

## President's Message

*Nancy Robnett Durban, PT, MS, DPT*

The Pain Special Interest Group is continuing its efforts in developing the Pain Specialization and Residency/Fellowship, the DPT Education Manual and Resource Guide for Standards on Pain Education, and Clinical Practice Guidelines for Education as an Intervention for individuals with musculoskeletal pain. We will continue to offer our members Pain Pearls and Pain SIG Research: Abstracts, Articles, and Reviews emails in the future. Lastly, the Pain SIG strategic plan is currently under revision and when complete will be on our website. Please watch your inbox for education opportunities coming your way.

Thank you to all physical therapist front line providers. The adjective used to describe this present time in our lives is “unprecedented.” Synonymously, unparalleled, extraordinary, record, first-time, unique, exceptional, unmatched, unrivaled could be used as a substitute. The way in which we respond to this time requires physical therapists to practice in innovative, unique, nontraditional, path breaking, pioneering, pivoting, or trailblazing ways. Our Digital physical therapy practice is evolving at rapid speed in response to COVID-19. The following is a point of view article aiming to review current evidence of digital physical therapy practice for patients with pain now and in the future and to reflect on the pain of it all. A special thank you to Alan Chong W Lee, PT, DPT, PhD, Board-Certified Clinical Specialist in Geriatric Physical Therapy for his insight and knowledge as a digital physical therapy practice subject matter expert.

### DIGITAL PHYSICAL THERAPY...THE PAIN OF IT ALL

*Nancy Robnett Durban, PT, MS, DPT*

Prior to COVID-19, telemedicine had mostly been used in emergency and natural disaster situations and during infectious disease outbreaks such as Severe Acute Respiratory Syndrome (SARS) pandemic in 2003.<sup>1</sup> The ability to use a secure telecommunication system between a health care provider and a patient remotely is known as telehealth while telemedicine and telerehabilitation are terms to define medical and rehabilitation professions using telehealth services. Prior to COVID-19, I taught the topic of physical therapy delivered by telehealth in a module entitled, “The Future of Physical Therapy Pain Management.” Well, the future is now. This pandemic has transformed health care delivery with digital practice and telehealth. The aims of this point of view article are to examine the evidence of digital physical therapy practice with patients/clients in the literature and its application to patients/clients with pain now and in the future.

Recently, the World Confederation of Physical Therapy and the International Network of Physical Therapy Regulatory Authorities combined their efforts to develop a Digital Physical Therapy Taskforce.<sup>2</sup> The aim of the Digital Taskforce was to propose an international definition and purpose for digital physical therapy practice. Digital practice is defined as, “a term used to describe health care services, support, and information provided remotely via digital communication and devices.”<sup>2</sup> The purpose of digital physical therapy is defined as a means, “to facilitate effective deliv-

ery of physical therapy services by improving access to care and information and managing health care resources.”<sup>2</sup>

It is safe to say the practice of digital physical therapy has “zoomed” in light of COVID-19. As discussed in Lee et al’s point of view article, “it is clear that digital practice is a transformation in physical therapist practice, in which communication-based services (e-visits, virtual check-ins) beyond telehealth, telerehabilitation, and telemedicine are added to increase remote access to care while preserving scarce resources, including personal protective equipment”<sup>3</sup> and reducing cross contamination caused by close contact of in-person visits. Offering unique or innovative physical therapy solutions to patients’ needs is not out of the norm during in-person physical therapist practice. We do this every day. What is out of the norm is trying to administer physical therapy without the hands-on touch so necessary to our delivery of service. Using the means of digital physical therapy practice to “touch” our patients during this time is necessary. Clearly, there are limitations associated without being able to touch a patient during a physical examination, but there are opportunities to perfect our listening and history taking skills.<sup>4</sup> These touch points will require both hands-on and virtual check-ins to complement the best care now and post COVID-19 in the digital age.

In the literature, there is supporting evidence to move forward in digital practice and telehealth for patients with knee osteoarthritis (OA).<sup>5-7</sup> These studies investigated digital practice intervention for patients with mild knee OA. In two separate studies, Hinman et al<sup>5</sup> investigated exercise management for patients with OA via skype. The Skype business and health care program include a secured encrypted platform for telehealth use. Additionally, Lawford et al<sup>6</sup> examined the perception of people with OA who received exercise support via the telephone services by physical therapists. Recently, the Center for Medicare and Medicaid Services (CMS) in the United States added telephone service codes during this public health emergency (PHE) period. The results of the investigations had similar outcomes. The study participants liked the convenience, time efficiency, not having to travel or wait in the waiting room with this digital form of care delivery models. They also liked having the one-to-one undivided attention of the physical therapist. However, participants in both studies indicated they would have liked an in-person visit initially to develop a patient-provider relationship. As for the physical therapists who participated in the studies, they reported that the flexibility of the treatment allowed the participant to cancel and reschedule, which was disruptive to their workflow. Additionally, the participating physical therapists reported some discomfort they experienced with having to rely on the participant reported information rather than hands-on evaluation and assessment. Investigators in the Lawford et al’s study<sup>7</sup> noted the physical therapists realized that telephone based physical therapy intervention exceeded their expectations and that the initial need for visual interactions was less of a problem than initially thought to be. Their experience led to a new interest in this delivery of service. The telephone interactions provided the physical therapists the opportunity to focus on effective conversation that allowed the patients to be more open than they experienced in the clinic. Physical therapists stated that the advantages were that the

phone intervention was convenient for patients, helped improve exercise adherence, and led to improvements in confidence, reduction of pain, and increased function. At the conclusion of the theses studies, participants reported satisfaction of results such as having reduction of pain, improvement of function, and self-confidence. Both investigators concluded that digital physical therapist exercise management of patients with OA has the potential as a treatment option either as a sole treatment model or in combination with in person physical therapy practice. Lawford et al<sup>7</sup> additionally concluded that telephone intervention should not be a substitute for the in-person physical therapy care. Telephone support has also been determined to help self-management of patients with low back pain,<sup>8</sup> neck pain,<sup>9</sup> and patients with fibromyalgia.<sup>10</sup>

In addition to digital physical therapy studies of patients with OA, Schulz-Heik et al<sup>11</sup> investigated the response of Veterans who participated in an in-person and telehealth clinical yoga program. Their results indicate no significant difference in satisfaction or overall improvement of Veterans who participated in yoga-based intervention via telehealth or in-person. More than 80% of participants who endorsed a problem with pain, energy level, depression, or anxiety reported improvement in these symptoms in a group-based exercise program via telehealth. This result may seem irrelevant but it is not. What is important is the fact that the Veterans in this clinical yoga program reported similar high levels of satisfaction and improvement in multiple problem areas supporting the use of yoga via telehealth. However, other novel telehealth for complex treatments such as mirror therapy for the treatment of patients with phantom limb pain has been initiated and may require further research investigation.<sup>12</sup>

In terms of reliability and validity of telehealth assessments, Truter et al<sup>13</sup> investigated the validity associated with the measure of spinal posture, active movements of the lumbar spine, and the passive straight leg raise (SLR) test remotely. In-person measurements by a physical therapist's assessments were compared with telehealth assessment of spinal posture, active movements of the lumbar spine, and the SLR test. Pain, disability, and clinical measurements were also assessed and compared. High levels of agreement were found with detecting pain with specific lumbar movements, eliciting symptoms, and sensitizing the SLR test between digital and in person assessment. However, only moderate agreement occurred with identifying the worst lumbar spine movement direction, SLR range of motion, and active lumbar spine range of motion and poor agreement occurred with postural analysis and identifying reasons for limitations to lumbar movements. The study concluded that there are some valid assessments of patients with back pain that can be done via telehealth such as detecting pain with specific lumbar movements, eliciting symptoms, and sensitizing the SLR test. The validity and reliability associated with the internet-based physiotherapy assessment for musculoskeletal disorders has also been investigated by Mani et al.<sup>14</sup> Their results indicated that the digital physical therapy assessment of pain, swelling, range of motion, muscle strength, balance, gait and functional assessment demonstrated good concurrent validity. Additionally, Mani et al's<sup>14</sup> results indicate low to moderate concurrent validity of lumbar spine posture, special orthopaedic tests, neurodynamic tests, and scar assessments. Mani et al concluded that internet-based telehealth physical therapy assessment is "technically feasible with overall good concurrent validity and excellent reliability, except for lumbar spine posture, orthopaedic special tests, neurodynamic tests, and scar assessment."<sup>14</sup>

A systematic review of the evidence on the effectiveness of exercise-based telemedicine in chronic pain has been conducted by Adamse et al.<sup>15</sup> There were 16 studies included in their meta-analyses. This investigation concluded that exercise-based telemedicine interventions do not seem to have added value to usual care. As substitution of usual care, telemedicine might be applicable but due to limited quality of the evidence, further exploration is needed for the rapidly developing field of telemedicine.<sup>15</sup> Therefore, exercise-based telemedicine interventions appear to be somewhat effective in reducing pain and improving physical activity and activities of daily living for chronic pain patients, when compared to no intervention when medically deemed necessary.

When there is no ability or it is not safe to practice in-person delivery of care, it is important to focus on the delivery of digital physical therapy for the treatment of patients in pain is effective and the improvement of function. There are limitations to this practice such as to provide acceptance and willingness to learning new valid and reliable delivery of care they may have not been taught in their academic training. Hence, the need for continuing education is critical. Due to COVID-19, further evidence and practice guidelines will be necessary since physical therapists can furnish telehealth and communication-based services (telephone, e-visits, virtual check-ins) by CMS during this PHE. For example, future practice and research must include both in-person care and digital practice in patients with pain to determine the best dosage and practice. Furthermore, future payment, regulation, and interstate practice must be addressed in order to safeguard patient privacy, provider malpractice, and reduce unwarranted services and potential abuse and fraud in digital practice.

In light of COVID-19, we are providing individualized personal digital physical therapy care, becoming digital savvy, and perfecting listening and digital skills. We have to. This will provide new opportunities for the physical therapy profession to deliver valid and reliable high-quality care so that patients/clients and providers will all benefit in the future and solidify the evidence. We are increasing accessibility. We are reducing barriers of time and space. We are providing individualized personal digital physical therapy care. We are keeping safe. But the pain of it all is not just about addressing the pain of our patients. The pain of it all expands to include the physical and emotional pain some physical therapists are experiencing delivering digital practice. Prolonged sitting, headsets, breathing through masks for hours, face shields, or goggles, work station ergonomics, and stress to name a few. There is a great expanse of professional and personal stress such as accommodating to necessary rapid change, not abandoning our patients, keeping ourselves and family members safe physically and financially. There is also a significant grief of loss...loss of loved ones, patients, celebrations of any kind (life, death, adoptions, weddings, birthdays, graduations, vacations, hugs...). In this ever rapidly changing time, we need to take a moment to take care of ourselves so we can take care of others. We know what to do. We are physical therapists. Check the ergonomics of your desk. Yes, sit with both feet on the floor. Practice what we are preaching to our patients. Take breaks, walk, run, or bike. Just move. Do something every day that brings you joy. Be mindful. Eat nutritionally. Drink your water. Get good sleep and take deep breaths.

In conclusion, we are physical therapists. We have been charged to transform society. Now we are transforming our practice. This transformation has to continue. It needs to become part of the now normal service delivery model of physical therapy as advocated by

the American Physical Therapy Association's House of Delegates.<sup>16</sup> The digital practice of physical therapy has and will continue to enhance our delivery of care. Ensuring digital physical therapy practice is embedded in our routine delivery of care will keep us digitally ready for the future. So, are you ready to embrace digital practice and telehealth—Pain of it all?

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## FOOT & ANKLE SIG

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partially, or fully, online. Our hope is this may allow an expanded opportunity to share that programming with the FASIG community. So, stay-tuned because at the time this edition of *OP* reaches you there will likely be more plans in place for this “virtual” conference. [www.aofas.org/annual-meeting](http://www.aofas.org/annual-meeting)

- We previously reported on the progress of the foot and ankle fellowship initiative. As an update, our Declaration of Intent Letter was accepted by the American Board of Physical Therapy Residency and Fellowship Education (ABPTRFE) in February 2020. We have now submitted a *Practice Analysis Survey* that will form the backbone of the document to develop the specialty practice. Please stay tuned for updates on this initiative as the FASIG and the AOPT are eager to move this process ahead. Again, many thanks to our Practice Analysis Coordinators, Project consultant, and the entire taskforce working on this.
- The FASIG Practice Committee together with guidance from the AOPT Public Relations Committee is working on creating infographics to share information about common foot and ankle pathologies. These will be shared across the AOPT. Versions may also be developed to inform patients about common conditions and what to expect when seeking treatment. A special thanks to the FASIG Practice Chair, Megan Peach, DPT, OCS, CSCS, who is coordinating this effort.

We wish everyone in the FASIG, and the whole AOPT, health and well-being as the world adjusts in the wake of the COVID-19 pandemic. We are certainly all impacted as educators, health care providers, parents, community members, citizens, and partners in the process to get through this uncertain time. We will see how the summer and fall progress to allow us to return to many of our prior activities—but likely with a new wealth of online experiences.

### The FASIG Leadership

<https://www.orthopt.org/content/special-interest-groups/foot-ankle>