-Chief for the last 3 years has resigned effective at the end of this year. Dr. Richard DiFabio took *JOSPT* to that next level and the Orthopaedic Section will be forever grateful for his countless hours of time and effort. We have been lucky that every new Editor-in-Chief has had just the right mix and knew how to take the *Journal* in a different direction. To begin I can't even tell you of all the things that Rick did for the *Journal*, sacrificing many hours of his valuable family life to make sure the *Journal* gets published on time and with a very high level of quality. Some may have disagreed with his poignant and witty Editorials, but Rick always made us think. During his tenure, many good things came about and the *Journal* took on a bold new look, especially under the cover. Rick culled the country to find an editorial board, which included an eclectic variety of seasoned researchers and teachers that looked like a Who's Who of orthopaedic and sports physical therapists. All of these board members spend many hours (and hours) over manuscripts, trying to improve *JOSPT* (and ultimately the practice of orthopaedic and sports physical therapy) and I am very grateful to every single one of them. I hope, by the time you read this, that we have selected a new Editor-in-Chief that will lead us to that next level. Hopefully, the Journal will continue to grow with our next Editor-in-Chief, whoever he or she may be. I would also like to acknowledge our hard working staff at the *Journal* office in LaCrosse. Although they are paid employees, they take their jobs very seriously. They care a great deal about the quality of the *Journal*, just as if it's their own. As I wrote this, I got a rejection notice from the *Journal* regarding one of the papers I submitted. Not even the President gets a break. Although I was personally disappointed, I realized that the reviewers and board members were just doing their job. Well, back to the drawing board.

Rick, does the Section still owe you some money? Well, I think I lost that check...just kidding. Thank you for all of your hard work and good luck to you on your next new assignment.



Michael T. Cibulka,
PT, MHS, OCS
President

Prework Screens: An Opportunity for Preventing Injuries

Deborah E. Lechner, PT, MS

Prework physical functional screening is an important component of a comprehensive injury prevention program. The development and execution of prework screens, however, is not without its challenges. The purpose of the prework screen is to decrease injuries and injury-related expenses. For employers, prevention translates into increased productivity and profit margin. For employees, prevention preserves earning potential and minimizes pain and suffering. To maximize the effectiveness, prework screening should be one element of a total prevention program. Other key prevention elements may include:

- graded work entry,
- education and training,
- hazard identification and control,
- fitness and wellness, and
- postinjury management (secondary prevention).

OPTIMAL SEQUENCE

Optimally the job applicant is interviewed and offered a position, contingent upon passing prework screening. These screens can include but are not limited to medical examination, drug screening, skills testing, and physical functional testing. If applicants are screened prior to a conditional offer, all applicants rather than just those applicants who receive a conditional offer must be screened. For this reason, preoffer testing is significantly more costly for the employer than postoffer screening. In addition, if applicants are screened preoffer, vital signs such as heart rate, respiration, and blood pressure cannot be monitored during testing, creating some serious implications regarding safety. A medical screening exam performed by a physician to help screen out those individuals who should not undergo physical functional testing for safety reasons also cannot be performed preoffer.

ADA AND EEOC CONSIDERATIONS

The ADA states that prework screening can only be performed on the physical demands required for the essential tasks of the job. A job task is considered essential by the ADA if it is the reason the job exists, there are a limited number of employees that can perform the function if the employee in question is unable or it is highly specialized so that incumbents are hired to perform that function. A one size fits all (one screen for many types of jobs) is in violation of the ADA.

The EEOC states that employers should not create adverse impact on any minority group. Adverse impact is a "selection rate for any race, sex, or ethnic group that is less than 80% of the selection rate for the group with the highest selection rate." Confused yet? Perhaps an example would help. Consider this scenario: 60% of male applicants pass a postoffer screen but only 15% of female applicants pass it. Would the postoffer screen be considered to be creating adverse impact? Absolutely. The pass rate for women is only 15% of the pass rate for men (.15 x .60 = .09). There are some jobs that will inevitably create adverse impact for females due to the difficulty and intensity of the requirements. In such cases, as long as the tasks are representative of the job and the performance of these tasks is a business necessity for the company, then the test will not be in violation of the EEOC.

> The purpose of the prework screen is to decrease injuries and injury-related expenses.

PITFALLS TO AVOID

Predicting Future Injury

Predicting future injury sounds impressive and is used by some providers as a sales tactic to convince industry to utilize their services. Predicting future injury, however, is a very risky business from a legal perspective. You must state exactly what will happen, how it will happen, when it will happen, and what the consequences will be. Regardless of the size of the providers database, predicting future injury is akin to using a crystal ball and about as reliable. As a credible provider, the physical therapist's role in prework screening should be limited to determining whether client abilities meet job demands.

General Strength Testing

General strength testing such as isokinetic testing has been shown to have little to no value in employee selection. A general fitness or agility test used with New York City firefighters failed to sustain legal scrutiny as far back as 1982 when the court ruled "Nothing in the concepts of dynamic strength, gross body equilibrium, stamina, and the like has such a grounding in observable behavior of the way firefighters operate that one could say with confidence that a person who possesses a high degree of these abilities as opposed to others will perform well on the job."

Making Comparison to Normative Data

Percentile rankings of applicants' physical abilities are useless and illegal. Employment cannot be granted nor denied based on a percentile ranking. If the applicant's abilities match the job demands, the applicant should be hired and placed. If the applicant's abilities do not match the job, and the applicant is not a person with a disability, the company does not have to hire the individual. The company may offer alternative placement or remediation but does not have to do so for individuals without disabilities. Consistency is important. If the company offers a remediation for one applicant, it must offer the remediation to all.

POSSIBLE LEGAL CHALLENGES

The 2 major possible legal challenges to prework screening are:

1. Test items do not reflect relevant demands of the job (ie, the test items are not a valid representation of the job).
2. The sample of incumbents tested was not sufficiently large or did not represent the population of workers.

A careful job demands analysis as described below can be the best defense against the first challenge. The test item must first pass the test of face or content validity. The question typically asked is: Does the test item look like the job task? Replicating the materials handled, distances, and duration of the job task as much as possible for each test item is critical. Having additional peer-reviewed data regarding criterion-

related or construct validity of the test items is also extremely helpful.

STEPS IN THE DEVELOPMENT PROCESS

The development phase of the prework screen is as important, if not more so, as the implementation phase. Often companies are hesitant to spend money on quality development. In this case, you must decide whether you want to be exposed to this level of risk. The following steps provide a comprehensive and defensible approach to the development of prework screens.

Focusing the Screen

Many employers will think they have to approach prework screens with a shotgun approach. They think they must screen for all jobs. The fact is that the 80-20 rule likely applies. Eighty percent of the injuries are probably occurring on 20% of the jobs. If screens are developed for those problem jobs they may greatly reduce injuries and minimize the cost to the company. Focusing the development of the screens to the most problematic job makes the project feasible for both the company and you. Particularly if you are new to prework screens, getting your feet wet with a smaller project may be the most prudent approach.

Performing the Job Demands Analysis

The job demands analysis is the foundation upon which the entire process of prework screens is based. A flawed or inaccurate job demands analysis makes for flawed task selection and inappropriate pass/fail criteria. The process for performing job demands analysis should be systematic and objective. Quantification through force measurements and videotaping are optimal but not always possible. Safety of the evaluator and workers during job demands analysis is not an insignificant matter, especially in some heavy manufacturing environments. Following all safety regulations and being escorted by personnel who know the plant are essential.

Some employers will want you to work from previous job demands analyses or job descriptions rather than spend the money to have you do your own analyses. If you are asked to develop your screens based on someone else's job description, ask questions regarding how the screens were developed. Ask to be allowed to casually observe the jobs. If you have concerns about the accuracy of the job descriptions, discuss your concerns with the employer and fully explain the implications of working from flawed job descriptions. If you must perform prework screens based on previously done job descriptions, be sure to include a clause in your contract with the employer that relieves you from responsibility if the job descriptions are flawed.

Customizing the Screen

Tasks can be selected from previously developed functional tests, such as FCEs, as long as they closely match the task performed on the job. Alternatively, entirely new tasks can be developed based on job demands. Factors to consider are the forces exerted, positions tolerated, repetitive movements, ambulatory activities, balance, coordination, and dexterity. Most employers are wanting screens that last no more than 30 to 60 minutes. You will seldom have time to test all essential physical demands. Therefore, the most demanding aspects of the job must be selected.

Developing Policies and Procedures

The best laid plans make for the most successful screens. Prework screens cannot be planned too carefully. Every aspect of the process from referral to reporting the results needs to be spelled out carefully in a policy and procedures agreement that both the provider and the company sign. There are many aspects of prework screening that are neither illegal or legal and can be handled in a variety of ways depending on company policy. The operative word, however, is *policy*. Policy that is followed strictly and consistently. Inconsistency can get the employer and provider into some uncomfortable legal situations.

In general, the provider should stay out of the hiring decision. Provide the employer with the information. Let the employer discuss test results and the hiring decision with the job applicant.

An informed consent form is essential. The form should describe the testing procedure and the inherent risks of testing. In postoffer testing, medical information and history can be revealed either through a physician's exam or patient self-report. Medical conditions that will be considered to be contraindications for testing should be defined in advance and agreed upon by the provider and employer. Applicants with medical conditions requiring precautions or restrictions during testing should be reviewed and cleared by the physician prior to functional prework screen.

One of the most important policies to determine is the mechanism for handling the reporting of test results. The preferred process typically involves faxing the report to the employer's human resources department. The applicant then returns to that department to learn test results. The employer must decide what to do with those failures. They must make reasonable accommodations for the person with a disability. They do not have to accommodate the nondisabled individual. Whatever the employer's decision, the policy must be implemented consistently across all applicants.

Other issues to be decided and questions to be resolved include:

- Will you perform some type of musculoskeletal screen prior to functional testing?
- Will you administer a medical screening questionnaire prior to functional testing?
- Will the applicant undergo a medical exam prior to functional testing?
- What will you do if the applicant shows up intoxicated or belligerent?
- Will the applicant undergo drug screening prior to functional testing?
- Where will the testing occur?
- How will the referrals be made?
- Where will you store test results? Medical intake information?
- What will you accept as appropriate lifting technique and what will you do with those whose technique is poor?

Testing Incumbents

Incumbent testing is a critical step in the process of developing the prework screen. This step helps to provide evidence in support of the validity of the protocol should the screens ever be challenged. The question is who should be tested and how many incumbents should be tested. The answer is as many as possible and as diverse a group as possible (gender, age, and ethnicity). The incumbents must be assured of the confidentiality of the testing and that results will not affect their performance appraisal. The extent of the incumbent testing may be limited by the number of workers performing the job.

(Continued on page 17)

Marketing Your Physical Therapy Practice to Employers

John M. Ritch, PT, MS, FACHE

INTRODUCTION

The emphasis of this article will be to discuss the planning, development, and marketing of a physical therapy program focused on industrial rehabilitation services. The approach will incorporate several aspects of an occupational rehabilitation service line that will enable all sizes of physical therapy practice to benefit from the content.

I would assume that almost all physical therapy practice settings have some level of involvement with patients who have workers' compensation claims. For many years, physical therapy has been an essential part of rehabilitation for work-related injuries. The objective of the marketing program will be to expand the physical therapy service line both in the perspective of service delivery capability as well as volume and market share for business growth.

Based on my direct involvement with occupational therapy service lines over the past 10 years, I have chosen to look at the marketing of this service from 3 levels of involvement with employers:

- Physical therapy rehabilitation services for the injured worker or "postloss" program.
- Physical therapist providing preventative services including education and ergonomics directly to employers or a "preloss" program.
- The development of onsite physical therapy services at specified employer locations.

While it is not essential to have all 3 of these components as part of your physical therapy occupational rehabilitation service line, each component should be explored for its potential in your service area.

The title, "Marketing Your Physical Therapy Service to Employers," is somewhat misleading from a comprehensive approach to the marketing effort. The article will deal with strategies and activities designed for marketing to employers and several other important constituencies that need to be included in the marketing program. These would include, and not be limited to, the following:

- Physicians, particularly Occupational Medicine,
- Occupational health nurses,
- Case managers,
- Workers' compensation insurance companies and managed care plans,
- Attorneys, and
- Unions.

The term 'multitiered marketing' applies well to the physical therapy occupational rehabilitation service line. Seldom is a single target approach successful. The need to know all the players involved with the prevention and treatment of work related injuries will be important.

For many years, physical therapists and other health care providers worked from the concept "we have built it, we are good, they will come."

MARKETING FUNCTION - AN OVERVIEW

Marketing is the discipline of understanding your customers, designing services to meet their needs, demonstrating results, and continuously monitoring to make sure you deliver what you promised. I have found this particular definition of the marketing function to be especially useful as it relates to the health care environment. Examining this definition into its component parts will serve as an excellent guideline for the structure of a physical therapy occupational rehabilitation service line.

One of the major drawbacks over the years related to physical therapy program success has been the lack of effective marketing and sales activities. For many years, physical therapists and other health care providers worked from the concept "we have built it, we are good, they will come." As competition increased and the health care dollar continued to shrink, this philosophy has been unsuccessful.

The following represents marketing approaches that are commonly observed in the health care field. I would like to briefly explore the components of these approaches and its potential for success. The first is not uncommon in the physical therapy profession. It is called the **product-driven orientation.** In the product-driven approach, the company sets about developing what they consider to be state-of-the-art products or services. The keystone mindset of this approach is "we are the expert, we have the knowledge." The business sets about investing time and money to develop so-called cutting-edge advances and services. A theoretical model is defined and product specifications developed. Finally, the new product is ready for delivery and the business begins the process of looking for customers to buy the product. Their attitude is "you need this product and you need to be educated about it." The product will sell due to its excellent quality. In my experience, this approach fails more frequently than it succeeds. The services are designed according to the experts and they frequently do not correspond to the needs, wants, or preferences of the potential buyer. In this case, the physical therapy business has not thought of the customer's needs. They have not aquired the customer's input.

The second marketing approach is called the **selling orientation**. In this case, the keystone of the approach is to develop fancy selling approaches and materials. The approach is to dress up the product for selling. "Bells and whistles" are included or promised, whether they exist or not. The attitude toward the customer is "they need to be sold." This could be likened to the hard-sell concept. The test of results for the selling orientation is the number of sales, not satisfied customers. This is not marketing; this is selling. Once again, the drawback of this approach is that the needs, wants, and preferences of the potential buyer have not been determined up front. Furthermore, if the product cannot live up to the aggressive sales approach, this will actually hurt the company vs. providing benefits or additional business.

Finally, the third model is called a **marketing orientation**, and this is

the approach that is used by successful organizations. In this case, the keystone is that the product and/or services matches the needs and wants of the potential customer. One of the best pieces of advice of this article will be that marketing to employers requires a great deal of front-end work, so-called due diligence, to be sure to determine what the true market opportunity is for the physical therapy occupational rehab service line. It is imperative to know as much about your targeted buyers as possible.

Through the marketing orientation approach, the physical therapist's first thoughts are of what the customer needs. Then second, service design begins to meet those needs and along the way, you need to be constantly aware of what other organizations (competitors) are doing. The test of quality and results from this approach is customer satisfaction. Remember, a satisfied customer means good word-of-mouth references as well as return business. In my organization's customer satisfaction survey, the questions that we feel are most important are as follows:

- Would you refer another employer to our service?
- Would you use our service again in the future?
- Would you brag about our service to others?

The physical therapy service that builds in the features that match the preferences of the marketplace, better than other organizations (competitors) in the service area, will be the one that succeeds best.

MARKET RESEARCH: THE THREE-STEP APPROACH

Of all the components of a formal marketing program, market research is probably the one that is most neglected. I believe that this often occurs because most physical therapy practices believe that it is too complicated, too time-consuming, or too costly to do effective market research. However, once one has seen the power of good market research in first deciding whether the program has potential or not and second in how the program is designed, they will be convinced that this is not only important, but an essential first step.

Market research does not have to be complicated. While it needs to be thorough enough to get a clear picture, it can be done in a way that is both expedient and effective. For a physical therapy occupational rehab service line, I would like to recommend a 3-step approach to your market research. The steps are as follows:

1. Internal analysis, which includes both a product line analysis and a company-wide SWOT analysis. This is the necessary first step.
2. An environmental assessment. The environmental assessment needs to be national, regional, and local in order to get a good picture as to what the potential is for your program.
3. The special market research in your community that includes a competitor analysis, as well as information about your identified customers.

Product Line Analysis

Begin with an investigation of your current services. This should be easy and not time-consuming. Hopefully you have the necessary data to do the internal assessment. Here are the categories that are recommended as it relates to an occupational rehab services line:

- Volume for the past year of work-related injuries treated in your clinic.
- What percentage of your total patient visits is represented by workers' compensation cases.
- From your referral log, identify the sources that refer workers' compensation patients.
- Make a list of all of the workers' compensation insurance companies and managed care plans.
  - The first list should be for the patients you have treated in the past year.
  - The second list should be all the plans in your service area.
- Make a list of the employers in your area.
  - The first list would be those employers from whom you saw workers' compensation cases in your clinic and during the past year.
  - The second list would be all of the employers in your area (ie, be realistic about the number of employers to include based on the size of your service area).

Note: A good source for a list of employers in your area would be the Chamber of Commerce or the Better Business Bureau for your community.

- Identify demographic data for the workers' compensation cases seen in your clinic during the past year. I would recommend the following: age, sex, type of injury (diagnosis),and zip code for patients and employers. You may ask why is this information important. Age and sex will help you identify what type of patients you're currently seeing. Older employees tend to experience more frequent injuries in the workplace, particularly musculoskelatal injuries. Type of injuries you have treated has obvious importance. The zip code breakdown both by patients and employers helps you identify geographic considerations, which may eventually relate to how and where you will deliver your services.
- Finally, analyze the services you are currently providing. As part of this analysis determine type of injuries, volumes, utilization, and outcomes (results). When you begin to call on local employers , you need to be able to discuss your current services and the positive aspects that you have identified through your internal assessment.

By starting with your own product line analysis, you will begin the process of identifying strengths as well as weaknesses in your program. This information will be helpful when you begin to meet with employers. One of the greatest fears for physical therapists marketing directly to employers is that they will be asked for a service that they currently do not have available. I recommend that it is better to say, "let us work on developing that service to meet your needs" as opposed to saying "we have it" when you really do not, and then fail in the delivery effort.

When marketing to employers, the availability of factual data is very important. Therefore, if you cannot identify your current referral sources, your volume of workers' comp patients, the insurance companies for your workers' comp patients, the utilization of your treatment of these patients as well as your outcomes, this needs to be done first so that you have the data when you begin to make your marketing calls.

Organizational SWOT Analysis

Depending upon your physical therapy practice, the organizational SWOT analysis can be very easy or very complicated. This is a self-analysis that uses the concepts of "S" for strengths, "W" for weaknesses, "O" for opportunities, and "T" for threats. For those that are part of a large hospital/health care system, the SWOT analysis is more involved. For the smaller private physical therapy practice, the

SWOT analysis will be quick and easy. No matter what size of organization you are and your ownership type, it is important to complete the SWOT analysis as part of your market research. Specific questions that clarify what the SWOT analysis is all about are: "Who am I?" "What is our organization's reputation in the market?" The SWOT analysis should begin with members of your organization. Next, include external resources in the SWOT analysis. This should include: physicians, vendors, former patients and families, board members, and community groups.

It is very important to be totally objective with the SWOT analysis. Involve a variety of people in order to get different and new perspectives. Most physical therapists believe that their department or practice function well. While this may be true, it needs to be tested with input from sources that are completely objective.

What are we looking to gain from a SWOT analysis? Strengths enable the physical therapist to establish a base on which to build. Appraisal of weakness enables the physical therapist to begin corrective action; this also may include gaps in the service line that need to be filled based on customer needs opportunities. The identification of threats enables the practice to begin to understand such limiting components as reimbursement, changes in the economy, and threats from the competition. Opportunities enable the physical therapist to strategize on how to deliver services to capture new business. When this information is known, it enables you to prepare effectively for how to overcome the market threats. As you conclude the SWOT analysis, you should be able to answer the following questions:

- Who are we today?
- What do we want to be known for in the future?
- How do we want to be distinguished from our competitors in the marketplace?

You should be able at this point to see where your advantages and strengths are and how to use them to pursue opportunities, as well as areas that you need to improve and the threats that you need to overcome.

Environmental Assessment

Now that you have completed the internal assessment, it is time to look external to your organization. The environmental assessment describes changes and trends that may have an impact on the future and may influence your marketing program. There are many sources that can help you with completing an environmental assessment. With the availability of information both in print and on the Internet, the ability to get a quick handle on what's happening environmentally should not present a problem. I recommend doing the environmental analysis on 3 levels: national, regional, and local. Obviously, local is most important but sometimes it needs to be put in perspective and compared to both national and regional trends. The following are examples of environmental assessment categories and what should be investigated:

- What is the growth of the population during the past 10 years?
- What is the projected growth within the next 3 to 5 years? This information is readily available through the recently completed United States 2000 Census. There are several websites that offer detailed information about population changes. As part of your population assessment, look at the demographics, particularly in your local area. What are the age ranges? Is there a large retirement population? Look for information on employment and employers, average family household income, and size of family.
- Government and political trends are important: What is the impact of recent elections, national, regional, and local? A good example of an environmental trend as it relates to government is the recent decision not to sign into law the new OSHA standards.
- What is the status of the economy? Obviously, our current economy is in a downturn. How does this impact you locally? How will this affect employers in your area?
- What are the trends in the labor market? Unemployment levels - compare your local statistics to regional and national. What is the make-up of the employers and the employees (ie, blue collar, white collar, type of industry, etc).
- The environmental assessment should include what is happening with health care insurance, managed care plans, and regulatory activity focused on the health care industry.
- What is happening from a popular culture prospective in the environment?
- What technological advances, both within the health care industry, as well as in general, are occurring in the environment? Examples would be recent breakthroughs in cancer treatment medication, technological changes that impact the workplace (ie, the higher incidence of cumulative trauma disorders related to the number of people using computers).

The environmental assessment essentially asks the question "what is happening in the country, in your state, and your hometown?" Having this information and updating it regularly will be beneficial to the physical therapy practice and marketing plan. Once again, the importance of these steps is to avoid the problem of developing a service that is not going to succeed because you failed to evaluate what's happening in the environment.

Market Research Specific to Employers in your Service Area

Based on the work you have completed on the internal assessment and the environmental assessment, you should have much of the information you need to complete your market research specific to the employers in your area. The following are where you need to start:

- A list of all employers in your service area. This should be done by size of employer (number of employees), type of industry (manufacturing, data processing, service, etc.), and length of time employer has been in your area. Well-established long-standing employers should be your priority, providing that they have needs for a physical therapy occupational rehab service line.
- Type of health care insurance and workers' compensation insurance for each employer. *Note*: It is important to know whether an employer is self-insured and uses a third party administrator to manage their health care and workers' compensation claims, or if they are using an insurance company or managed care plan for both types of coverage (ie, health and accident and workers compensation insurance). What insurance and managed care plans are you contracted with as a provider? With what plans do you need to pursue a contract?
- Determine the incident rates of work related injuries by employer and by industry type. This information can be obtained from the Bureau of Labor Statistics, which has a website.
- In your community, determine which physicians are involved with Occupational Medicine Services. Large employers may have on-site medical ser-

vices. Most medium and small employers will utilize a community-based occupational medicine physician or primary care physician.

The important objective of the local market research is to determine who "directs traffic" as it relates to workers' compensation referrals. If they choose to, employers can exert direct influence on the other sources (case managers, physicians, and insurance claims representatives) to send patients to specific providers. It will be important to market directly to all of the other potential referral sources. When you have analyzed your existing business in step one, you should know which physicians, case managers, and insurance companies are involved with the patients you are currently treating. You will then need to compare that list to determine the sources from whom you are not receiving patients.

An exciting part of doing your local market research will be actually to incorporate making visits (marketing calls) to local employers, occupational medicine physicians, case managers, and insurance companies. I strongly recommend doing both market research and sales calls in a combined effort. At this time, you know enough about your existing service, its strengths and patients' results to call on employers and the other references to promote your service and to gather more information. Remember the important premise that we're using in the marketing orientation approach. We're basing our service delivery development on the needs, wants, and preferences of the local employers, occupational medicine physicians, case managers, and insurance companies. The next section will prepare you for making cold calls and other types of marketing activities.

SERVICE LINE BUSINESS PLAN

At this point you have completed your market research. Before developing your marketing plan and initiating the various activities, it will be necessary to develop a mini-business plan for your physical therapy occupational rehabilitation service line.

The objective for the development of the business plan is "What will be the financial impact of this program?" The physical therapist must keep in mind that program development activities required to strengthen the service line, as well as the marketing plan and activities themselves, will cost the clinic time and money. The basic question is "What will be the return on investment for developing and promoting the physical therapy occupational rehabilitation service line?"

It is important for all physical therapy programs to have an organized approach to provide service to the employers in their community. Employers represent a major constituency in your market. One must remember that not only are there opportunities to provide services in the occupational rehabilitation arena, but strong relationships with employers will also have a positive bearing on the health and accident insurance cases as well. It will be detrimental not to have a marketing strategy focused on employers. The following are some basic recommendations regarding the development of a business plan for the physical therapy occupational rehabilitation service line.

1) **Worker Compensation Physical Therapy Rehabilitation Management** - Objective: grow the number of worker compensation cases seen in your physical therapy clinic. This requires the physical therapist to know the reimbursement for worker compensation cases, utilization requirements, outcome reporting, billing, and collections. Is workers compensation business good for your clinic?
2) **Prevention or Preloss Physical Therapy Services** - Preloss refers to the interface with the employer to prevent injuries or to minimize the impact of injuries in the workplace. The physical therapist needs to understand what these services include, the costs to deliver the services, and appropriate pricing. In certain situations, some of these services can be used as "lost leaders" in order to build relationships and opportunities with employers.
3) **Specialized Services** - One example would be the purchase of a Functional Capacity Evaluation Program to augment your occupational rehabilitation service line. **Step 1:** Know what the need and interest in referrals and payment for FCEs is in your service area. **Step 2:** Know what the competition is doing related to FCEs. **Step 3:** Complete a return-on-investment analysis, not only for the FCE component, but for any major capital purchase that is considered a necessary part of your occupational rehabilitation service line.

DEVELOPMENT AND IMPLEMENTATION OF A MARKETING PLAN

A marketing plan provides the structure necessary to implement a variety of activities and decisions that are needed to promote your occupational rehabilitation service line and to secure additional business. At this stage, much of your marketing plan has taken shape due to the analysis and research. The following are some examples of marketing plan activities that not only are effective for promoting your service and securing business, but also contribute to the ongoing effort to maintain a flow of up-to-date market information.

- **Activity #1:** Take the initiative to meet with employers at their place of business. A major challenge will be getting to meet with the appropriate person who can make a decision about referrals and purchasing services. From experience, I would recommend getting an initial meeting and using that opportunity to determine who the "players" are at the place of business related to workers' compensation prevention and rehabilitation. On the initial visit it will be important to have a description of your current service and if possible a track record with that employer's employees. Be sure to prepare a list of questions that relate to the information you wish to obtain. Make sure that you listen effectively throughout the meeting as this will provide you with specific information relevant to that employer's needs.
- **Activity #2: Focus Groups.** A focus group of employers in your marketplace is an excellent way to learn about their needs and perspectives on work-related injuries, both prevention and treatment. Employers like all of us are busy and it will be hard to schedule a focus group. Consider scheduling a focus group around a breakfast or lunch meeting. Another approach would be at a location where employers are gathered for other purpose (ie, conference, seminar, etc).
- **Activity #3: Conferences, Seminars, and Meetings Focused on Employer Needs.** This may provide the physical therapist with an opportunity to have an exhibit booth or even be part of the presentations that are offered at the conference.

- **Activity #4: Lunch and Learn.** Our organization has used the concept of "Lunch and Learn" to create an environment where employers, case managers, and physicians can be invited to meet regarding workers compensation topics. We utilize a central meeting place, have lunch, and provide a variety of learning and discussion groups.
- **Activity #5: Community Social and Recreational Activities**. I recommend that the physical therapy practice take an active part in community events. Examples include: Chamber of Commerce meetings and activities, community fund-raising events, community recreational events. If your physical therapy practice has the resources to be a sponsor or advertiser in community events, it provides both visibility and direct contact with local employers. The ability of the physical therapist to volunteer for certain community events will also create relationships with employers in the area. Our organization participates in Chamber of Commerce meetings; we sponsor road races, triathlons, and other recreational events. We sponsor educational seminars for employers and case managers and work closely with local physicians, particularly those involved with occupational medicine. The following marketing axiom provides us with rationale for why the above described activities are important. "The more complex, expensive and risky a purchase decision is, the more a personal marketing strategy is needed. Therefore, developing relationships with referral sources and buyers by using personal selling techniques, is a critical marketing strategy, especially in a service industry situation."

IMPLEMENTATION OF THE MARKETING PLAN

Physical therapists have the training and potential to be an effective part of the marketing plan, implementation, and marketing activities. First of all, they are knowledgeable and have experience in the delivery of the services that are promoted to employers and the related purchasing parties. Physical therapists are organized, motivated, and are effective listeners and good educators. The emphasis in our training to evaluate and do research should make the process of market research less cumbersome. From my experience, and that of several of my colleagues, the marketing and selling of occupational rehabilitation services is a lot about education (the consultative sale).

I also will stress that if an individual is not comfortable in a marketing/selling situation, they should not participate and have someone who has the interpersonal skills represent the physical therapy service. In order to provide a broader perspective for this article, I asked several of my colleagues from around the country to comment on their experience related to marketing a physical therapy/occupational rehabilitation service line to employers. Their collective feedback is as follows:

- Multitiered approach to the marketing effort.
- Know all the various contact possibilities related to workers' compensation rehab and prevention, ie, top decision makers such as owners, presidents, and CEOs; Human Resource Department; case managers; insurance representatives; safety managers, occupational medicine physicians, industrial nurses, and community resources.
- When marketing to physicians, the emphasis on clinical services and patient results are the most important criteria.
- When marketing directly to employers, it is important for the physical therapist to think about the economics of the services delivered. The employer is interested in how to save money and improve the bottom line performance of the company. The marketing strategy for the physical therapist should be geared toward making the employer's job for preventing and managing work-related injuries less complicated.
- The communication between the service provider and the employer needs to be outlined clearly and will represent an important part of the marketing strategy. Employers want to know what is going on, on a timely basis. One program uses a daily FAX system to keep employers aware of employee status and progress.
- The more progressive employers will tend to be more open and creative about the application of the physical therapist expertise and will involve them in such areas as: job site analysis; strategies to decrease the cost related to work related injuries; work conditioning; on-site services including training, ergonomics, and work style consulting.
- Involvement with caseworkers and case managers is extremely important. We do training seminars for the case managers and seek their feedback.
- Other effective activities are to encourage the insurance companies and their case managers to actually come to the physical therapy clinic at the same time the client is being treated.
- Several organizations use education and prevention services as an entry point to build rapport with employers in their service area. Certain services are delivered for free in order to demonstrate to the employer its potential value. If this is a strategy that is adopted, it should be incorporated as part of the cost of the marketing program.
- My organization's experience with prevention and other preloss types of services is that it is not an easy sell to employers. Therefore, strategies to demonstrate the value of these services need to be considered as part of the marketing strategy.
- Testimonials from other employers regarding favorable results in their setting often is an effective tool in the marketing effort with new employers.
- Physical therapy programs are beginning to experiment with the concept of establishing a fee based on the employer's cost savings derived after the delivery of the prevention/preloss services. This concept is good and will create interest from the employer, but there must be an effective tracking system that captures and communicates the cost saving clearly to both parties.

The following are additional marketing activities that should be included as part of the promotion and sales of the occupational rehabilitation service line.

- Marketing materials such as brochures and other print descriptions of the services provided are a necessary part of the marketing plan. These materials should be factual. Employers like quantifiable facts. The use of pictures, graphs, and other types of visual graphics are recommended.
- Exhibits at trade shows, conferences and seminars provide good visibility. I recommend the selection of a few good opportunities to be visible and interface with employers, case managers, and physicians involved with the Workers' Compensation field.

- Advertising in trade publications, newspapers, television, and radio all have a role but are expensive and need to be evaluated for its return on investment.
- Direct mail campaigns, fax "mail" campaigns, and telemarketing should be considered.
- Cold calls both by telephone and in person are necessary to get the door open, and should be considered as the part of the process.

In conclusion, I would reinforce the fact that the most effective marketing activities tend to be those where there is a face-to-face connection. This will take considerable effort on the part of the physical therapist. You need first to gain experience, and second to master the marketing and selling process. This requires persistence and good follow through.

TRACKING AND FOLLOW-UP ACTIVITIES

Set up a system that will track the various marketing activities utilized in your marketing plan. The tracking system should be simple, but provide the information that helps you determine what is working and what needs to be improved. The tracking system can be computerized or a paper system, but it should establish a filing system for each contact and maintain regular updates throughout the marketing process. The tracking system will help improve the marketing effort and will provide necessary information on the services to be provided from a clinical perspective.

Be prepared for new business to happen! The physical therapist should have prepared the following documents in advance:

- **Contracts and Letters of Agreement** - Contracts and Letters of Agreement are used to finalize a sale. They should be legally appropriate, but not overwhelming in length or legal language. The best model is one that is generic covering all of the legal aspects of the relationship with an addendum that clearly defines what will be delivered, the time frame, and the fee structure.
- **Format for Submitting a Formal Proposal to a Prospective Client** - The proposal format would lay out the sections of who you are, what you have to offer, how it would be delivered, and what your pricing structure would be. Most proposal formats should be flexible enough that they can be completed to meet the specified needs of a given employer.
- **PowerPoint Presentations** - The presentations are designed to market certain services available in the physical therapy occupational rehabilitation service line.
- **Financial System** - A financial system that tracks revenue and cost, and, has the structure for billing and collections for the services provided in the occupational rehabilitation service line. (There needs to be a billing system for physical therapy/rehabilitation service, prevention/ergonomics, and onsite contracts).

CONCLUSION

Always start with effective analysis and research, both internal and external. The market research strategy applies to any service line developed within your physical therapy practice. The process does not have to be overwhelming or a complicated research engagement. Follow the guidelines described in this article. Gather the necessary information quickly. Use resources both within your practice and external to it, and be objective about where the information leads you related to the marketing plan and program development.

Take the initiative and create situations for interpersonal communication with employers, case managers, insurance companies, physicians, nurses, attorneys, and other parties involved with the Workers' Compensation prevention and rehabilitation field. Never promise what you cannot deliver. If you do not have the service ready or do not have the answer to a specific question, simply state that you will work on this particular need and you will get back with the contact person as soon as possible. Remember, in the beginning it will not be possible to deliver all the services needed by the employers in your service area. The important component here, is to be confident and capable in what you can deliver and to promote that effectively.

Deliver what you promised and do it both timely and with results. Remember, a satisfied customer is important for many reasons. They represent the potential for repeat or additional business. Satisfied employers provide testimonials and references which is a strong component of your marketing effort to new employers. It is easier to sell repeat business or additional new services and products to a satisfied, existing customer than it is to get business from a brand new customer.

Think of employers and all the related constituent parties involved as an important part of your overall approach to the delivery of physical therapy services in your community. Employers and their employees are members of the community. They have families, relatives, friends, and a variety of other contacts through business, church, and social events. My company's experience has demonstrated that being a quality provider for physical therapy services in the workers' compensation environment has provided opportunities for additional business from area employers related to the every day health and accident cases. Finally, the development, implementation, and on-going delivery of an occupational rehabilitation service line is both exciting and rewarding to the physical therapist clinician and manager. Business and industry customers can be demanding and outcome oriented. In my opinion this is good for our practice and keeps us aware and alert of the realities of providing health care in a business oriented manner.

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John M. Ritch is the Executive Vice President for Acquisitions and Business Development for the Brooks Health System, Jacksonville, Florida. Mr. Ritch has extensive experience in the physical therapy/rehabilitation field.

Successful Onsite Therapy
Outcomes Tell the Story

Diane Kolarczyk, PT

I began working with business and industry as a therapist in the late 1980s. I was the clinical manager of an outpatient orthopedic spine rehabilitation program with a caseload that included approximately 20% workers' compensation. The program was initiated at the request of a new spine surgeon, and I was brought in to develop a program to complement his skills. He brought new state-of-the-art surgical techniques, and I was charged with developing a new state-of-the-art rehabilitation program. I brought with me a background in inpatient neurorehabilitation. The program we created focused on function. In the case of our workers' compensation clients, that function was primarily focused on return-to-work (RTW). I also incorporated the program evaluation principles that had become so familiar to me on the inpatient neurorehabilitation unit. The data we collected and reported to our referral sources is what would today be referred to as "outcomes." The use of the data to demonstrate the success of our treatment received overwhelming support from the case managers and employers with whom we worked. Very quickly our workers' compensation caseload increased to well over 60% and the demand for our data and our services grew. For me it was the beginning of a very successful relationship with business and industry.

I first became involved in providing onsite therapy services in 1995. The program strategy I've developed is rooted in my initial experiences in outpatient orthopaedic spine rehabilitation. The onsite programs are comprehensive in nature and incorporate much more than traditional clinic-based therapy services. In fact, traditional clinic-based therapy services are often de-emphasized in the onsite environment. These onsite program strategies have been successfully implemented for some of the largest employers in the country. The outcomes of these programs tell the story of its success.

HIGHLIGHTS OF SUCCESS

- Decreased new hire injury rate by 72%
- Decreased overall injury rates up to 50%
- Decreased reinjury rates up to 60%
- Decreased lost work days up to 38%
- Decreased rehabilitation costs up to 52%
- Decreased average visits/case to 6.4 from a community-based average of 10+
- Improved worker morale with employee satisfaction rates > 93%
- Decreased legal exposure in the RTW process by providing objective, legally defensible assessments

For each employer, the above percentages can be translated into both direct and indirect costs savings that can be applied to the company's bottom line. The value of onsite programs is found in the amount of money the company saves. One should be able to translate outcomes into actual dollars saved. Specific outcomes are in part dictated by the specific needs of that company. I have been most successful in implementing and expanding onsite programs that are able to provide a significant cost savings within the first year of implementation. Success must be early and it must be significant to be of value.

MY APPROACH

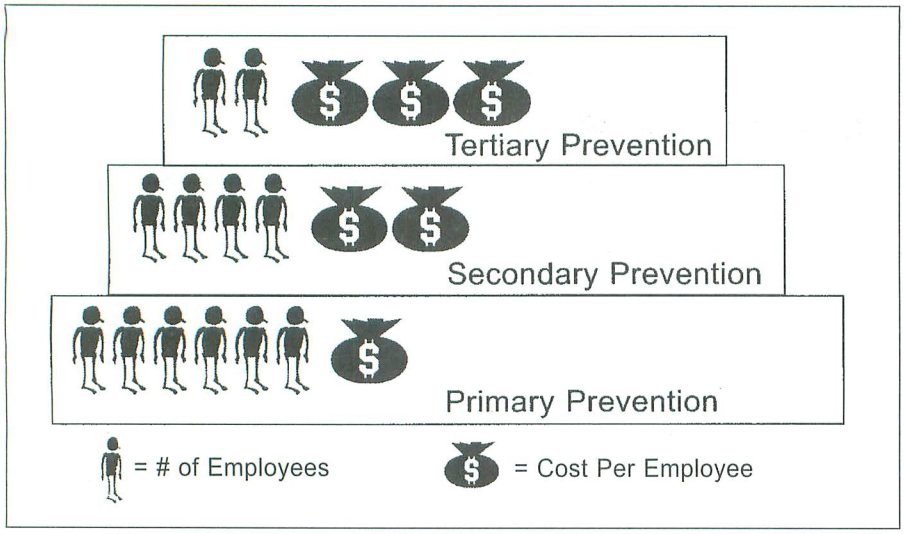
Onsite therapy provides the best opportunity to bring effective industrial therapy programs to business and industry. The program philosophy I advocate is one of *prevention*. Prevent the injury from occurring (Primary Prevention). Identify the signs and symptoms of injury early to prevent restricted or lost workday injury (Secondary Prevention). Effectively manage an injury for a safe and effective RTW to prevent reinjury (Tertiary Prevention). I believe the most effective programs are those that have been *customized* to meet the specific needs of the company site where services will be provided. A program's success can be demonstrated by providing measurable, objective *outcomes* that are meaningful to the employer. In my experience, a meaningful outcome is one that demonstrates cost savings.

ONSITE PREVENTION PROGRAMS

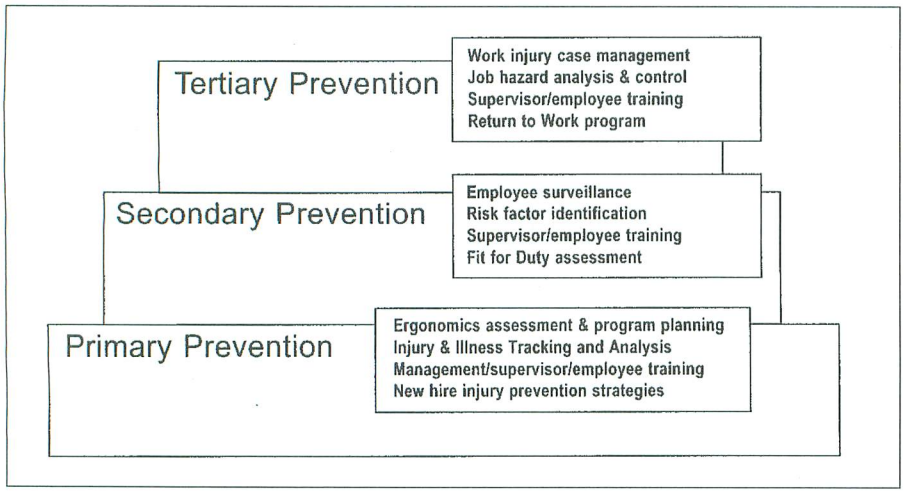
A successful program depends upon the effective integration of human resources, safety, medical, management, employee/union representatives, and rehabilitation. Injury prevention and management onsite crosses over and is impacted by management and human resource policies, union contracts, state workers' compensation law, productivity requirements, and quality controls. An onsite program that operates in isolation of the employer rather than as a member of the employer's team will have a much more difficult time making significant improvements. As a member of the team the therapist is able to take advantage of the expertise and knowledge of the other members. Our expertise lies in the prevention and treatment of musculoskeletal disorders. We need to remember that we are not the experts in the operation of that business. All recommendations for programs or services or specific employee interventions should be feasible and realistic for the environment. We provide recommendations and the team makes decisions. Keep in mind that we are there to have a positive impact on the company's bottom line.

Primary prevention programs involve all employees and typically become part of the new hire process. Secondary prevention programs emphasize both passive and active surveillance in an effort to identify the signs and symptoms of work injury and illness. These strategies help identify high-risk employees and facilitate early intervention. Tertiary prevention programs manage cases where an injury has occurred. The emphasis is placed on preventing disability, maintaining/returning the employee to work in a safe and timely manner, and preventing reinjury. Rehabilitation should focus on the specific abilities required to perform the job.

Program Costs



Sample Program Services



The costs and the percentage of the workforce involved vary based on the prevention strategy. The specific program services implemented are customized for each worksite and should be determined in conjunction with the employer based on an initial assessment.

EMPLOYER ASSESSMENT

Effective onsite program development begins with an assessment of the workplace. Begin by meeting with management and requesting information to complete a record review. The records reviewed should include the OSHA 200 Log, First Aid Cases, Workers' Compensation Claims information, and Safety Department Records. Review 3 to 5 years of records in order to establish trends. At minimum, the OSHA 200 Log should be available. The employer is required by Federal law to post it annually.

The OSHA 200 Log includes the number of injuries, illnesses, as well as the number of lost and restricted workdays. It will allow you to determine the company's incidence rate (number of injuries and illness per specified number of hours worked) and severity rate (# of lost/restricted workday injuries and illness per specified number of hours worked). It also will provide the total number of lost and restricted workdays. First Aid Cases are those in which an incident has occurred but did not meet the criteria to be included on the OSHA 200 Log. Workers' Compensation Claim information will provide insight into the amount of dollars being spent and where those dollars are going (rehabilitation, diagnostic testing, surgery, etc.). Safety records should be reviewed for any programs related to the prevention or response to work-related injury or illness. Some employers may not share the Workers' Compensation or Safety information until you have established a working relationship.

The assessment will help you to identify high-risk areas. Remember, you want to make a significant impact early so high risk areas should be a higher priority. Meet with representatives of management, human resources, medical, safety, and employee/union to discuss your findings. You need to get a feel for the corporate culture and those strategies that are best suited for implementation in this specific environment. Implementing strategies that will not be fully supported are doomed to failure. A successful strategy has a high potential for success based on both need (high risk area) and feasibility/employer support. Work with the employer to:

- determine and prioritize program strategies;
- set specific, measurable goals to include timeframes; and
- use the information gathered during the assessment to establish benchmarks by which you will measure future program performance.

The most common outcomes used in the onsite environment are related to injuries and illnesses. The most important factor related to cost is the number of lost workdays. Reducing lost workdays is one of the most effective ways to reduce employer costs. Some of the most common outcomes include:

- incidence rate,
- severity rate,
- total number of lost workdays,
- total number of restricted workdays,
- average number of lost workdays/case,
- number of new hire injuries within the first 12 months of employment, and
- number of reinjuries within the first 12 months of case closure.

You may use OSHA's cost figures to estimate onsite program savings. OSHA states that lost/restricted workday injuries cost employers an average of $27,700 per injury while injuries and illness not resulting in lost/restricted workdays cost employers an average of $7,000. OSHA's cost estimates include indirect costs resulting from lost productivity, worker replacement, and workers' compensation administration. If you're using actual workers' compensation claims information be sure to include the cost for administration of the program. And don't forget to include the cost of the onsite program when determining company savings.

Onsite programs offer many advantages over community-based programs.

Among them are earlier intervention, improved communication with the employer, and more accurate information regarding the physical requirements of the job. These will often positively impact treatment that often result in decreased visits per case. It is beneficial to compare average visits per case onsite with that found in the community. This can also be a significant source of cost savings.

OUTCOMES REPORTING

It is important to establish up front what information the employer is willing to provide to you and at what intervals. Some employers I've worked with did not share information because they did not have a process in place to collect it. You will find employers who will track only that which is required by law. Often times these employers will only provide the information required by the OSHA 200 Log and only on an annual basis. Some employers who use Third Party Administrators (TPAs) to administer their workers' compensation programs may not have specific information. You may or may not, with the employers help, be able to obtain information from the TPA. You should be able to track much of this information on your own. It is your responsibility. I've developed an outcomes and utilization database to track much of this information independent of the employer. I have found the information invaluable in demonstrating program success, justifying program expansion, and in selling onsite services to perspective employers. You must be able to demonstrate your value if you want to work with business and industry. And remember, that value most often comes from saving money.

THE STORY HAS A HAPPY ENDING

When I speak with people about this topic I enjoy being able to say that when done right, I've never been involved in an onsite program that hasn't had a positive impact on work injury prevention and management. There are many opportunities for therapists to provide these services. For those of you new to the business environment, I encourage you to take some time to prepare yourself before you start. *It is a very* different world from that of health care. Be prepared. For those with Internet access visit the OSHA website at www.osha.gov to begin to explore the topic from the employers point of view. It is also helpful to visit your state's workers' compensation site. Laws vary from state to state and you need to understand the basic requirements of your state. Remember to listen and be open-minded. There is no one-way to make these programs work. Onsite programs can provide an opportunity to for everyone to win.

Diane Kolarczyk, PT is a work injury specialist in Crown Point, Indiana.

(Continued from page 8)

Modification if Needed

After the incumbent testing is complete, necessary modifications in procedure, minimum requirements, or scoring can be made. Now is the time to change any forms or procedures. If significant changes are made, it may be necessary to perform another round of incumbent testing.

Implementation

If the planning work has been thorough with policies and procedures in place and if incumbent testing has worked out all the kinks, the implementation phase is much easier by comparison. Most employers are expecting you to spend approximately 30 to 60 minutes with the applicant. The charge varies greatly according to geographic region and market. Typically the price ranges from $50/test to $150/test.

Tracking Outcomes

The decision regarding which outcomes to track should be one that is made *prior* to implementing the screen. Having some baseline data to which post implementation data can be compared is helpful. Without knowing the injury and severity rates prior to implementing postoffer screening, how can the employer know whether the screening was helpful? Collecting information regarding cost of the injuries may be more of a challenge, especially if data from human resources and safety has not been linked to payroll data. A good question to ask the employer is: How will you know if this prework screening program has been successful? Making sure that both you and the employer have the same criteria for success is extremely important. Ask to see baseline data prior to implementation. Once the screens have been in effect for 6 months, it is helpful to start asking about injury and severity rates to determine if your process is beginning to have the desired effect.

IN SUMMARY

The prework screening process provides an opportunity for the therapist to serve industry and workers. To be legally defensible and ADA and EEOC compliant, however, takes careful planning and preliminary testing prior to program implementation. The testing should have face validity and the process should be consistent.

Deborah Lechner, PT, MS is the current President of the Occupational Health Special Interest Group and the President of Ergo Science, Inc.

Ergonomics

Employee Education & Ergonomic Workstation Evaluation: A Perfect Fit for Physical Therapists

Marnie Myhre, PT, MS

In spite of the recent setback dealt to the OSHA Ergonomic Standard in Washington, ergonomics is alive and well in 21st century America. Ergonomists come from many different disciplines: engineers, psychologists, occupational and physical therapists, and exercise physiologists, to name a few, bringing a variety of perspectives to the job of fitting the task to the worker. The physical therapist's special knowledge of the musculoskeletal system and kinesiology provide us with an opportunity to have a positive impact in a realm outside the clinic, an opportunity that we might easily overlook. I was asked recently by a safety director to provide ergonomic training to a group of engineers. I somewhat hesitantly explained that my background was in physical therapy bringing the medical perspective to the field and not the design area. She responded enthusiastically—that was exactly what her engineers needed. Though professionals in each of these disciplines are working toward a common goal, too often one perspective can be overlooked, providing an opportunity for others with different skills and backgrounds. Two key components of an ergonomic program are education and ergonomic workstation evaluation. The physical therapist specializing in ergonomics can offer these valuable services to clients outside the clinic setting.

EDUCATION FOR EMPLOYEES

Ergonomic training for companies and industries offers physical therapists an opportunity to utilize their natural skills of education in anatomy, posture, and exercise; skills that physical therapists apply daily in their work with patients. The overall goal of ergonomic training is to reduce the incidence of workplace injuries by increasing awareness of ergonomic principles and workstation design, thereby improving posture and minimizing muscular fatigue. Training is most effective when customized for each company's employees and workstations. Prior to on-site training, ergonomic instructors should become familiar with the work performed at each company and incorporate photographs, or other direct references that work into training sessions for employees. Participants can therefore see directly how modifications can affect their own work situations.

Ergonomic training sessions should cover necessary information regarding anatomy and the injury process responsible for repetitive motion and back injuries, now called Musculoskeletal Disorders (MSD). Training should then emphasize the ergonomic principles necessary to minimize stress and fatigue on the muscles, joints, and nerves that are caused by awkward postures and positions, repetition, force, vibration, and contact stress. Photographs of employees performing tasks properly and improperly, from the ergonomic perspective, can help to effectively illustrate the impact of each of these factors.

Ergonomic training is most effective if designed to be participatory in nature. The training session needs to be open to discussion and problem solving by the participants. Having slides of employees in different positions at their workstations encourages employees to identify problems in the work place and to trouble shoot to develop possible solutions to ergonomic problems. Hopefully, they can then take this information back to their worksite and make the necessary changes to their workstations or offer suggestions to their supervisors regarding how to do so.

Education in exercise and proper stretching technique also is important, as muscles get tight from repetitive or static work. Stretches must be covered in great detail; focusing on the muscles being stretched and making sure all the stretches are being performed correctly. One company that implemented an effective ergonomic training and stretching program saw great benefits in reducing costs related to MSD workers' compensation injuries. That company enjoyed a cost savings of over $100,000 as a result of significantly reduced numbers of lost workdays due to MSDs.[1]

ERGONOMIC WORKSTATION EVALUATION

Beyond issues related to worker education and training, ergonomic analysis also involves the measurement and evaluation of workstations and work methods involved in a job or task. The objective of the evaluation is to have direct, hands-on analysis of the actual working procedures in the department or of the employee to clearly identify workstation design or work method problems and also positional and body mechanics issues.

This analysis can begin with a questionnaire given to the employee(s) being evaluated. Responses provide valuable information concerning the work tasks themselves, the amount of time workers spend completing each task, and the perception workers bring to their job. While the employee is completing the form, measurements of the workstation height, equipment position, and heights, weights, and reaches can be taken.

The next step in the analysis involves the observation of the employee doing what they regularly do on the job. For an office worker this may entail a relatively simple observation of how they set up and perform keyboard work if that is their main task. For a pharmacy technician this may involve following them around the hospital loading medications into the necessary containers on the floor and determining the frequency of various wrist movements and shoulder reaches. For a stockroom worker this may involve assessing the amount of weight lifted or push/pulled, at what angles, and how far. Here the NIOSH lifting equation may be applied to determine the force generated at the low back by the lifting required by a particular task.[2] Jobs that involve high frequency repetitive movements can be captured on video and reviewed later

to examine finer wrist and hand movements and determine frequencies that can be difficult to gather at the time of the analysis. All of this data must be recorded, and there are many forms available for that purpose. The old Ergonomic Standard (www.osha.gov) lists some, NIOSH includes many in their Elements of Ergonomics Program (www.cdc.gov/niosh)[3] and Comprehensive Loss Management, Inc. (clmi-training.com) offers many such forms as a supplement to the various ergonomic safety programs they offer.

Once these observations and measurements are recorded it is essential to elicit ideas directly from the employees regarding changes they would like to make on workstation design and job performance. Many times employees will have the best ideas concerning how to improve their jobs. Also, ideas generated by employees and supported by a professional, with appropriate ergonomic modifications, will have a better chance of being accepted by the employees they most directly affect. Discussion and the development of trust are important in this endeavor. When possible, it is best to perform these evaluations without the supervisor present to facilitate a more open discussion. One-on-one discussions may disclose other issues involved; occasionally managerial/employee relation concerns can aggravate the injury process and must be addressed.

An integral part of the worksite evaluation is ergonomic education and training for the individual employee. My experience has shown that there is more acceptance of necessary changes to work and workstations when awareness of postures, body mechanics, and ergonomics is included in the analysis. Also, incorporating education in proper stretches appropriate to the type of work performed is important. Stretching and changing positions through different work tasks or taking regular rest breaks is important in minimizing the strain many jobs place on the body.

Any report that is generated needs to summarize the analysis of work methods, posture and positions, and general body mechanics observed along with recommendations for optimal physical parameters and positioning for workstations and equipment. If engineering or physical design controls will be particularly difficult or expensive to implement, a report of administrative recommendations, such as timing of breaks and potential job rotation or job enlargement, increasing the variety of tasks in a job, can be offered.

EFFECTIVENESS

Ample evidence of the effectiveness of ergonomic programs has already been supplied by OSHA in support of the Ergonomic Standard that recently fell victim to political pressure in Washington. Ergonomic programs are effective and necessary to reduce worker's injuries due to MSDs and the workers compensation costs related to them. More evidence of the value of ergonomic programs for companies can be found in "Ergonomics That Work,"[4] a compilation of case studies put out by CTDNews which explains how individual companies have cut workers compensation injuries, lost workdays, and ensuing costs through ergonomic programs. Ergonomic programs work and are good for business. They have been proven to increase productivity, decrease cost, and increase workers' morale. Employee education and ergonomic workstation evaluation are two essential components of the effective ergonomic process, and physical therapists already possess the essential, basic tools for implementing both.

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Marnie Myhre, PT, MS is Manager of Ergonomic Services at Comprehensive Loss Management, Inc.

Book Reviews

Coordinated by Michael J. Wooden, PT, MS, OCS

Castro WH, Jerosch J, Grossman TW: *Examination and Diagnosis of Musculoskeletal Disorders: Clinical Examination; Imaging Modalities*. New York, NY: Thieme; 2001:464 pp., illus.

Examination and Diagnosis of Musculoskeletal Disorders is written by 3 physicians and is intended for orthopaedic surgeons and residents. The text was originally published and copyrighted in 1995 and 1996 in Germany and has recently been translated to the English language by the third author. The purpose of the text is to provide the reader with an in-depth and comprehensive review of examination and imaging techniques for the spine and extremities. Each chapter is dedicated to a particular body part and includes the history component, physical examination (including special tests), and the specific imaging modalities used for diagnosis. Imaging studies presented in the chapter entitled "Spine," for example, include radiology, ultrasound, myelography, nuclear medicine studies, computed tomography, magnetic resonance imaging, discography, and diagnostic injection techniques. Additional imaging studies described throughout the text include pedobarography for the foot, arthrography for the extremities, and tenography for the ankle. Other topics discussed within the imaging component of each chapter are standard and special views, and normal and abnormal findings. In addition, much attention is given to various musculoskeletal diseases and disorders.

Examination and Diagnosis of Musculoskeletal Disorders contains a substantial collection of photographs, drawings, and diagnostic images. With over 1100 illustrations, this text provides the reader with ample opportunity to further comprehend examination techniques and imaging studies. Of particular interest and clarity are images of 3-dimensional CT reconstructions for the spine and extremities.

Although this book is intended for the orthopaedic surgeon and resident, its value as a reference for the physical therapist cannot be overstated. The physical examination component of each chapter outlines key points in the history and physical examination that are clinically useful to the physical therapist. While the sections on imaging studies may provide more detail than the therapist might appreciate, this vast amount of information serves as an excellent resource for further comprehension of musculoskeletal disorders and the diagnostic imaging tests associated with them.

I would not recommend this book if it were to be considered for the sole purpose of learning more about physical examination, since other texts provide greater depth and breadth of material on that topic. However, I would recommend this text as a means to introduce a complete clinical picture of musculoskeletal disorders by its systematic presentation of patient history, physical examination, and related diagnostic images.

Castro and his coauthors have succeeded in producing a well-organized and comprehensive addition to the orthopaedic literature. It is a highly recommended addition to the orthopaedic physical therapist's library.

Phyllis Clapis, PT, MS, OCS, CSCS

Maitland G, Hengeveld E, Banks K, English K.: *Maitland's Vertebral Manipulation*, 6th ed., Boston, Mass: Butterworth Heinemann; 2000:472 pp., illus.

This is the 6th edition of Geoffrey Maitland's classic text, *Vertebral Manipulation*. The strengths of the previous editions have been retained and there are some notable additions. Throughout the book, key concepts to be emphasized are highlighted, providing the reader with quick references to important information. Chapters dealing with prognosis and physical therapy for animals have been added.

The book consists of 16 chapters and 4 appendices. References are listed throughout the text and also can be found in the bibliography. Similar to previous editions, a glossary is found in the beginning of the text so that the reader will be clear about what they are reading. The first chapter serves as an introduction to the concepts put forward in the remainder of the book. The second chapter is written from the physician's viewpoint and touches on those patients who may present with nonmusculoskeletal pathology and the indications/contraindications for manipulative therapy. Communication is the topic of the third chapter. Communication with patients is one of the cornerstones to Maitland's approach and has been stressed in past editions, and this remains unchanged. This chapter is one of the reasons why this text is considered a classic.

The fourth chapter examines the importance and relevance of assessment. The fact that this is a dynamic and cooperative process is stressed. Prognosis is the focus of the fifth chapter. This is a unique section because the physiotherapy prognosis—not the medical prognosis—is stressed. The assessment and reassessment of the patient is integral to developing a prognosis, as is keeping an open mind.

Patient examination is the title of the sixth chapter. The subjective and physical examination processes and specific tests are reviewed. More importantly, the planning of one's examination relative to establishing a hypothesis is discussed at great length. The principles, selection, and application of techniques are covered in the next 3 chapters. The thought process that a clinician should perform when selecting a technique is described in the format of graphs, as well as expounded upon in the text. It also is stressed that the signs and symptoms with which the patient presents will dictate the treatment choice, not their diagnostic label.

Specific examination and treatment techniques for the regions of the cervical spine to the intercoccygeal regions make up the content of chapters 10 to 14. The sketches that illustrate the various procedures are clear and numerous. For each of the regions, specific subjective and objective data is stressed as appropriate. Body charts are used along with case histories as

teaching tools. Chapter 15, Examples of Treatment, gives 24 case histories. This is one of the more valuable sections of the book as it provides the connection between the material in the text and the patients that are encountered clinically.

Physiotherapy for animals is the topic for the last chapter, a notable addition. Drawings were included that demonstrated cervical vertebral mobilization of a horse under anesthesia. If there was a section of the text that could have been omitted, this would be it. While veterinary physical therapy may be increasing in popularity, I feel that this book should stay focused on humans.

The 6th edition of *Vertebral Manipulation* is clear and concise. It maintains the common themes of constant communication, assessment, intervention, and reassessment through the text. This book should be a fixture in every physical therapist's library regardless of the setting in which they practice.

Jeff Yaver, PT

Cantu R, Grodin A. *Myofascial Manipulation, Theory and Clinical Application,* 2nd ed. Gaithersburg, Md: Aspen Publishers Inc.; 2001:261 pp. illus.

Cantu and Grodin bring their years of experience as manual therapists and instructors in the beautifully illustrated book, *Myofascial Manipulation. Myofascial Manipulation* is a book not meant to be an exhaustive review of the literature but techniques that Cantu and Grodin have used effectively in the clinic. This is the 2nd edition of *Myofascial Manipulation* with the first being very successful (1992). The 2nd edition has strengthened its scientific foundation on the chapters of neuromechanical aspects of myofascial pathology, muscle pain syndromes, and histopathology of connective tissues. This book is written for the manual therapy audience. Myofascial techniques are designed to be used in conjunction with joint mobilization and exercise.

The authors emphasize the need for manual therapists to have an appreciation of the historical basis for myofascial manipulation (Chapter 1) to gain a greater appreciation of the current field of manual therapy. Modern theories and systems of myofascial manipulation (Chapter 2) are reviewed that have influenced the authors the most over the years. The authors stress that for a manual physical therapist to be successful in treatment of the myofascial tissues, he or she must have a thorough understanding of histology and biomechanics of myofascial (Chapter 3), histopathology of myofascia and physiology of myofascial manipulation (Chapter 4), neuromechanical aspects of myofascial pathology and manipulation (Chapter 5), and muscle pain syndromes (Chapter 6). The muscle pain syndrome chapter was particularly strong. It explored the etiology, symptomatology, pathophysiology, and medical/therapeutic management of common pain syndromes (fibromyalgia, myofascial pain syndrome, and soft tissue lesions). This chapter discusses the role of the physical therapist and physician in the evaluation and treatment of these conditions. This chapter has 447 references regarding muscle pain syndromes.

The bread and butter of this book are the chapters on evaluation and treatment of the myofascial system. The evaluation chapter discusses the examination of impairments and diagnosis followed by a variety of treatments for these impairments. Chapter 8 illustrates the treatments for impairments with an atlas of therapeutic techniques. Expanded from the 1st edition, the techniques have photographic illustrations with the purpose of the treatment, patient position, therapist position, hand placement, and execution for each technique.

Cantu and Grodin bring art and science in the book *Myofascial Manipulation*. It is a text that provides easy and quick access to techniques that can be used in the clinic. I highly recommend this text to all that practice manual therapy.

Daryl Lawson, MPT, PT

Manheim CJ. *The Myofascial Release Manual*, 3rd ed. Thorofare, NJ: Slack Inc., 2001:277 pp, soft cover, illus.

The Myofascial Release Manual is a how-to book for myofascial release techniques. The purpose of this 3rd edition as stated in the preface is to answer many of the common questions asked by therapists learning myofascial release.

The text is divided into 5 sections. The first section provides a brief but complete overview of myofascial release. This section has several contributing authors. Conceptual and anatomical constructs of myofascial release are presented. An interesting history and evolution of myofascial release is outlined. General indications, precautions, and contraindications are described adequately. The author also has valuable advice on how to learn the techniques.

Section 2 details basic myofascial release techniques for the upper and lower quarter. Gross and focused stretches are presented for almost every muscle or body region. Both photographs with descriptions and detailed descriptive text are used for each technique. Force vectors of stretch are included in all photographs.

Section 3 describes more advanced myofascial release techniques. Included in this section are releases for: diaphragm, pelvic floor, anterior chest wall, myofascial trigger points, scar mobilization, strum release, dural dysfunction, and combined releases.

Section 4 focuses on evaluation and initial assessment. This section briefly describes the evaluation process and general considerations. This section seems to be out of sequence with the rest of the book but is informative.

The last section of the text provides information about additional resources including references, index, and posture evaluation charts.

Overall, this text is well organized with a strong attention to detail both in written descriptions and photographs. This subject matter does not easily translate into written text, yet the author and her contributors have done an excellent job of conveying the "feel" of the techniques.

I would highly recommend this text for any clinician interested in manual therapy. This text is an excellent reference for physical therapy students and experienced clinicians alike. This text is not recommended for those looking for validated critical review of myofascial release. Ideally, the techniques described would be best learned if facilitated by continuing education or mentoring with a manually-trained professional.

Timothy J. McMahon, MPT, OCS

Kumar S. *Multidisciplinary Approach to Rehabilitation.* Boston, Mass: Butterworth-Heinemann; 2000:383 pp., hard cover, illus.

As mentioned in the preface, the goal of this book was to "draw the attention of entry-level professionals to broader aspects in rehabilitation that affect their clients and themselves." Nineteen individuals representing many different rehabilitation disciplines contributed to this book, making it a comprehensive source of current multidisciplinary ideas.

The book contains 16 chapters. The first 3 chapters introduce the reader to the rehabilitation team, describe teamwork in rehabilitation, and discuss ethical dilemmas that members of the rehabilitation team may encounter. The next several chapters address more specific issues, including clinical reasoning and decision-making, case management, cultural diversity and health behavior, attitudes toward disability from the perspective of both the health professional and client, and sexuality among individuals with disabilities. I thought the chapter on clinical reasoning and decision-making was particularly useful and well written. In this chapter, the authors discuss the nature of sound clinical reasoning and decision-making, common errors in the process, and the key dimensions of collaborative decision making.

Important clinical issues are discussed in chapters describing functional assessment, ergonomics, and vocational rehabilitation. In a chapter on health promotion, the author describes the challenges associated with health promotion and discusses different models that may serve as the framework for multidisciplinary approaches to health promotion. Some "nonclinical" aspects of rehabilitation are discussed in chapters dealing with clinical supervision, administrative and legal issues in rehabilitation, and the role of rehabilitation professionals as consultants in business and industry.

Despite having several contributors of varying backgrounds, this book is written in a consistent manner throughout. Extensive reference lists are provided for each chapter. Several of the chapters have case studies, which assist in the practical application of the material. While this book is comprehensive and very well written, it would have been strengthened with a chapter discussing the psychosocial aspects of rehabilitation. Nonetheless, this book is highly recommended for entry-level physical therapists and physical therapist students.

Michael D. Ross, PT, DPT, OCS

Request for Recommendation for Orthopaedic Section Offices

The Orthopaedic Section of the APTA needs your input for qualified candidates to run for the offices listed below. If you would like the opportunity to serve the Section or know of qualified members who would serve, please fill in the requested information. Return this completed form to the Section office by July 2, 2001. The Nominating Committee will solicit the consent to run and biographical information from the person you recommend.

Print Full Name of Recommended Nominee

Address

City, State, Zip

(Area Code) Home Phone Number Office Phone Number

Nominator

Address

City, State, Zip

Phone

is recommended as a nominee for election to the position of:
CHECK THE APPROPRIATE POSITION:

☐ **DIRECTOR:** (3 yr. term)
Takes on the responsibility and duties and acts as liaison to various committees as designated by the President.

☐ **TREASURER:** (3 yr. term)
Should have good working knowledge of accrual accounting, annual and long range budgeting, reserve funds and investment strategies. Nominees will have served on the Finance Committee for no less than one year from the time they would assume the office of Treasurer.

☐ **NOMINATING COMMITTEE MEMBER:** (3 yr. term; 2 yrs. As member, 1 yr. as Chair)
Should have broad exposure to membership to assist in formation of the slate of officers.

PLEASE RETURN BY JULY 2, 2001
TO:
Stefanie Snyder, Orthopaedic Section, APTA, Inc.
2920 East Avenue South,
Suite 200, LaCrosse, WI 54601

Occupational Health Physical Therapists Special Interest Group

Orthopaedic Section, APTA, Inc.

Summer 2001 Volume 13, Number 2

MESSAGE FROM THE PRESIDENT

As the Occupational Health SIG moves into the second quarter of 2001, I feel a distinct sense of pride as I look at our recent accomplishments and anticipate upcoming projects. As President, I am particularly proud of our Board members for their dedication and hard work, without which none of this would have happened. I'd like to take this opportunity to update you on the progress of some of our old and new projects.

I also invite you to read the main body of *OPTP*. This quarter is a special issue related to the practice of Occupational Health Physical Therapy! The Orthopaedic Section editorial staff's choice of Occupational Health as the special issue topic speaks to the importance of this expanding area of physical therapy practice. While some other opportunities in physical therapy practice are shrinking, Occupational Health opportunities continue to grow! If you are not a member of the OHSIG, it's easy to join! Just contact the Orthopedic Section office 800-444-3982 and ask to be placed on our membership list. No pain. No money. It's that simple!

Practice Guidelines

We are wrapping up our compendium of guidelines. Our 2 final sets of guidelines: Legal and Risk Management and Injury Prevention have been approved by the APTA Board of Directors. We are currently investigating mechanisms for publication by APTA. Our goal is to have this publication issue resolved by the end of 2001. Thanks to the entire OHSIG Board of Directors, Committee Chairs, and Members-at-Large who participated in the development, critique, and revision of these guidelines. A special thanks goes to Bonnie Sussman for her tireless pursuit of APTA BOD approval and her continued work to get these guidelines published.

Membership Needs Survey

Our recently revised Membership Needs Survey is published on our website. Here's your opportunity for input! Go to the web site, fill out the survey, and let us know your opinions on CSM programming, specialization/certification in occupational health physical therapy, and the O*NET. Tell us how we can best meet your needs as a member.

Web Page. Check out our new webpage! www.orthopt.org

Bylaws

Our Vice President, Bonnie Sussman, is in the process of revising our bylaws. The primary goal of this revision is to bring OHSIG bylaws into compliance with the bylaws of the Orthopaedic Section. Our revision should be complete by mid-2001.

2001 CSM Programming

Our 2001 CSM programming was a big success!! Our speakers provided excellent insight as to the development and details of the new OSHA Ergonomics Standards. Information also was provided regarding the services and resources available through OSHAs Web site that might assist physical therapists as they work in the field of work-related injury management and prevention. Although the standards were recently repealed by Congress, the information presented will assist those who attended as they develop ergonomic and injury prevention programs for business and industry.

2002 CSM Programming

We have exciting preliminary plans for our upcoming CSM programming in Boston! Bonnie Sussman will be presenting a preconference workshop on Office Ergonomics. We will cosponsor programming during CSM with the Hand Rehabilitation Section that addresses research and clinical practice relative to office seating and computer input devices (mouse and keyboard). In addition, we will be hosting our annual business meeting and hot topics forum. We'll keep you posted as details emerge.

Research Retreat

Our Research Committee, under the leadership of John Stevenson, PT, PhD, is planning a research retreat for the summer of 2002. Topics and speakers are to be decided but an overall theme is likely to be the Effectiveness of Ergonomic Interventions. Our goal for the retreat is to assist with dissemination of the most recent research regarding the effectiveness of ergonomic intervention, particularly as it relates to the office environment. The presenters will focus on clinical research with emphasis on take-home information that therapists can use in their daily practice. We also hope that a discussion of current research will spark ideas and interest in future research as the gaps in our knowledge are identified by the presenters. John is looking for committee members who might be willing to assist with the planning, arranging, and reviewing abstracts for this retreat. If you are interested, please contact him at 616-895-2675 or Stevensj@gvsu.edu.

Practice Analysis Grant

Ken Harwood, PT, PhD will spearhead our application process for obtaining a practice analysis grant from the

Orthopaedic Section. We view the practice analysis as the first step in helping the OHSIG define the practice of physical therapy as it relates to occupational health. The information learned through such an analysis of our practice will help us decide whether and how to approach credentialing and/or certification of physical therapists in this area of practice. We plan to submit this grant application for fall of 2001. If awarded, the practice analysis process would begin in January 2002 and may take up to 12 to 18 months to complete. The completion of a practice analysis is no small undertaking. Ken will be assisted by members of the OHSIG Board in this process and we welcome any volunteers who would like to assist him and us in this effort. If you are looking for a research thesis, this may be an opportunity for you! If you are interested in helping with the grant application process or carrying out any aspect of the process once we begin, contact Ken at 212-305-1649 or kh111@columbia.edu.

O*NET Response

Donna Bainbridge from the APTA Office of Practice solicited our assistance with responding to the Department of Labor's and the International Association of Rehabilitation Professionals' request for input on O*NET. O*NET is the proposed replacement for the current Dictionary of Occupational Titles and has been developed largely without input from the rehabilitation or medical communities. Our lack of input has resulted in a classification that may be very challenging to use for the purposes of rehabilitation and disability determination. The DOL turned to IARP who in turn has invited other professional rehabilitation associations to participate in an interagency task force to provide input on O*NET. As President of the OHSIG, I assisted Donna in identifying experts to review materials and the appropriate materials for review. Donna is in the process of collating expert responses into a paper that will summarize the experts' viewpoints. I will be serving as liaison to the AOTA and IARPS as we work together on the O*NET issue.

Home Study Course

Frank Fearon, Associate Professor at North Georgia College and State University will coordinate our next home study. Frank will identify potential topics and related authors to be submitted to the OHSIG for discussion and approval at our next conference call.

Welcome New Secretary

Karen Elton was recently appointed as our new Secretary to complete the term vacated by Michael House. Karen practices in Bend, Oregon and has 16 years of experience in industrial rehabilitation. She currently coordinates the Work Injury Management Programs for 55 Therapeutic Associates offices in the western U.S. In addition to her administrative responsibilities, she also performs direct patient care and worksite consultation. She brings extensive knowledge of practice in the area of assessment, treatment, and prevention of work-related injuries. We welcome her and appreciate her valuable input and dedication.

Clinical Research Network

Have you heard about the proposed Clinical Research Network funding that is being planned by the Foundation for Physical Therapy? The Foundation is actively fundraising with a goal of nearly $2,000,000. Their hope is that funding for the CRN will begin toward the end of 2002. They are getting close to being able to issue the request for applications! The purpose of this network is to promote collaborative research to evaluate the effectiveness of physical therapy practice. For further information, to donate, or to get your questions about the CRN answered, contact the Foundation for Physical Therapy at 800-875-1378 or through e-mail at foundation@apta.org.

In closing, I'd like to restate my appreciation to our hard-working Board members and invite any of you out there to participate on committees. We need members for the Practice, Research, Membership, and Education committees. I look ahead to the remainder of 2001 as a productive and energetic time as we move the practice of Occupational Health Physical Therapy forward!

Deborah E. Lechner, PT, MS
President

CALL FOR NOMINATIONS

This Fall, the Occupational Health Physical Therapy Special Interest Group will be electing two officers, Vice President and one member of the Nominating Committee.

Both terms are for three (3) years, commencing February 2002. The Vice President serves as a voting member of the OHPTSIG Board of Directors. The member of the Nominating Committee elected this year will be Chairperson of the Nominating Committee during the third year of his/her term (2004-2005).

Nominations for these two positions are now being solicited. Self-nominations are acceptable. The Nominating Committee will contact individuals suggested to verify interest, and to obtain any necessary information on personal background. Those making nominations need to supply a full name, address, telephone number, and e-mail address if possible for a potential nominee. The Nominating Committee will take care of the rest of the work.

Nominations should be submitted by mail, fax, or e-mail to:

Scott D. Minor, PT, PhD
OHPTSIG, Nominating Committee
Washington University School of Medicine
4444 Forest Park Blvd., Campus Box 8502
St. Louis, MO 63108
(314) 286-1432 (voice)
(314) 286-1410 (fax)
minors@msnotes.wustl.edu (e-mail)

The deadline for submissions of names to the Nominating Committee is *August 17, 2001.* The final slate of candidates will be available *September 1, 2001.*

OHSIG Officer Listing

PRESIDENT	**Deborah Lechner, PT, MS** ErgoScience, Inc 4131 Cliff Rd Birmingham, AL 35222 Ph: 205 595-4536 Fx: 205 592-9528 Email: deborahlechner@ergoscience.com
VICE PRESIDENT	**Bonnie Sussman, PT, MEd** Cioffredi & Associates Physical Therapy PO Box 727 Lebanon, NH 03766 Ph: 603 643-7788 Fx: 603 643-0022 Email: bsussman@tpk.net
TREASURER	**Mark Blankespoor, PT** 1316 N Prairie St Pella, IA 50219-1383 Ph: 641 621-0230 Fx: 641 621-0319 Email: worksystems@lisco.com
SECRETARY	**Karen Jean Elton, PT** Physical Therapy Associates 2600 NE Neff Road, Ste B Bend, OR 97701-6337 Ph: 541-389-1387 Wk: 541-388-7738 kelton@taiweb.com
PRACTICE & REIMBURSEMENT	**Kenneth J. Harwood, MA, PT, CIE** Columbia University 710 West 168th St, 8th Fl New York, NY 10032 Ph: 212 305-1649 Fx: 212 305-4569 Email: kh111@columbia.edu
RESEARCH	**John Stevenson, PhD, PT, CEA** Physical Therapy Program 318 Henry Hall Grand Valley State University Allendale, MI 48858 Ph: 616 895-2675 Fx: 616 895-3350 Email: Stevensj@gvsu.edu
EDUCATION	**Ray Vigil, PT, OCS** Body Mechanix Physical Therapy 6810 N. Broadway, Suite C Denver, CO 80221-2849 Ph: 303 428-0866 Fx: 303 428-0511 Email: Vigil7777@aol.com
NOMINATING	**Scott Duesterhaus Minor, Ph.D., P.T.** Washington University School of Medicine 4444 Forest Park Blvd., Box 8502, Room 1113 St. Louis, MO 63108 Ph: 314-286-1432 Fx: 314-286-1410 Email: minors@msnotes.wustl.edu
MEMBERSHIP	**Steve Allison, MHS, PT** Tri-State Physical Therapy, Inc. South Park Medical Plaza 2120 Bert Kouns, Suite B Shreveport, LA 71118 Ph: 318 687-4156 Fax: 318 687-9755 e-mail: occfit@shreve.net

FOOT & ANKLE

SPECIAL INTEREST GROUP
ORTHOPAEDIC SECTION, APTA, INC.

Hello to all Orthopaedic Section Members

My name is Steve Reischl, and I am the new President of the Foot and Ankle Special Interest Group. At the Combined Sections Meeting in San Antonio, our SIG was active in educational programming and in our Business Meeting. I will give a brief summary of the activity at the meeting and the goals for the upcoming year.

At CSM, the SIG presented 4 hours of programming on "Management of Lower Extremity Injuries in Runners." Mark Cornwall, PT, PhD as Vice President was in charge of getting together a program that once again "packed the room" with over 250 participants in the audience. A special thanks goes to: Blaise Williams, PT, PhD; Melissa Hatley, PT; Irene McClay, PT, PhD; and outgoing FASIG President, Tom McPoil, PT, PhD. Their insight into this complex subject was greeted with enthusiasm in the audience.

The Business Meeting was led by outgoing President, Tom McPoil. Minutes of the meetings were printed in the last issue of *Orthopaedic Practice* 2001;13(1):32. Key points of the Business Meeting were:

1. Tom McPoil and Irene McClay reported on the first annual Foot and Ankle Special Interest Group Research Retreat. As reported in a previous edition of *Orthopaedic Physical Therapy Practice,* this meeting was represented by a wide range of researchers presenting information on static and dynamic classification of the foot. Please see the March 2001 edition of *Journal of Orthopaedic and Sports Physical Therapy* for the Proceedings the Foot Classification Conference (pages 153-160).
2. From the discussion about the research retreat, this meeting will be organized on a 3-year basis and will be planned as a long-term goal for the FASIG.
3. Election for officers of President and Secretary/Treasurer were completed with Steve Paulseth as Secretary/Treasurer. Steve Paulseth has been involved in this SIG for several years, and I am looking forward to working with him over our term together.
4. Results of the survey sent out to members of the FASIG and through the newsletter will be discussed in depth.

GOALS FOR THE UPCOMING YEAR

1. FASIG will continue to present programming at the Combined Section Meeting. At this time, Mark Cornwall has completed the slate of 4 hours of programming. In upcoming newsletters, we will keep you informed of the programming.
2. Because of the positive response to the Foot Classification Conference, it was decided that this type of conference would be ongoing on a once per 2 to 3 year basis. During our Business Meeting, future topics of the conference were suggested. As important to the content of the meeting is PAYING for the meeting. The extra funding will come through the FASIG organizing continuing education courses with the Orthopaedic Section, which has been done in the past as stand alone course or as a preconference course for CSM.
3. Continue with ongoing mission of the FASIG.

In closing I wish to acknowledge the dedication and service of Tom McPoil. He has been at the front of the formation of this SIG and has held the leadership position through 2 different terms as President. His dedication to the advancement of physical therapists has been met with praise on National, Section, and State levels of our profession. He continues to do research that challenges all physical therapists to look again at how we will manage patients with foot and ankle conditions. He will not be far from the decisions made in this SIG.

As your new President, I will do my best to keep the activity of the FASIG at the same high level you have come to expect. I can be reached by email at reischl@earthlink.net for questions or comments.

Sincerely yours,
Steve Reischl, DPT, OCS
President

ORTHOPEDIC SECTION, APTA
PHYSICAL THERAPIST FOOT CARE SURVEY

NAME: _____ ADDRESS: _____

PHONE (DAY): _____ E-mail: _____

1) What is your current primary practice environment?
   a) General/Acute inpatient
   b) Rehabilitation inpatient
   c) Rehabilitation outpatient
   d) Outpatient - Hospital Based
   e) Outpatient - Private Practice
   f) Outpatient - Nonprivate Practice
   g) Home Health
   h) Other Specify: _____

2) What is your major job responsibility(s)?
   (33.3% or more of the day - Circle all that apply)
   a) Staff PT
   b) Senior PT
   c) Supervisor
   d) Director/Chief
   e) Clinical Instructor
   f) Clinical Coordinator
   g) Other Specify: _____

3) Primary patient population seen in your practice?
   a) Sports Medicine _____
   b) Performing Arts _____
   c) Diabetes _____
   d) Pediatric _____
   e) Geriatric _____
   f) Amputee _____
   g) Wound care (nondiabetic) _____

4) The number of patients/clients seen per week with foot and ankle conditions?
   a) 0 b) 1-3 c) 4-7 d) 8-12 e) >12

5) Types of foot and ankle conditions you treat each month? (Check all that apply)
   a) Posterior tibialis tendonitis/dysfunction _____
   b) Achilles tendonitis/rupture _____
   c) Plantar fasciitis _____
   d) Posterior heel pain _____
   e) Ankle sprain _____
   f) Stress fracture of leg or foot _____
   g) Tarsal tunnel syndrome _____
   h) Hallux limitus/rigidus _____
   i) Fracture of the Ankle, Foot or Toes _____
   j) Hallux Valgus/Bunion _____
   k) Bunionette (5th toe) _____
   l) Metatarsal head pain _____
   m) Mortons toe _____
   n) Mortons neuroma _____
   o) Interdigital neuroma _____
   p) Chronic lateral ankle instability _____
   q) Chronic lower leg pain (shin splints) _____
   r) Claw or hammer toe _____
   s) Diabetic foot care _____
   t) Sesamoiditis _____
   u) Rheumatoid foot & ankle problems _____
   v) Plantar fibromas _____

6) Please indicate a **percentage** of the frequency of physical therapy visits you see for each patient/client with foot and ankle conditions?
   a) 3 times per week _____
   b) 2 times per week _____
   c) once per week _____
   d) once per 2 weeks _____
   e) once per month _____
   f) other _____

7) Please indicate the percentage of time that you use the following specific treatment interventions in your management program. Please provide an answer for each intervention.
   a) Patient/Client education _____
   b) Manual stretching _____
   c) Joint mobilization _____
   d) Soft tissue mobilization/myofascial release _____
   e) Strengthening exercises _____
   f) Home stretching program _____
   g) Physical agents (heat, cold) _____
   h) Electrotherapeutic modalities _____
   i) Fabrication of foot orthoses _____
   j) Footwear assessment/recommendations _____

8) There is a wide variety of foot orthoses that can be used in the management of patients/clients with foot and ankle disorders. Please indicate the types of foot orthoses you utilize in your practice
   a) Over-the-counter foot orthoses purchased by patient elsewhere
   b) Prefabricated foot orthoses dispensed by the therapist or office
   c) Prefabricated foot orthoses with modifications done by therapist
   d) Foot orthoses fabricated in the practice location by physical therapist
   e) Foot orthoses fabricated in the practice location by another health care professional
   f) Foot orthoses fabricated from a cast sent to outside laboratory

9) The state in which you currently practice _____

10) In your state is direct access available? Yes___ No___

11) If you answered YES in question #10, do you see foot and ankle patients/clients via direct access? Yes___ No___

12) If the state in which you currently practice does permit direct access for physical therapy and you answered NO in question #9, would you please provide a reason fornot seeing patients/clients with foot and ankle disorders via direct access? (eg, insurance reimbursement issues; malpractice issues)
   Reason(s): _____

13) Do you participate in Primary Care Physical Therapy? Yes___ No___

14) If you answered yes in question #13, do your practice privileges allow you to... (Circle all that apply)
   a) Order/request radiographs
   b) Order/request other imaging procedures (bone scan, CT scan, MRI)
   c) Order/request blood or other laboratory tests
   d) Order/request medications
   e) Order/request casts/braces
   f) Order/request other tests/procedures/equipment

Thank you!

Orthopaedic Section, APTA, Inc., 2920 East Ave. South, Suite 200, La Crosse, WI 54601
800/444-3982 * 608/788-3965 (FAX)

FOOT & ANKLE OFFICER LISTING

CHAIR:

Stephen F. Reischl, PT, DPT, OCS (562) 427-2225
2650 Elm Ave, Ste 214 (562) 427-5656 FAX
Long Beach, CA 90806-1600 reischl@earthlink.net

VICE CHAIR:

Mark Cornwall, PT, PhD, CPed (520) 523-1606
Northern Arizona University (520) 523-9289 FAX
Dept of Physical Therapy mark.cornwall@nau.edu
NAU Box 15105
Flagstaff, AZ 86011

SECRETARY/TREASURER:

Stephen G Paulseth, PT, MS (310) 286-0447
2040 Ave of the Stars Ste P104 (310) 286-1224
Los Angeles, CA 90067-4708 paulsethpt@earthlink.net

NOMINATING CHAIR:

Byron Russell, PT (509) 623-4306
EWU Dept PT 353 PAU (509) 623-4321 FAX
526 5th Street bryon.russell@mail.ewu.edu
Cheney, WA 99004-2431

PRACTICE CHAIR:

Joe Tomaro, PT, MS, ATC (412) 321-2151
490 East North Ave, Suite 501 (412) 434-4909 FAX
Pittsburgh, PA 15212 tomaro@dug3.cc.edu

ORTHOPEDIC SECTION, APTA

PHYSICAL THERAPIST FOOT CARE SURVEY

The Foot and Ankle Special Interest Group (FASIG) would like to request your help in filling out the "Physical Therapist Foot Care Survey" below. Your help in completing the survey and faxing it back to the Orthopaedic Section is very important so that we can use the results to establish a database of physical therapists currently providing various levels of foot and ankle care. In addition to gaining insight into the number of therapists actively involved in providing foot and ankle services, the information obtained from the survey will allow the FASIG to develop a referral data base of physical therapists who can provide various levels of foot and ankle care. In appreciation of your efforts in filling out and returning the survey, the FASIG will place your name in a drawing for the Foot and Ankle Home Study course.

Again, thank you for taking the time to fill out and return this important survey!

Performing Arts Special Interest Group • Orthopaedic Section, APTA

Message from the President

Hello. I hope that everyone is preparing for an enjoyable summer, and are getting involved in the multitude of summer programs for dance, figure skating, gymnastics, and music. Please let us know what you are doing by contacting your regional director today (see contact information below)!!!

The PASIG continues to be busy. We have instituted much more structure to our committees, so that we will be able to more consistently follow through with suggestions from our membership. As always, we welcome anyone's participation. Below is a list of our committees and its purposes. If you are interested in getting involved in any of them or have any questions, please let me know.

Practice Committee: To develop, in coordination with the membership, the practice guidelines and standards for physical therapy for performing artists; to assist in the development and implementation of student affiliations as well as advanced clinical mentorships/residencies/fellowships; to serve as an advocate for performing arts physical therapy practice issues; to facilitate communication among members regarding practice patterns and exchanges of clinical information [Time Commitment: 8hrs/quarter].

Education Committee: To develop and coordinate 3 hours of annual programming for PASIG membership; to coordinate with the Research Committee for 1 hr. of annual "Dialogs in Performing Arts Research" programming [Time Commitment: 10 hr/1st and 2nd quarter; 3 hrs/3rd and 4th quarter].

Research Committee: To facilitate clinical research in physical therapy for performing arts; to facilitate dissemination of research relevant to performing arts physical therapy [5hrs/1st and 2nd quarter; 3 hrs/ 3rd and 4th quarter].

Membership Committee: To develop outreach mechanisms to increase retention of current mechanisms, and recruitment of new members [6 hrs/quarter].

Public/Media Relations Committee: To raise awareness of performing arts physical therapy within the physical therapy profession, the performing arts community, and with the public at large; to assist members in marketing their services to the performing arts community; to act as a clearinghouse for clinical pearls, regional news, and specific membership achievements; to act as an ambassador for performing arts clinicians [3 hrs/quarter].

Regional Directors (Subcommittee of P/M Relations): To highlight regional activities of the performing arts physical therapy community, and PASIG members in particular; to foster communication and interaction among PASIG members; to act as an ambassador for the PASIG Executive Board to the regional members [3 hrs/quarter].

Finally, I would like to update you on the practice analysis. The Performing Arts National Advisory Group met for 2 days in Arlington, VA in March and made a first cut at describing the knowledge, skills, and abilities as well as the duties of a therapist working with performing artists. An outside facilitator, Mary Millidonis, PT, MMSc, OCS, guided the meeting. We have spent the spring revising the description and developing a survey instrument. We will pilot the survey this summer, and then distribute it to the membership at large for your responses. This process will culminate in a *Description of Specialized Clinical Practice for Physical Therapy in the Performing Arts*. If you would like to know more about the practice analysis, please e-mail me.

Have a great summer. Let us know what's going on in your neck of the woods.

All My Best,
Jennifer M. Gamboa, MPT
President

COMMITTEE UPDATES:

All committees have met or are in the process with the President to develop strategic plans for the year. Committee membership involves a 3-year commitment. Some committees still need members. If you have an interest in committee involvement, please contact the Committee Chairperson, who is listed in the directory on the last page of this newsletter.

EDUCATION COMMITTEE
CSM 2002 PASIG PROGRAMMING

The planning for next year's CSM programming is already underway. Programming will be divided into 3 areas:

1. Content Presentations: Presenters will discuss the role physical therapists play in influencing young musicians and dancers to develop healthy training practices.
2. Research Forum: A dialogue will be facilitated between a panel of researchers and clinicians to improve evidence-based practice in performing arts physical therapy.
3. Shop Talk: Clinicians will present how they apply the *Guide to Physical Therapist Practice* to performing arts physical therapy.

We invite all of our members to participate in any of the above presentations and as always, any ideas and suggestions are most welcome. Please contact Lynn E. Medoff, MPT, MA at (520) 527-8601 or email: lemedoff@hotmail.com.

Lynn E. Medoff, MPT, MA
Vice President—Education Committee Chair

PUBLIC/MEDIA RELATIONS COMMITTEE

The PASIG has begun contacting our membership through the new "Regional Directors." The goal is to contact each member and discuss your needs from the PASIG and any concerns that might exist. Currently we have divided the membership into 6 regions and we have openings in the following regions for Directors:

1. Northwest (ID, MT, NE, ND, OR, SD, WA, WY)
2. West (CA, CO, NV, UT, TX, NM, AZ, HI, AK)

This is an excellent opportunity for you to meet and network with fellow PASIG members. If you would like to get more involved with the PASIG and would like to get to know more of your fellow PASIG members, consider becoming a "regional director!" Contact Jeff Stenback, PT, OCS at (305) 595-9425 or e-mail: JSPTOCS@aol.com.

Jeff Stenback, PT, OCS
Treasurer – Public/Media Relations Committee Chair

NOMINATING COMMITTEE

Call For Nominations!

We are in the process of nominating members of the PASIG to run for office. Our goal is to put together an Executive Board that represents dance and music equally, and represents therapists from across the country. This is your opportunity to become a part of the governing board of the PASIG. We invite you to run for President, Treasurer, or a member of the Nominating Committee. Following is an outline of the responsibilities of these offices and guidelines for nominations.

President: Three year term; serves as the official head of and public spokesperson for the PASIG; facilitates growth and development of the PASIG; presides over all meetings of the PASIG and the Executive Board; acts as a neutral member of the PASIG in voting matters; exercises the right to vote to resolve a tie vote; is a liaison to the Section.

Treasurer: Three year term; assists in growth and development of the PASIG with the Executive Board; assumes responsibility for the submission of the PASIG budget; receipt, disbursement, and accurate recording of all PASIG funds; presents a written financial report at PASIG and PASIG Executive Board meetings.

Nominating Committee Member: Three year term; one of three committee members; assists nominating committee chair to network among the PASIG membership and help develop candidates for office; assists in overseeing the PASIG election process. A new Nominating Committee member is elected yearly, and in the last year of the term assumes the Chairperson position.

Nomination Guidelines: Nominees must be PASIG members, therefore also Orthopaedic Section members. Nominees must give their consent to be nominated before their names are put forward. Nominees may be self-nominated. Nominees' names should be submitted to Amy Wightman, Nominating Committee Chair, by e-mail at abwightman@hotmail.com, or by phone (860) 643-3562. Nominees should be prepared to provide a **brief** biography and candidate statement describing their goals for the office for which they are nominated.

Amy B. Wightman PT
Nominating Committee Chair

GET INVOLVED IN THE PASIG AND THE FUTURE IS YOURS !

Join your fellow PASIG members in becoming an ambassador for the Performing Arts! The PASIG wants to encourage all our members to become actively involved by serving as committee members, regional directors, officers, and by offering your input at business meetings and through communication with other PASIG members. Remember, when you give of your time and energy to the PASIG, it's like giving a gift to yourself! The PASIG is only as strong as its members.

PASIG EXECUTIVE COMMITTEE

President:
Jennifer Gamboa, MPT
Body Dynamics
3017-B Clarendon Blvd.
Arlington, VA 22201
Ph: 703.527.9557 / FAX: 703.526.0438
Email: jenn526@aol.com

Vice President:
Lynn E. Medoff, MPT, MA
Northern Arizona University
Physical Therapy Clinic
PO Box 15046
Flagstaff, AZ 86001
Ph: 520.523.2280 / FAX: 520.523.4315
Email: lemedoff@hotmail.com

Treasurer:
Jeff Stenback, PT, OCS
Orthopedic Rehailitation Specialists
8720 North Kendall Dr, Ste 206
Miami, FL 33176
Ph: 305.595.9425 / FAX: 305.595.8492
Email: jsptocs@aol.com

Secretary:
Susan C. Guynes, PT, MHS
Department of Physical Therapy
LSU – Health Sciences Center
1900 Gravier Street, 7th Fl.
New Orleans, LA 70112-2262
Ph: 504.568.6552 or 504.568.3434
FAX: 504.568.6552
Email: sguyne@lsuhsc.edu

Past President:
Brent Anderson, PT, OCS
w: 305-284-4534
Email: baudbo@newsson.med.miami.edu

COMMITTEES

Education Committee Chair:
Lynn Medoff, MPT, MA
(contact info above)

Practice Committee Chair:
Jennifer M. Gamboa, MPT
(contact info above)
Members: Mark Erickson, Marshall, Hagins, Nick Quarier, Donna Ritter, Jeff Stenback

Nominating Committee Chair:
Amy B. Wightman, PT
Eastern Rehabilitation Network
252 North Main Street
Manchester, CT 06040
Work phone: (860) 643-3562
Work fax: (860) 643-3565
Home phone: (860) 875-5304
E-mail: abwightman@hotmail.com
Members: Monica Michalski Merry, Terry A. Sneed

Public/Media Relations Committee Chair:
Jeff Stenback, PT, OCS
(contact info above)
Members: Joe Berman, Susan Guynes, Jill Olsen

Regional Directors (Subcommittee of Public Media Relations Committee)
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  Needs volunteers

Membership Committee Chair:
Donna Ritter, PT
Pitman Creek Physical Therapy
700 Alma, Suite 135
Plano, TX 75075
Ph: 972.424-584/VM/Page:214.892.0049
Email: drpt@airmail.net

Research Committee Chair:
Lisa Sattler, PT
1140 First Ave. Apt. 6
New York, NY 10021-7961
Phone: 212-838-6847
Members: Scott Stackhouse

PERFORMING ARTS SPECIAL INTEREST GROUP • APTA

MEMBERSHIP FORM

To be a PASIG member, you must also be a member of the Orthopaedic Section. You may use this form for **new membership, change of address, or updating your information.**

Name: _____
Address: _____
City, State, Zip: _____
Home Ph: (_____)_____
Business Ph: (_____)_____
Email:_____
APTA member number:_____

What percent of your patient population are performing arts patients?

____Dancers ____Gymnasts ____Skaters
____Musicians ____Singers ____Circus Performers

If you are affiliated with any performing arts schools, companies, or groups, please list them:

_____
_____
_____
_____

Do you accept Student Affiliations? ____Yes ____No

Are you interested in serving as a mentor to other physical therapists or physical therapy students interested in the treatment of performing artists?

Physical Therapists _____Yes _____No
Students _____Yes _____No

Are you interested in serving on any of the PASIG Committees?

_____Practice _____Public/Media Relations
_____Education _____Regional Director
_____Research _____Membership

Pain MANAGEMENT

SPECIAL INTEREST GROUP • ORTHOPAEDIC SECTION, APTA, INC.

President's Message

It is with extreme joy that I thank all of you in the Pain Management SIG for my election. I would like to first thank Tom Watson (past president) for all the hard work that he did to get us where we are now. His vision to the future has always been a powerful force to the formation and growth of the SIG. Also thanks go to John Garzione for his role as Secretary.

We had a wonderful day-long course this year with our highlight speaker David Butler, giving us his fresh ideas in the field of neurobiology. It was a tremendous success!

I hope to see all of you in Boston at CSM in February 2002 to hear Kathleen Sluka, PT, PhD share her insights and research in the areas of musculoskeletal pain and fibromyalgia. We will try to have our meeting immediately following her presentation so that as many can attend as possible. This must be YOUR SIG and new and fresh ideas will be welcomed.

I would like to congratulate John Garzione as our new Vice President and Elaine Pomerantz as our new Secretary.

With the aging of the baby boomers and some of the recent legislation concerning Medicare we are creating a series of upcoming decades that will be laced with chronicity. Chronic pain will become a much larger factor that therapists will be faced with on a daily basis. We must sharpen our skills at breakneck speed to stay current with recent advances both clinically and in research. We also have a handicap in this country with the development of new modalities with which other places in the world have greater freedom. With the increase exponentially of the information age we are finding it harder and harder to stay attuned to current thinking even in a narrow field such as Chronic Pain Management. It is important in this field to take a global view and not a myopic approach.

I would hope that all individuals interested in the Pain Management SIG actively contribute to make this truly helpful and service-oriented to the rest of the members so that we may all benefit. I would like to actively seek each of you to send papers for input to this newsletter on the topic of pain management. We are allowed a maximum of four pages per quarter and hopefully we can fill it with useful information from all of us to all of us. Please send your articles to my email at indusrehab@aol.com. If there are any topics you wish to discuss, feel free to call me at 972-887-0029 ext 211.

I look forward to an open forum where we all can share, learn, and grow as we become all that we can be.

Joe Kleinkort, PT, MA, PhD, CIE

Is a Heel Pain or Plantar Fasciitis?

Tom Watson, PT, MEd, FAAPM

Pain of the sole of the foot can be very difficult to address appropriately. X-rays are often negative and there are no significant objective signs such as muscle weakness or loss of motion. Tenderness is subjective at best but can help you to develop a working assessment and treatment program.

In the book, *Foot and Ankle Pain*, Rene Cailiet, MD (FA. Davis Company, 1980, chapter 7) describes painful conditions of a heel. It goes on to describe tenderness at the anterior medial portion of the calcaneus as plantar fasciitis. This is the attachment site of the plantar fascia. This condition occurs more frequently in males than females. A painful heel is more general across the calcaneus and not as well localized. Many of my patients will describe the pain moving medial to lateral to middle of the heel. There is usually no loss of sensation or strength associated with either condition.

Treatment approaches include:

1. A 1/4 inch heel pad—a piece of felt cut to fit the inside of a shoe is inexpensive and very effective. A hole may be cut into the felt corresponding to the localized site of pain.
2. Ischemic compression along the arch of the foot into the attachment of the plantar fascia or across the calcaneus. Hold the compression until there is no discomfort.
3. Iontophoresis, with dexamethasone, 2 or 3 times depending upon the response.
4. Interferential current at "0" hertz in a crossed "X" pattern with moist heat.
5. Microcurrent stimulation at .5 hertz through the area of pain.
6. Ultrasound continuous to the area of pain.
7. Taping from mid arch across the calcaneus up the Achilles tendon maintaining a maximum of 5° to 10° of dorsiflexion.

Combinations are frequently more effective than individual modalities or procedures. Using 1, 2, and 3 along with taping have been very effective for the patients I've treated.

Differential diagnosis that may cause heel and sole of foot pain include trigger points in adductor hallicus, peroneus tertius, medial head of the gastronemius, medial distal soleus, tibialis posterior, flexor digitorum longus, and retro-Achilles bursitis, hair-line fracture of the calcaneus, and common calcaneal tendonitis.

Proper evaluation and palpation are extremely important to derive an appropriate site of treatment. Look and listen, as the patient will usually lead you to the source of pain, and palpate. Then you can arrive at appropriate assessment and treatment intervention.

REFERENCES

Cailliet R. *Foot and Ankle Pain.* FA Davis; 1980.
Travell J. *Myofascial Pain and Dysfunction.* Williams & Wilkins; 1992.

Animal Physical Therapist

SPECIAL INTEREST GROUP

Orthopaedic Section, APTA, Inc.

ANIMAL PHYSICAL THERAPIST SPECIAL INTEREST GROUP
DIRECTORY OF OFFICERS & CHAIRPERSONS

President
Cheryl Riegger-Krugh, PT, ScD
Physical Therapy Program
C-244 4200 E. Ninth Ave
University of Colorado
Health Sciences Center
Denver, CO 80262
Work: 303-372-9141
Fax: 303-372-9016
E-mail: cheryl.riegger-krugh@uchsc.edu

Vice President and International Liaison
David Levine, PT, PhD
Department of Physical Therapy
University of Tennessee at Chattanooga
615 McCallie Avenue
Chattanooga, TN 37403
Home: 423-886-1098
Work: 423-755-5240
Fax: 423-785-2215
E-mail: david-levine@utc.edu

Treasurer
Nancy Murphy, PT
PO Box 6386
Ketchum, ID 83340
Home: 208-788-9215
Work: 208-622-6930
E-mail: nmurphy@svidaho.net

Secretary and Public Relations Coordinator
(Newsletter, Logo, Brochure)
Stephanie Fagin, PT
6540 Emigration Canyon
Salt Lake City, UT 84108
Work: 801-231-2543
E-mail: steph.jsilver@aros.net

Committee on Practice
Caroline Adamson, PT, MS
Colorado Canine Sports Medicine/ Rehabilitation Clinic
Alameda East Veterinary Hospital
9870 E. Alameda Avenue
Denver, CO 80231
Work: 303-366-2639
FAX: 303-344-8150
E-mail: carolineadamson@juno.com

Clinical Competency Subcommittee
Nancy Ford, PT
900 Clintonville Road
Wallingford, CT 06492
Home: 203-981-1055
Work: 203-265-1975

Chair of Education
Kristinn Heinrichs, PT-SCS, PhD, ATC, CSCS
P.O. Box 61281
Savannah, GA 31405
Phone/FAX 912-303-0711
E-mail: kheinrichs@cstone.net

Newsletter Coordinator
Arlene White, PT
6343-2 Riverwalk Lane
Jupiter, FL 33458
Home/Fax: 561-575-0735
E-mail: ArlyFAMU96@aol.com

State Liaison Coordinator
Siri Hamilton, PT, LVT
University of Tennessee College of Veterinary Medicine
Dept. of Small Animal Clinical Services
2407 River Drive
Knoxville, TN 37901-1071
Work: 865-974-2993
E-mail: sirivtpt@utk.edu

Nominations Committee
(Vacant committee chair)

PTA Representative
Angela D. Frye-Lewelling, PTA
235 Douglas Dam Road
Kodak, Tennessee 37764
Work in human practice:
(865) 429-6584
Work in animal practice
(865) 974-2993
E-mail: K9LPTA@ AOL.COM

Orthopaedic Section Board Advisor
Ann Grover, PT

SIG Coordinator and Off-Site Continuing Education Coordinator
Stefanie Snyder

CALENDAR OF EVENTS

1. The home study course ***Basic Science for Animal Physical Therapists*** is now available. Contact 877-766-3452 for more information.
2. Canine Physical Rehabilitation Short Course: A 2½ day course for Veterinarians and Licensed Veterinary Technicians offered by The University of Tennessee, College of Veterinary Medicine, June 1-3, 2001. For a brochure, call Barbara Campbell at 865-974-7264 or email bcampbe4@utk.edu
3. Canine Physical Therapy I (June 18-19, 2001): A 2 day preconference course for physical therapists and physical therapist assistants immediately preceding the Annual Conference of the American Physical Therapy Association, (June 20-23, 2001) in Anaheim, California. For more information, contact APTA at 1-800-999-2782.
4. The American Veterinary Medical Association (AVMA) will be having a seminar on postoperative rehabilitation as part of their 2001 Symposium. The seminar is on Saturday July 14, 2001 at the AVMA convention in Boston, MA. Contact Dr. Laurie McCauley for more information.
5. North Carolina College of Veterinary Medicine in collaboration with Elon College Masters in Physical Therapy Program is sponsoring a new course. The course will be held at North Carolina College of Veterinary Medicine, April 30-May 4, 2001. This comprehensive course will cover canine anatomy, tissue physiology, and common physical therapy interventions for orthopaedic and neurologic conditions. It will also feature numerous labs for practicing techniques learned. For more information contact Dr. Elizabeth Rogers at (336) 278-6350.
6. The American College of Veterinary Surgeons (ACVS) will be having a seminar on postoperative rehabilitation as part of their 2001 Symposium. October 11-14, 2001 at the Hyatt Regency in Chicago, Illinois.
7. The 2nd International Symposium on Rehabilitation and Physical Therapy in Veterinary Medicine will be held August 10-14, 2002, Knoxville, Tennessee, USA. This conference will be instrumental in shaping the field of Veterinary Rehabilitation and Physical Therapy, and will consist of 5 full days of programming by speakers from around the world who are involved in this field. This is an excellent opportunity for physical therapists, physical therapist assistants, veterinarians, veterinary technicians, and students of these fields to come together in a collaborative manner to learn and share their expertise with each other. For more information go to the official conference Web site, email: Conferences@utk.edu, or call (865) 974-0250.

UPDATE: *Legalizing the treatment of animals by physical therapists in Florida*

ANIMAL THERAPY, by Mr. Gary Walters, President FPTA

The animal therapy focus group met during the spring conference. This group was organized following a plea from a group of members who have a desire to treat animals. Since this group of members wanted their issues heard, the Board of Directors passed a motion to form this focus group.

Prior to this meeting Mark Stoff and I met with the leaders of the Florida Veterinary Association to discuss the physical therapy treatment of animals. During this meeting they made it quite clear they would oppose any legislative initiative allowing PT/PTAs to treat animals. They believe there exists no body of knowledge from which to teach and also no individuals qualified to teach any information regarding the physical therapy treatment of animals, at this time. They also were very clear that pursuant to their practice act anyone could treat animals through an employment arrangement and under the supervision of a Veterinarian. However, that person would be unable to call himself or herself a physical therapist or physical therapist assistant.

Those proponents of animal therapy, in an attempt to answer questions related to member concerns, will be including

a questionnaire in an upcoming edition of the Update. Please take the time to fill out the questionnaire and return it so that we may have a better understanding of your concerns.

I will be scheduling a follow-up meeting in the future, after we have compiled the answers to the questionnaire. The primary focus of this meeting will be to discuss the findings and also to determine future direction. To get involved please contact Arlene White (561) 575-0735 for more information.

Cross Training

The SIG often receives questions about how to prepare for a career in animal rehabilitation. There are no clear answers, but we can offer advice from our members. The SIG is fortunate to have access to 3 physical therapists that have followed different paths to a similar goal. Steve Jacobs is a PT who is currently enrolled in veterinary school. Jan Steiss is a veterinarian that has recently completed a PT program. Lin McGonagle is a PT who has recently completed a veterinary technician program. We posed a series of questions to the group. Perhaps their experiences will help you in your future decisions.

1. What is your educational and professional background?

Jacobs: I received a Bachelor's of Science in Biology from McKendree College in Lebanon, IL in 1989. I received a Master's of Science in Physical Therapy from Washington University School of Medicine in St. Louis, MO in 1991. I owned and operated 2 outpatient orthopaedic physical therapy clinics in Illinois from 1992 to 1994. I sold my practice to HealthSouth and worked as an administrator from 1995 to 1999. I began the veterinary medicine program in August of 1999 at the University of Illinois. I'm currently in my second semester of my second year.

Steiss: I received a Bachelor of Science degree from the University of Waterloo, Ontario, Canada, in 1970. Doctor of Veterinary Medicine (DVM) from the Ontario Veterinary College in 1975 and PhD from the University of Georgia in 1981. In June 2000, I graduated with a Masters in Physical Therapy from the University of Alabama at Birmingham.

My clinical practice in veterinary medicine included working in a mixed practice after graduation from veterinary college, before returning to graduate school. As a faculty member in the Department of Small Animal Medicine and Surgery at Auburn University (1986-1999), my clinical duties included electromyographic testing on dogs with neuromuscular disease. My clinical experience in physical therapy has included clinical rotations (Warm Springs, Georgia, for neurorehabilitation; Hughston Sports Medicine Hospital and HealthSouth for orthopaedic rehabilitation, and East Alabama Medical Center for acute care). At the present time, I am starting to work with a Hippotherapy program in this area.

McGonagle: My background includes a Bachelor's degree in Animal Science from Cornell University in 1981, a Master's degree in Physical Therapy from Beaver College in 1985, and an Associate's Degree in Veterinary Science in 2000. My clinical experience over the past 15 years includes acute care, neurorehabilitation, home care, school-based pediatrics, and early intervention. I have owned a part-time private practice for the past 8 years.

2. What prompted you to return to school?

Jacobs: I saw numerous negative changes occur in the health care arena during my career as a physical therapist. The control of patient care was being removed from the physical therapist. Along with these changes, my mother became terminally ill which helped me realize the brevity of life. It has been a dream of mine since childhood to be a veterinarian. With the support of my wife, I realized it was time to pursue this dream.

Steiss: During my graduate school program at UGA, I became interested in neuromuscular disorders in small and large animals. I was performing a lot of electromyographic examinations at UGA. Later as a faculty member at Auburn University College of Veterinary Medicine, I saw numerous dogs and horses with muscle and nerve disease. It seemed to me that as veterinarians, we had a very good understanding of the medical causes of neuromuscular disorders. However, we were also seeing sporting dogs and other working dogs which had neuromuscular disorders, especially myopathies, which were not due to a medical problem but appeared to be associated with the athletic training and activities these dogs were engaged in. I realized that the physical therapy profession had a lot to offer in the study of human athletes and that the information could be applied to the prevention, diagnosis and treatment of some of these neuromuscular disorders in dogs and horses.

McGonagle: Cutbacks in Medicare caps decreased home care cases in my practice. This allowed me an opportunity to return to school that I had not anticipated for 8-10 years.

3. What school did you select and why?

Jacobs: I chose the University of Illinois to attend veterinary school. I had the best chance of being accepted at this university since it was in-state for me. Also, in-state tuition was more attractive than paying out-of-state tuition.

Steiss: I selected the Division of Physical Therapy at UAB for several reasons: (1) their program is a 2-year Masters degree program; (2) the faculty are excellent and dedicated; (3) there was a "special student" category for nontraditional students such as me; (4) the division head, the late Dr. Marilyn Gossman, and the faculty were interested in the idea of my enrolling in their program; (5) the faculty were willing to allow me considerable flexibility with scheduling; (6) the administration was willing to give me credit for some of the courses that I had taken previously at veterinary college or in graduate school (eg, pharmacology, pathology); and (7) finally, their campus was relatively close to Auburn (about 100 miles).

McGonagle: I chose Delhi because of their academic program, primate courses, and relative proximity to home (approximately 140 miles 1-way).

4. What was the most difficult aspect of going through the program you chose?

Jacobs: One of the most difficult things has been adjusting to becoming a student again or as one professor has said, "being a second class citizen." It has been challenging to gear back from a professional career with constant decision-making and challenging patients to a life of books and studying.

Steiss: The obvious difficulties were the time taken from family since I still had 2 young children, and also the driving. There was a lot of juggling required between professional and family concerns.

McGonagle: The 5-hour round trip commute was challenging. The worst part of the experience was to be away from my family. Dealing with a significant drop in my income took some planning and family cooperation, but was manageable.

5. We all have expectations as we try new adventures, what surprised you the most about the program you attended?

Jacobs: One surprise has been the enormous amount of material that is presented and must be learned. It amazes me to think that a veterinarian must learn every aspect of medicine from pharmacology to radiology to oncology and so the list goes on and on. In addition to all of these areas to learn, there are numerous variations between the different species that also must be learned. The knowledge of the professors and the expertise in their field is fabulous. The amount of research that is conducted in the field of veterinary medicine is impressive as well.

Steiss: I learned to appreciate that the profession of physical

therapy has a coherent scientific basis that can be adapted to veterinary medicine, especially in the area that interests me most, the neuromuscular system. It became apparent that the function of nerve and muscle is very similar among species and that the principles of neuromuscular rehabilitation can be transferred to animals.

I learned to appreciate the ongoing commitment of the APTA and the Foundation to support research, both basic and clinical, to provide a scientific foundation to their profession. I also appreciated the warmth and genuine concern with which the faculty treated their students, and the collegiality among the faculty.

McGonagle: I was pleasantly surprised that there are many more women returning to college after 40 than I expected. The "hands on" approach to the program allowed me to gain clinical skills as I went through the program. I also came to appreciate that many of the courses—radiography, pharmacology, surgery, and anesthesia—helped me to better understand human medicine and health care.

6. What courses in the program were the most helpful in preparing you to provide animal PT and why?

Jacobs: The most beneficial course thus far has been gross anatomy. The knowledge of the musculoskeletal system is of utmost importance in order to provide effective and safe rehabilitation for animals.

Steiss: Probably the most helpful courses were those related to orthopaedics, neurology and modalities, functional anatomy, and gait analysis because they involve the neuromuscular or musculoskeletal systems and many similarities exist among species, fortunately.

McGonagle: The courses that I found particularly helpful were: Anatomy and Physiology, Medical Sciences-Animal Diseases, Pharmacology, Surgery-Orthopaedic Approaches.

7. How did the staff and faculty react to your goals for animal rehabilitation?

Jacobs: The reaction to my pursuit of animal physical therapy at the university has been extremely warm and positive. The orthopaedic surgeons are aware of the benefits of this service and have been very receptive. Most people realize the progression of physical therapy in the veterinary profession and are interested in learning more about it.

Steiss: The faculty members were extremely supportive while I was a student, and they were interested in the comparative aspects. For instance, it was fascinating to study human functional anatomy and then go back to look at what happened during evolution to the limbs of the horse and how this changed the biomechanics. Several faculty staff, such as Cara Adams, have collaborated on research projects with me. Cara drove to Auburn University several times, so that we could conduct the study on therapeutic ultrasound penetration through dogs' skin.

McGonagle: A few members of the faculty were very supportive and hoped that we could develop a training program at the school after I graduated.

8. Was your curriculum modified in any way to address your interest in animal PT?

Jacobs: So far, there has not been any flexibility to change the curriculum to address my interests. However, there have been numerous opportunities to pursue my interests with the veterinarians in my free time. I have been able to work with several of the orthopaedic surgeons at the university. This work has involved writing rehabilitation protocols, consulting on cases, contributing to lectures, and research projects. Flexibility exists later in the program that can address my interest in animal PT.

Steiss: Not really – I followed the same program as other students since the faculty felt that on graduation I would need to have the same skills as other entry-level PT graduates.

McGonagle: No modifications were made – I went through the program as any other student would. However, many of my undergraduate courses transferred easily and my CPR requirement was waived because of my previous training and experience.

9. How did (will) your most recent degree prepare you for a career in animal rehabilitation?

Jacobs: The degree in veterinary medicine along with a degree in physical therapy will provide the ultimate education for performing animal PT. The veterinary medicine degree will provide a vast knowledge base for the overall health and fitness of the animal. The physical therapy degree provides the basis for the application of physical therapy procedures in a safe and effective manner for each case. However, I do not feel it is necessary for a physical therapist to become a veterinarian in order to provide animal physical therapy.

Steiss: Going through the UAB program has allowed me to select some of the neuromuscular conditions which originally were a puzzle to me (such as cold tail in Labrador retrievers, gracilis myopathy in German Shepherds) and see them through the eyes of a physical therapist. It has provided an entire new armamentarium of treatments which were not available to me before, or which I did not understand sufficiently well to be qualified to use, such as ultrasound therapy, etc. It also has made me realize the importance of active exercise, which is where much of my effort is now directed for sporting dogs, especially those undergoing rehabilitation from orthopaedic or neurological surgery.

McGonagle: In New York state you must be a veterinarian or veterinary technician to work with animals, so having this degree was the only way for me to legally offer physical therapy services to animals. I believe that veterinarians are more likely to refer cases to me now because they can relate better to my recent training.

10. How long did it take you to complete the program?

Jacobs: The veterinarian program takes 4 years to complete.

Steiss: I took some of the courses as sabbatical leave or annual leave from Auburn University, and completed the program over 6 years. I enrolled in 1994 and graduated and was licensed as a PT in 2000.

McGonagle: For me, the veterinary technician program took a year and a half to complete 32 credits. There are many lab courses, so it can be difficult to finish the program in 2 terms. I chose to go part-time 2 semesters and full-time my last semester.

11. What are the basic costs: tuition, books, fees, housing?

Jacobs: Tuition is about $10,500/year. Books are about $600-800/year.

Steiss: Housing costs were minimal since I was able to live at home, except for 2 quarters when I roomed in Birmingham. I received a graduate fellowship from the Physical Therapy Division to help with tuition. I was also in a slightly different situation, since I had been working as a full time faculty member at Auburn University since 1986 and therefore had some savings to fall back on.

McGonagle: Tuition was about $5,000 for three semesters. Books were about $800. Housing was $2,500 for nights I stayed over in a motel when I had early classes or labs.

12. What are your plans for the future?

Jacobs: After graduation, I plan to work in a veterinary practice that uses physical therapy or a facility that is looking to start a program prior to opening my own facility. I would like to be heavily involved in providing rehabilitation for the animals as well as performing general veterinary care. I would like to develop surgical skills especially in orthopaedics and progress towards a career specifically related to canine sports medicine.

Steiss: I am working in the Department of Rehabilitation Sci-

ences at UAB, in the Division of Occupational Therapy, teaching courses such as neuro-anatomy and starting a research program. My plans are to help to build bridges between veterinarians and physical therapists/occupational therapists. As a veterinarian, I am seeing case referrals on weekends. I am in the fortunate situation that I can go back to the university and brainstorm with the OT and PT faculty members to get their input on the treatments for specific cases. For instance, one of the faculty members who is a certified hand therapist is currently involved in designing a splint using low-temperature thermoplastics for a dog with chronic contracture of the carpus and digits. As a faculty member, I have been lucky to have a division head, Claudia Peyton, who supports my efforts to develop an elective course within the Department, which will cover animal therapy and animal-assisted therapy. These electives will take the form of an introductory course followed by separate canine and equine elective courses.

McGonagle: My plans include creating a Rehabilitation Service at Cornell University Hospital for Animals where I would be involved in clinical practice, research, and education. My research interests involve postoperative rehabilitation in dogs and back pain in horses. I will occasionally offer consultant services to Tuft's University and University of Pennsylvania's veterinary programs. I will contribute to the next International Rehabilitation conference for physical therapists and veterinarians and remain active with the SIG. In fact, Jan and I are already discussing plans for an Equine Rehabilitation course for APTA's 2002 Annual Conference as well as 3-day training program for the SIG.

13. Would you recommend this route for other colleagues who are interested in animal rehabilitation?

Jacobs: I would recommend this route for those interested in animal PT in addition to the practice of veterinary medicine. I believe it is not necessary to go to these extremes in order to practice solely animal PT. I feel a good veterinary technician program can teach the principles needed to complement a PT degree in order to provide effective animal PT.

Steiss: I agree with Lin – it depends! You need to look at how much time you can commit to pursuing another degree program, and what you ultimately want to accomplish in your professional life. There are various ways to have collaboration among professionals with DVM, PT, PTA, and veterinary technician degrees. And now, fortunately, there are introductory animal physical therapy courses being taught.

McGonagle: I like to answer this kind of question with. . . it depends! If you are a PT or veterinary technician and have a desire to learn about performing surgery, administering pharmaceuticals, and want to be the primary case manager in rehabilitation medicine, then I would pursue veterinary school.

If you are already a PT and want to be part of a rehabilitation team, then becoming a veterinary technician may help veterinarians relate to you more easily. It also may allow you to gain skills with handling animals and better understand the field of veterinary medicine. I would recommend enrolling in a veterinary technician program but only taking the courses that are most helpful to animal rehabilitation, unless you need the degree or want more letters after your name.

If you are a veterinarian and want to provide PT evaluation and treatment yourself, I would go to PT school.

If you are a veterinarian and want to add rehabilitation services to your practice, I would attend an introductory animal PT course and then hire an experienced PT.

If you are a veterinary technician and want to provide PT services as an evaluator and make decisions about programs, then I would recommend PT school.

If you are a veterinary technician and want to be part of a rehabilitation team, then I would encourage the veterinarian you work for to hire an experienced PT.

From a legal standpoint, I would recommend becoming a veterinary technician to PTs who live in states that require animal practitioners to be veterinarians or veterinary technicians. Veterinary technician programs require less time and are less costly than veterinary school and you have the potential to get to your goal faster.

From a clinical perspective, I believe that the PT degree is the essential academic training needed to provide rehabilitation services to animals.

From an educational perspective, I do not believe that every PT should become a veterinary technician. The majority of the program will not be clinically relevant to rehabilitation practice. Veterinary technician programs are certainly relevant to learning about animals and providing support to veterinarians in practice, but there is very little reference to physical therapy in these programs. You will not learn rehabilitation techniques in veterinary technician programs or even, to my knowledge, in veterinary schools except at the University of Tennessee and at North Carolina State University.

14. What would be included in your "ideal educational program"?

Jacobs: I feel a physical therapy degree is essential for the evaluation and treatment of animals or humans. In order to be an effective animal physical therapist, course work in animal gross anatomy, neurology, and physiology is necessary. An animal behavior course is also very important along with a strong clinical education program for the practice of animal PT.

Steiss: The "ideal" program depends a little on which species of animal you want to work with in the future, but the core courses such as anatomy, physiology, animal handling and an introduction to orthopaedic and neurological diseases would be part of the program.

McGonagle: I would recommend the development of a module-based program that fosters a Team Approach to rehabilitation. We need to address the training on different levels for PTs, PTAs, veterinarians, and veterinary technicians. I believe programs for PTs and PTAs should include animal anatomy and physiology, pharmacology, surgical procedures for orthopaedic and neurological cases, medical sciences–diseases, signs, symptoms, treatment, evaluation procedure, rehabilitation treatment techniques, animal behavior.

15. What are your thoughts on credentialing in animal rehabilitation?

Jacobs: I feel credentialing is necessary and should be mandatory. It provides a minimum standard for every clinician interested in practicing animal PT. It would give the practice of animal PT credibility among the professionals. I think the APTA could offer it along with input from the AVMA. Both organizations could meet to establish the minimum requirements necessary to produce qualified animal physical therapists. A certain number of clinical hours with a given species should be included in order for the practitioner to work with that species.

Steiss: This is a complicated issue that hopefully will receive the attention of both the AVMA and APTA. I am basically in favor of some form of credentials that would ensure competence since there is considerable public demand for these services, especially in the larger cities. I agree that these questions need to be answered in the near future. We need to educate others about who we are and what we are doing; for instance, many veterinarians are not aware that "physical therapy" is a protected term.

McGonagle: I believe that credentialing is essential and that it is important that we establish standards for practice. The SIG has been committed to this process even before it was an official part of the Orthopaedic Section. Ideally, this process would be a joint venture between the APTA and the AVMA.

REQUEST FOR PROPOSALS

ORTHOPAEDIC SECTION, APTA, INC.

CLINICAL RESEARCH GRANT PROGRAM

Purpose: The Orthopaedic Section must support its members by funding studies designed to systematically examine orthopaedic practice issues. The purpose of this grant program is to address the urgent need for clinical research in orthopaedic physical therapy.

Targeted Recipients of the Grant Program: The grant program is designed to provide funding for any Orthopaedic Section member who has the clinical resources to examine a well-defined practice issue, but who needs some external funding to facilitate the completion of a clinical research project.

Studies Eligible for Funding: The four types of studies that will qualify for funding are studies that: 1) examine the effectiveness of a treatment approach on a well-defined sample of patients with orthopaedic problems; 2) examine patient classification procedures for purposes of determining an appropriate treatment; 3) further establish the meaningfulness of an examination procedure or a series of examination procedures used by orthopaedic physical therapists; and 4) examine the role of the orthopaedic physical therapist in the health care environment. Authors must stipulate which purpose their grant is designed to address.

Categories of Funding: Two Grants at $10,000 maximum
Two Grants at $5,000 maximum

This program is designed for therapists who are ready to begin a project but need additional resources. The grant may be used to purchase equipment, pay consultation fees, recruit patients, or fund clinicians. Clinicians receiving funding from this program will be expected to present their results at CSM within 3 years of receiving funding. Recipients will receive $300.00 to allay costs associated with presenting at CSM.

Criteria for Funding:
Applications for this grant must be 10 pages or less and include the following

- A specific and well-designed purpose that is judged to be consistent with the four types of studies eligible for funding and described above
- The sample studied must include patients. For studies examining the role of the orthopaedic physical therapist in the health care environment, the sample studied would be therapists involved in the delivery of care
- Priority given to projects designed to include multiple clinical sites
- Priority given to studies examining treatment effectiveness
- Institutional Review Board approval from participating site(s) and letter of support from facility(ies) participating in the study
- Principal investigator **MUST BE AN ORTHOPAEDIC SECTION MEMBER**
- Priority given to projects that are currently not receiving funding
- Evidence of some pilot work
- A copy of the Principle Investigator (PI) and Co-Investigator(s) (CI) curriculum vitaes (not to exceed 3 pages each). The curriculum vitaes are not to be included in the 10 page limit
- A one-page summary showing proposed wok and timetable
- The funding period will be 1 year, renewable for up to 3 years, if judged to be appropriate

Determination of the Award: Deadline for submission of grant proposals is December 1, 2001. Each application should include one original and six copies of all material. The Grant Review Committee will review and evaluation each eligible application. A total of $30,000 is budgeted for grants each year (two at $10,000 and two at $5,000). All applicants will be notified of the results by March 1, 2002.

To receive an application, call or write to:

Clinical Research Grant Program
Orthopaedic Section, APTA, Inc.
Attn: Stefanie L. Snyder
2920 East Ave. South, Suite 200
La Crosse, WI 54601
800/444-3982 * 608/788-3965
e-mail: SSNYDER@CENTURYTEL.NET

Orthopaedic Physical Therapy Practice
Orthopaedic Section, APTA, Inc.
2920 East Avenue South, Suite 200
La Crosse, WI 54601

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