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Apr. 1, 2013 Vol. 24 No. 7

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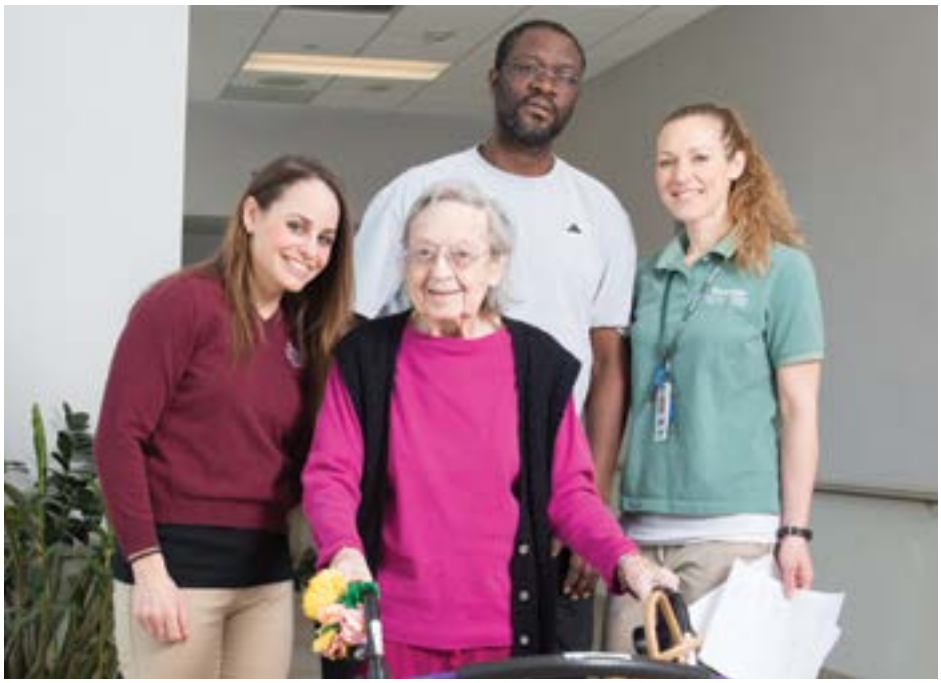

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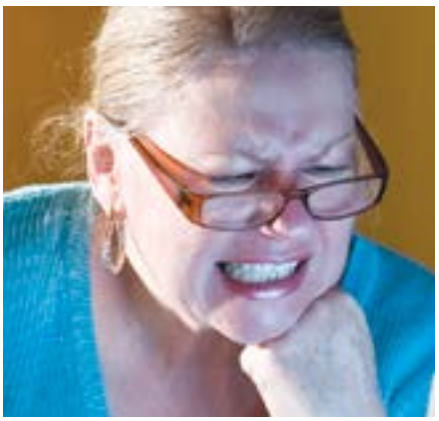

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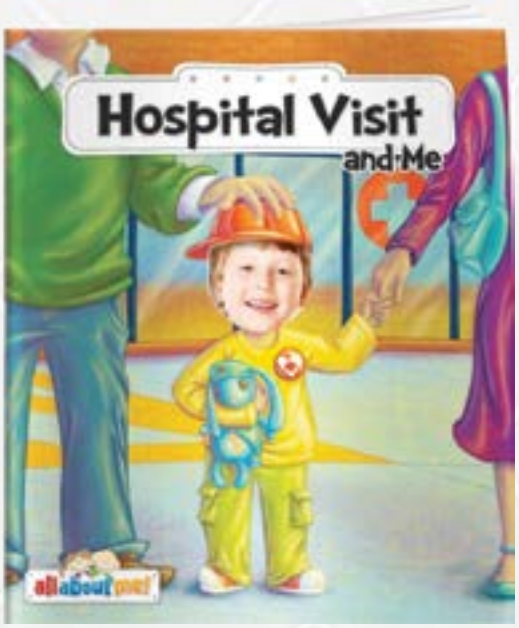

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Asking for PTO As a Student
Lauren wonders how to handle an upcoming schedule conflict as she readies for her yearlong clinical.

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Will Travel For Work
Now on her second business trip, Lisa feels much more prepared than the first time around.

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PT 4/1/13

By Brian W. Ferrie

Arkansas

New Legislation Reduces Out-of-Pocket Expenses

The American Physical Therapy Association, Alexandria, VA, issued a press release March 21 applauding the passage of new legislation that has made Arkansas the third U.S. state to limit patient copays and other forms of cost-sharing for services provided by physical therapists.

Senate Bill 277, which was promoted by the Arkansas Physical Therapy Association (ArPTA), was signed into law by Gov. Mike Beebe on March 14. As a result, patients will now pay less out of their own pockets when they visit a physical therapist, resulting in improved access to vital health care.

SB 277 specifies that patient copays, coinsurance and office visit deductibles charged by health benefit plans for services provided by physical therapists, occupational therapists and speech-language pathologists may not be higher than those charged for services provided by primary care physicians. The bill was authored by Sen. Jonathan Dismang (R-28) and Rep. Joe Farrer (R-43) and will take effect 90 days after the legislature adjourns.

"ArPTA worked hard to produce and introduce this bill with our sponsor, Sen. Dismang," said ArPTA President Steve Forbush, PT, PhD, OCS. "We are pleased that Arkansas legislators agreed there is a need for this legislation and moved it through both the House and Senate with unanimous votes. High copays in our state were preventing patients from receiving the care they need. ArPTA appreciates their efforts to make physical therapy more accessible by passing this bill." ■

By Lisa Lombardo

Meniscal Tear Treatment: PT or Surgery?

Last month, my mom, who is 67, had surgery on a torn meniscus in her right knee. She's not even sure how she tore her meniscus, and it was a very light tear; could have been something as simple as planting her foot wrong or her foot coming lose from her shoe, causing the twist. I wouldn't consider her extremely "active." She has a full-time desk job but does walk for about 20 minutes a day at lunch when weather permits.

Before her surgery, I did some investigating on whether surgery was necessary, and what she could expect to be able to do once her treatment was complete. I asked her if the doctor had suggested physical therapy as an option, rather than the surgery. She was told the surgery, done in an outpatient office, was very non-invasive and with some rest and proper pampering of her knee, she'd be fine in a few weeks. And she now is, having recently returned to work. Other than the exercises she was told to do every day after she got home, she was told post-op physical therapy wouldn't be needed.

It turned out that her surgeon removed some arthritic cartilage too, so perhaps the surgical intervention was the best option, in her case. But it did make me wonder if physical therapy was even put forth as a viable alternative to having the surgery. Perhaps the doctor took a look at the tear and decided surgery would be minimal enough to go right to the source. And when my mother first experienced the tear, she was in a great deal of pain; at the outset, the combination of the tear and arthritis formed in the knee made walking near to impossible.

New research from Brigham and Women's Hospital suggests that physical therapy may prove just as effective as surgery for some patients. These findings were presented in March at the annual meeting of the American Academy of Orthopedic Surgeons and simultaneously published online in the *New England Journal of Medicine*.

Researchers at seven major universities and orthopedic surgery centers around the U.S. assigned 351 people with arthritis and meniscus tears to get either surgery or physical therapy. The therapy was nine sessions on average plus exercises to do at home, which experts say is key to success. After six months, both groups had similar rates of functional improvement. Pain scores also were similar.

Thirty percent of patients assigned to physical therapy wound up having surgery before the six months was up, often because they felt therapy wasn't helping them. Yet they ended up the same as those who got surgery right away, as well as the rest of the physical therapy group who stuck with it and averted an operation. The research was supported by the National Institute of Arthritis and Musculoskeletal and Skin Diseases of the National Institutes of Health.

Should my mom have been encouraged to opt for PT rather than the surgery? It might have saved her time off from work, but would it have prolonged her pain? Can patients assume doctors do consider PT as an option, but decide on a patient-by-patient basis who needs surgery and who can heal just as well without it? I'd be interested to know what readers think. ■

Lisa Lombardo is editor of ADVANCE *and can be reached at llombardo@advanceweb.com*

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Practice Protection

Professional negligence can take many forms—be sure your practice is covered

By Franklin Rooks Jr., PT, MBA, Esq.

When people hear the word "liability" in a medical setting, their first inclination generally is to think about a type of malpractice. Medical malpractice — the term ascribed to actionable negligence attributed to a medical professional — carries tremendous liability.

But in a medical setting, negligence isn't limited to just health care providers and the treatment they give to patients. Negligent acts can be committed by all employees, and in many instances the negligent acts of your employees can be attributed to you, the employer.

What is Professional Negligence?

Negligence, by definition, exists when damages are caused by the actions (or omissions) of a person, whereby that person breaches a duty of care owed to another person. A breach of the duty owed to another person is aptly summarized as the "failure to exercise the standard of care that a reasonably prudent person would have exercised in a similar situation."

Negligence is expressed in terms of the following elements: the existence of a duty owed to another person; the breach of that duty; the existence of damages; and that damages were caused by that breach of duty.[1] One of the principles of negligence is that a person is liable for conduct that results in damages or injury if the person should have reasonably foreseen that their conduct would cause damages or injury.[1]

To illustrate this principle, consider the driver who approaches an intersection marked by a stop sign, and who does a "rolling stop." The person slows down as he approaches the intersection, but does not completely stop. He then proceeds through the intersection and collides with another vehicle.

Under the legal negligence doctrine, the driver had a duty to other vehicles on the road. That duty was to stop at the stop sign, and to look both ways before proceeding through. The rolling stop was a breach of that duty; the collision was caused by that breach, and damages resulted to the other driver.

Negligence in the employment setting is similar, but there are some variations.

'Respondeat Superior'

Practice owners have a duty of care to "business invitees." That is, you have the duty of exercising reasonable care for the safety of all persons on the premises; the practice owner is liable for any injury caused by the breach of such duty.

That duty also extends to the acts and omissions of your employees. Employers can be held liable for the acts of their employees under several different theories. One of the common mechanisms is respondeat superior.[1] The phrase is Latin for "let the superior answer." This doctrine holds the employer accountable for an employee's negligent acts committed within the scope of employment.

In order to impose vicarious liability on an employer for the damages caused by its employee, the injurious act must be incidental to the employee's authorized conduct or, to an appreciable extent, must further the employer's business interests.

A simple example is the janitor who is mopping the floors, spills water, but fails to clean it up. A patient walks by without seeing the spilled water, slips, and falls. The janitor is functioning within his scope of employment, but failed to take the necessary steps to prevent this easily foreseeable injury. The employer would bear liability for this negligent act.

Sometimes, negligent acts are not as straightforward as spilling water on the floor. Another legal theory used to hold employers accountable for the actions of its employees is "negligent supervision." Under this theory, it must be demonstrated that the employer knew or should have known its employee behaved in a dangerous or otherwise incompetent manner.

Additionally, it must be demonstrated that the employer failed to adequately supervise the employee, and that the employer's negligence in training or supervision of the employee was the cause of the injuries. The employer's liability for negligent supervision is direct, not vicarious.[2]

Damage does not have to take the form of a personal injury. Injuries can also be financial. Consider the front desk staff member who fails to take the necessary protective steps to safeguard a patient's credit card information when collecting a co-payment. If the patient's credit card information ends up in the wrong hands, it could almost certainly lead to a financial injury. Your practice has a duty of care to the patient to maintain the integrity of their financial information. A breach of that duty, either through an act or failure to act (omission), could lead to a

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cause of action against the practice.

Negligence generally does not relate to intentional acts. That is, the driver who rear-ends another driver because they were distracted is quite different than someone plowing into the trunk of another person's car on purpose. Respondeat superior is generally applicable to the negligent acts of an employee that are performed in the scope of employment, in furtherance of the employer's business interests.

Nevertheless, an employer can be held liable for the intentional acts of an employee that are committed outside of the scope of employment through another legal doctrine.

Negligent Hiring and Retention

As a practice owner, you may be exposed to liability for hiring or retaining incompetent employees. The negligent hiring doctrine sets forth the premise that employers have a duty to use reasonable care in the selection and hiring of employees.

The duty owed by the employer to the practice's patients (customers) is to hire safe and competent employees. When an employee commits an intentional or criminal act against a patient (customer) while working for the employer, liability is established by demonstrating that the duty was breached and that damages resulted as a result of that breach of duty.

When an employee steals a patient's credit card information, the employer could be exposed to liability via the negligent hiring or negligent retention doctrine. The theft of credit card information is clearly outside the scope of employment, even though it may occur at the workplace. The employee's acts are intentional ones, not negligent.

Still, the direct cause of the damage to the patient is attributable to the employer. The employer's negligence is rooted in the hiring or retaining of an employee that the employer knew or should have known was incompetent. The challenge lies in establishing that the employer knew or should have known that the employee was incompetent.

Establishing incompetence is circumstance-specific. Generally, the degree of care an employer should exercise in selecting or retaining an employee is that degree of care that a reasonable person of ordinary prudence would use in consideration of the nature of the employment and the consequences that could result from the employment of an incompetent person.

"The degree of care should be commensurate with the nature and danger of the business and the grade of service for which the employee is intended, as well as to the hazards to which other employees would be exposed from the employment of a careless or incompetent person."[3]

Court cases have demonstrated numerous ways in which incompetence can be shown — habitual drinking of liquor, habitual carelessness, forgetfulness, inattentiveness, inexperience, physical or mental defects, propensity for horseplay, recklessness, maliciousness or viciousness.

It's important to mention that liability could attach if a former employee commits negligent or intentional acts while working for a new employer, if a negligent reference was provided that employer. Some jurisdictions have recognized that a duty of care exists when a current or past employer provides a reference to a prospective employer. That duty is to not "misrepresent facts in describing the qualifications and character of a former or current employee, if making misrepresentations would present a substantial, foreseeable risk of physical injury to third persons."[4]

Negligence Takes Many Forms

Negligence can be more subtle than the more obvious and common causes you may be familiar with. As a practice owner and employer, you have a duty to protect your patients, and that duty encompasses everything from safety hazards such as slippery floors to protections against the acts of your employees.

A comprehensive liability policy can further protect you from legal action as a consequence of your employees' actions. According to the American Physical Therapy Association (APTA), professional liability insurance is designed to protect a physical therapist's assets and cover expenses in the event of a malpractice suit.

Under both respondeat superior and the negligent hiring/negligent retention doctrines, an employer can be held liable for damages caused by the acts and omissions of its employees.

Respondeat superior is not applicable when the employee's actions are committed purely out of a personal motive. When an employee's personal motives usurp the employer's legitimate business pursuits, negligent hiring and negligent retention doctrines may be applicable. In addition, an employer can also be held liable if it provides misleading reference information about an employee under certain circumstances. ■

References are available online at www.advanceweb.com/pt.

Franklin J. Rooks Jr. is a physical therapist and practicing attorney in Philadelphia. This article is not legal advice and is intended to provide only general, non-specific legal information. This article does not cover all of the issues related to the topic discussed. The author can be reached at fjrooks@gmail.com

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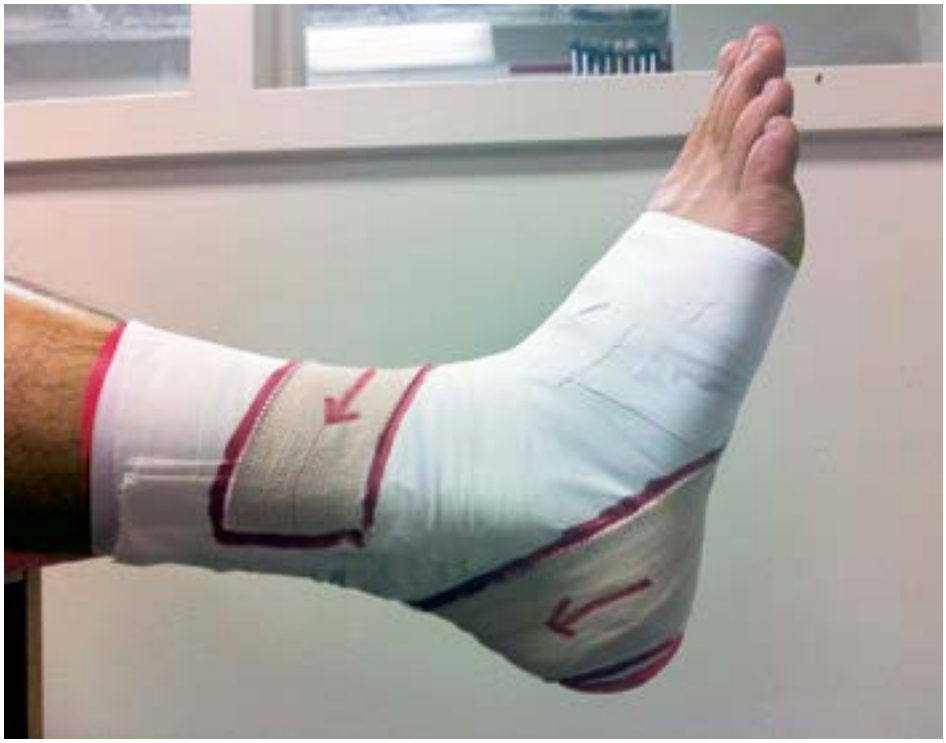

Comfort and Function

Selecting the right tape to meet sport-specific needs

By Lauren J. Stephenson, MA, ATC

As clinicians, we know that understanding the whole picture is imperative in devising a comprehensive and effective rehabilitation plan when working with patients who have musculoskeletal injuries. We assess not only the injury site, but also deviations, deficiencies and malalignments throughout the kinetic chain in order to best address the source of the problem and return our patients to full activity as safely and efficiently as possible.

This concept is similar when applying tape to an athlete who has sustained an injury to the lower extremity. The clinician must take into consideration the properties of each type of tape, the nature of the equipment for the sport, the position the athlete plays, and the patient's personal preferences in addition to the injury. By incorporating these principles, taping procedures applied to the lower extremity will be functional, which will facilitate healing while allowing the athlete to continue participating in his sport.

Functional Taping

In order for any taping procedure to be functional, the patient has to be willing to keep it on while participating in sport. There are several factors that go into whether or not athletes will be compliant with wearing a supportive external device. Primarily, the taping procedure must be comfortable for them. While part of the equation depends on the actual application of the tape, the other is choosing a tape that will serve its purpose in providing support, allowing the joint to move through a pain-free range of motion while maintaining neurovascular integrity. Part of ensuring comfort and function is having an understanding of how taping procedures can be integrated into protective equipment.

The primary purpose of taping a joint is to support and protect injured joint structures. In many sports, other protective devices such as guards or padding are required to maintain safe play. The clinician must consider how a taping procedure fits underneath or outside of protective equipment. For example, a football player wears a cleat that's more of a high-top, with a wide heel counter, midsole and toe box. The structure of this type of cleat allows the clinician to add a significant amount of tape to the foot and ankle without causing too much crowding in the shoe.

While identifying functional differences between sports is fairly easy, the clinician must also take notice that within one sport each position may require different athletic abilities.

Conversely, a soccer player traditionally wears a cleat that is a half- to a full-size smaller than his shoe size in order to allow for better ball handling. The soccer cleat design usually has a low top, narrow heel counter, midsole and toe box. Using a similar taping procedure to that used on the football player would not only compress the foot in the shoe, but would limit the ability of the soccer player to feel the ball, therefore limiting effective play. While the soccer player may have the same injury as the football player, the clinician can't apply the same taping procedure and maintain compliance.

In addition to understanding the structure and function of sport-specific equipment, the clinician must also consider the nature of the sport the athlete participates in. While this does include equipment, it also encompasses the amount of contact involved and position the athlete plays. There's a significant difference in the amount of contact sustained by a wrestler and a baseball player. A wrestler is constantly engaged in full-body contact with his opponent, while a baseball player rarely makes any contact with his opponent, interacting more with equipment (e.g., gloves, bats, helmets, guards) than other athletes. Taping procedures that are applied to a wrestler must therefore be secured so that they continue to provide joint support throughout the full-body contact sustained in a match.

Different sports also require different functional motions. A baseball shortstop primarily functions in the frontal plane, requiring more lateral support than a sprinter, who primarily functions in the sagittal plane and would

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require more anterior/posterior support.

While identifying functional differences between sports is fairly easy, the clinician must also take notice that within one sport each position may require different athletic abilities. This is most easily depicted in football where linemen function mostly in the sagittal plane in short, explosive motions, and receivers are required to have greater endurance, moving over longer distances and performing cutting maneuvers to avoid being tackled. The type of tape and procedure that are chosen to support an injured joint must take all of these factors into consideration. Examples of how these principles are applied to toe and ankle taping procedures are provided below.

First Metatarsophalangeal Joint Taping

There are two main methods of taping the first MTP joint to prevent hyperextension: (1) the more traditional toe strapping, and (2) "whale tail" or turf toe strap. The toe strapping method is more economical since athletic tape is less expensive than the moleskin used for the turf toe strap. More athletic tape is required, however, to achieve limited hyperextension, therefore the turf toe strap could benefit athletes who prefer less tape on the foot or have limited space in their footwear.

Additionally, the toe strapping allows for more motion at the first MTP when compared to the turf toe strap, so this method may be best for athletes who require greater amounts of MTP extension to perform in their sport, such as sprinters. As a general rule, an elastic anchor around the midfoot will be most comfortable since it allows the foot to spread during weight-bearing stances.[1]

- Apply a lightweight elastic anchor to the midfoot.
- Apply a non-elastic 1-inch anchor to the great toe.
- Using non-elastic* 1-inch tape, apply three to four strips from the distal to the proximal anchor on the plantar aspect of the toe overlapping by half a tape width.
- This procedure can be modified to use half-inch heavyweight elastic tape for athletes who require more hyperextension to perform their sport. Turf Toe Strap:[1]
- Apply 2- or 3-inch either pre-cut ("whale tail") or manually cut "T" moleskin to the great toe, wrapping the "T" portion around the distal aspect of the toe and closing it on the dorsal aspect of the toe.
- Anchor the remainder of the moleskin to the plantar aspect of the foot.
- Apply a non-elastic 1-inch anchor to the distal toe to secure the "T" strap.
- A lightweight elastic anchor can be applied proximally around the midfoot, but due to the strong adhesive properties of moleskin, it isn't required.

Ankle Taping

Ankle injuries are the most common in athletics, and therefore, ankles are the most commonly taped joint. The traditional closed basket-weave procedure can be modified in numerous ways to be functional for athletes. These modifications can be based on level of support by choosing different types of tape or by adding straps to support specific structures.

In athletes who function primarily in the sagittal plane, such as runners, sprinters, long/triple jumpers and swimmers, lower levels of medial/lateral support are required. This can be achieved by making adjustments in the materials used for the stirrups and heel locks.

In this circumstance, the clinician would use athletic tape for the stirrups and a more elastic, lightweight tape could be substituted for the heel locks. This provides support, but does not restrict inversion and eversion as much.

Athletes who perform planting and cutting maneuvers in the frontal plane may require increased medial/lateral support to be able to participate post ankle sprain. Moleskin can be used as a stirrup to limit inversion by anchoring it first medially and pulling laterally. Based on the needs of the athlete and sport, the moleskin stirrup can also be applied with equal tension medially and laterally by placing the ankle in a neutral position and anchoring the middle of the strap under the calcaneus and pulling evenly proximally, anchoring the medial and lateral sides simultaneously.

Combining this with 1.5- to 2-inch heavyweight elastic tape pulled out toward the end of its elastic range for the heel locks provides the ultimate amount of support for the lateral ankle ligaments.

As inversion and eversion occur at the subtalar joint, a subtalar sling can be added to the closed basketweave to further limit these motions in more severe ankle sprains. A lateral subtalar sling is used for lateral ankle sprains.

For medial ankle sprains, a medial subtalar sling is applied; however, this places the ankle in an open packed position and increases risk of an inversion injury. The clinician should therefore also apply a lateral subtalar sling for medial ankle sprains, placing the ankle in a neutral position. This procedure is done with 1.5- to 2-inch heavyweight elastic tape.[1]

1. Apply anchors, stirrups and horseshoes of closed basketweave.
2. Anchor heavyweight elastic tape on the medial plantar forefoot, angling the tape toward the distal fifth metatarsal.
3. Course the tape over the lateral foot toward the lateral malleolus.
4. Wrap the tape posteriorly around the lower leg.
5. Anchor the tape on the lateral lower leg.
6. Apply heel locks with 1.5-inch non-elastic athletic tape.
7. Close procedure.

Athletes are strong-willed and motivated patients. Their goal is to be on the field or court every day working to their maximum abilities. Choosing a functional taping procedure that supports an injured structure and addresses the needs of the sport and the athlete will increase compliance, protecting the injury and allowing the athlete to continue to participate safely. ■

Reference

1. Beam, J. (2006). *Orthopedic Taping, Wrapping, Bracing & Padding*. Philadelphia: F.A. Davis Company.

Lauren J. Stephenson is clinical assistant professor at the athletic training program at Stony Brook University, Stony Brook, NY.

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FROM HOSPITAL TO HOME

Physical therapy is a key component in facilitating smooth transitions for patients

By Karyn A. Baig, PT, DPT, and Jenna Tucker, PT, DPT

Inpatient rehabilitation for patients with brain injury (BI) typically focuses on interventions that improve independence with functional mobility activities including transfers, ambulation and elevations. In the clinical setting, it's easy to control external factors that could present safety risks or force patients to make split-second decisions. In the "real world," our patients will confront new and unfamiliar situations every day. So, how do we best prepare them and their families to successfully transition from hospital to home and back into the community?

Common Challenges

Our patients are particularly challenged by dynamic balance tasks, divided attention/dual tasking, and endurance-based activities.[1] Visual impairments related to the area of the brain injured may also affect patients; a visual field cut or visual neglect can impede safe negotiation of an open environment.[2]

In general, those with BI experience impaired executive functioning, a broad term that refers to difficulty with higher-level cognitive processes including initiation, planning, hypothesis generation, cognitive flexibility, decision-making, self-monitoring, judgment and use of feedback.[3] More specifically, impaired executive functioning may negatively impact an individual's ability to successfully conquer his environment as he struggles with navigational and daily life skills that involve time management, sequencing and memory.[2]

What Is an Advanced Mobility Group?

Individuals with BI face a unique variety of challenges that impact rehabilitation and eventual reintegration into the community. We, as therapists, require a creative, individualized approach to address and ultimately overcome these challenges.

At Kessler Institute for Rehabilitation in West Orange, N.J., we're addressing these needs through an Advanced Mobility Group (AMG). Patients must meet specific criteria to participate in this 60-minute adjunct therapy (see Table 1), which involves completing the Modified Multiple Errands Test (MMET; see Table 2) and performing various executive functioning tasks within the hospital and outdoors on hospital grounds to simulate "real-life" situations.[4]

At left, Karyn Baig, PT, DPT, (far left) and Jenna Tucker, PT, DPT, physical therapists at Kessler Institute for Rehabilitation inpatient spinal cord injury unit, assist patients Edith Granick and Ade Adesanya on a walk. Above, the therapists help patients through their task lists.

KYLE KIELINSKI

While the MMET is standardized, the remainder of the treatment is not. After collaborating with the patient's interdisciplinary team to discuss the most salient deficits, the AMG lead (a physical or occupational therapist) customizes a session to directly address these deficits. Individuals must ambulate with minimal assistance or better and are accompanied individually or in a group of up to three. When working in a group, patients are encouraged to collaborate to foster social support and communication.

Performing tasks outside the controlled clinical environment is important for many reasons. It allows the therapist to present specific challenges the patient will confront upon returning to the community. By observing the patient in real-life scenarios, the AMG lead is able to provide detailed feedback on high-level cognitive deficits noted to the interdisciplinary team, who in turn are able to develop more targeted treatment interventions. These observations can also be relayed to patients' families to create safe environments upon discharge and reinforce strategies to ease the transition from hospital to home.

Developing Insight Into Deficits

Self-awareness, more often of cognitive than physical deficits, is often diminished in patients with BI and they may be resistant to external feedback from therapists and family. Returning to more realistic environments, where they're forced to make decisions and self-monitor, can promote improved insight into deficits and greater motivation for overcoming them, especially when tasks are related to personal goal attainment.[5,6] During AMG, compensatory strategies for physical and cognitive deficits are reinforced, allowing the patient to better prepare emotionally for eventual community reintegration.

Mrs. W.: Multidisciplinary Approach

The following cases illustrate AMG's role in building awareness and just how important a multidisciplinary approach is in addressing challenges to create a more optimal outcome. Mrs. W. participated in AMG with emphasis on community distance ambulation over varied terrain, transfers to and from various surfaces, executive function, topographical orientation, time management, divided attention and dual tasking.

During a particularly challenging dual-task activity the patient became emotional,

Table 1. Criteria for Adjunct Therapy	
Inclusion Criteria	**Exclusion Criteria**
Ambulation with or without assistive device, with no more than minimal assistance	Patients who present as an "elopement risk"
Ambulation greater than or equal to 150 feet	Patients with a "wander-guard"
Functional endurance to tolerate 10-15 minutes of mobility tasks without a rest break	Ambulation with more than minimal assistance
	Contact precautions

anxiously stating, "I can never go home like this." Following the session, the neuropsychologist was apprised of the episode and recommended reassessment in one week, following targeted interventions. The patient's primary therapists were made aware of the specific deficits noted and underlying emotional difficulties. The AMG lead then made specific recommendations to address them. For example, in physical therapy, ambulation over varied surfaces/terrains would be the focus, as the patient feared negotiating her steep driveway.

Speech and occupational therapy would concentrate on executive function tasks, particularly computer usage, as this was a vital component of her occupation. In addition, all therapies would practice divided attention and dual-task activities, to ensure a safe transition to an open environment. The team was able to successfully tailor interventions to meet these needs. Upon reassessment the following week, Mrs. W. demonstrated improvements in all areas, and completed the program with significantly less anxiety regarding discharge.

Mr. Z.: Time for Self-Evaluation

At the conclusion of each AMG session, patients have the opportunity to self-evaluate and are provided with feedback from the lead to help build awareness into deficits. The way feedback is provided is important. For those who present with defensive coping strategies in response to feedback, a less confrontational approach is recommended. For these patients, repetitive task performance required for procedural learning and habit formation may be more effective since it can elicit behavioral change without explicitly detailing task performance.[5,6] In this case, follow-up sessions with the AMG lead may be necessary. With non-defensive patients, a more direct feedback approach is warranted because they're more receptive to assistance in recognizing how impairments interfere with tasks and learning adaptive approaches.

This was the approach taken with Mr. Z., a patient who believed he was safe for discharge without the assistance of a caregiver. Upon leaving the familiar gym environment for AMG, Mr. Z.'s deficits were significantly exacerbated in executive function, way-finding in an unfamiliar environment, topographical orientation, divided attention with visual

Table 2. Modified Multiple Errands Test

How efficient would you rate yourself with tasks such as shopping, finding information and meeting people on time?
a) very inefficient b) inefficient c) efficient d) very efficient

How familiar are you with the hospital and grounds?
a) very inefficient b) inefficient c) efficient d) very efficient

Task	Order of Tasks	Observations
Photocopy this list		
Go to the front desk and ask for the cafeteria		
Find the ATM machine		
What is the opening time of the hospital gift shop on Tuesday?		
What is the closing time of the cafeteria on Wednesday?		
List one Item from today's lunch menu		
Find out how much a Gatorade costs		
Locate the fish tank on the first floor		
Find out how many tables are in the caferia		
Meet at the first floor lobby by _____ a.m.		

How well do you feel you accomplished this task?
a) very inefficient b) inefficient c) efficient d) very efficient

Source: Kessler Institute for Rehabilitation, West Orange, NJ.

scanning and dynamic balance on uneven indoor and outdoor surfaces. Mr. Z.'s left-sided inattention, which appeared minor in the gym, was drastically amplified in an unfamiliar environment.

For example, while ambulating throughout the hospital, the patient walked directly up to a wall; even after maximal verbal redirection over a six-minute period, the patient then required maximal tactile cueing to eventually turn down the appropriate hallway on the left — his side of inattention. Following this session, Mr. Z. better appreciated the impact of his deficits on mobility within an open environment. In addition, the therapists and doctors were able to better educate the patient's family on areas where assistance and education would be required.

As exemplified by these two cases, it's vital that ambulatory patients with cognitive and physical impairments participate in activities in open environments to simulate potential home and community scenarios. With a stronger understanding of limitations observed in AMG, therapists are able to better forecast unsafe situations that may materialize upon discharge, and relay this information to patients and family. In doing so, therapists are better able to take all necessary steps to reduce the risk of consequences from these deficits, enabling the safest possible transition back home, and ultimately, to the community. ■

Resources are available online at www.advanceweb.com/pt.

Karyn Baig is a senior physical therapist at Kessler Institute for Rehabilitation inpatient spinal cord injury unit, West Orange, N.J. Jenna Pikowski Tucker is a staff physical therapist at Kessler Institute for Rehabilitation inpatient brain injury unit.

Standing for Independence

Standers can be helpful for children with a variety of diagnoses, even those categorized as being independent

By Amy Marso, MSPT

For PTs working in pediatric physical therapy, the decision to use a stander for many of the children we see is often a good choice. Standers are used by children with a variety of diagnoses including, but not limited to, cerebral palsy, osteogenesis imperfecta, spina bifida, muscular dystrophy, hypotonia or any other developmental delay and/or neurological disorder that causes a child to be unable or delayed in ability to independently achieve an upright standing position.

Benefits of Standing

When using a standing program, we often think first of the many benefits to the child's musculoskeletal system. In 1992, Stuberg conducted a study having children with developmental disabilities complete a standing program for eight weeks, which resulted in significant increases in bone density in the patella, tibial plateau and supracondylar femur.[1]

In 2007, Pin published a systematic review of studies examining static weight bearing in children with cerebral palsy and reported that static standing in a standing frame increases bone mineral density.[2] Static weight bearing is also assumed to prevent tightness or contracture of soft tissues and restore length of muscle by prolonged stretching.[3]

In 2009, Gibson reported that standing nonmobile children with CP for a six-week trial resulted in an increased popliteal angle as well as the caregivers reporting improved ease of transfers.[4] There is also evidence to support the idea that static weight bearing through the lower extremities may temporarily reduce spasticity as a prolonged stretch in children with cerebral palsy.[2]

In addition to the effects on the musculoskeletal system, standers are thought to benefit patients by improving circulation and increasing cardiovascular endurance, improving bowel and bladder function, reducing the risk of pressure sores, and providing psychological and social benefits since children are able to interact with their peers in a standing position.

There's also evidence that a standing program can result in changes to a child's functional mobility skills.[5]

When to Begin and Continue Standing

A child with any of the diagnoses listed above who is not standing independently by 12-15 months will likely be a candidate to begin a standing program. While the decision to begin a standing program is often straightforward with young patients, the decision becomes more difficult once that child is able to stand or ambulate independently.

The school-based physical therapy team will need to look at various factors including the benefits of standing, opportunities for standing in the student's natural environment, and how standing may impact learning at school. These decisions may range anywhere from continuing or modifying the current program, to changing the equipment a student may be using, or in some cases possibly discontinuing a standing program.

We also need to think outside the box and realize there may be some students in the adolescent and young adult age ranges who would also benefit from a standing program.

Case Study

I recently made a request to a physical medicine and rehabilitation doctor to begin a standing program at school with an ambulatory student who was new to my caseload. The doctor responded by stating this patient was an independent and, therefore, there would be no reason to use a stander with him.

The student is a 15-year-old male with spina bifida. He ambulates with a crouched gait pattern and fatigues quickly, but he is able to ambulate throughout his school environment independently. At school, he wears bilateral ground reaction ankle-foot orthotics at all times. When traveling long distances, he uses a wheelchair due to fatigue. He's able to go up and down stairs at school with the use of a railing for safety, and he requires a longer period of time than his peers when transitioning between classes.

At the beginning of the school year, this student was completing an independent stretching program each day at school. He admitted that he only completed this program when he was made to do it at school. He was uninterested in making any changes to his stretching program or adding any type of strengthening/endurance activities to his daily exercise program.

This student presented with decreased range of motion in both knee and hip extension bilaterally. When talking with this student and his parents, they reported he had never used any type of a standing device. I felt he would be a good candidate for a standing program to achieve a prolonged stretch with the goal of improving range of motion and functional mobility. When looking for evidence to present to his doctor supporting use of a standing device for this purpose, I came up with very few sources. Much of the literature on passive range of motion is inconclusive as to any clinically significant increases in range of motion.[6,7]

After talking further with the doctor and explaining the goal of the standing program,

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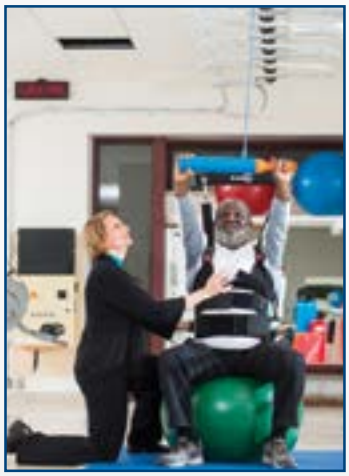

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he was in agreement with the plan and said that he could not see any harm in trying a stander. The next task was to convince a 15-year-old boy who had never tried a stander before to use it on a daily basis at school. The best agreement we could come to was to begin a six-week trial period where he would stand each morning in the resource room for a period of 20-30 minutes. He was very apprehensive about how the stander would look to other students, so using it while he was in the resource room, with only one other student present, was critical to his agreement to try the stander.

The standing program required a great deal of encouragement from staff at the school since the student often said his legs hurt or he was tired during the first few days. As we progressed through the trial period, he became more comfortable and required less encouragement each day. The student was allowed to pump the stander up himself to a comfortable position with a slight stretch on his legs.

Results

At the end of the six-week trial period, range-of-motion measurements were taken again for hip and knee extension bilaterally. At this time, he demonstrated an increase in range of motion in all joints. Staff at school reported functional changes as he was now able to transition between classes, including going up and down stairs at a pace closer to that of his peers. The student reported that he felt like he could "stand up taller and walk faster."

The objective measures of range of motion and walking speed were encouraging, but just as hopeful were the changes in the student's attitude. He was now willing to begin some daily strengthening exercises at school and was expressing a desire to want to push himself physically. This student's family takes a trip to Disney World each year, which was scheduled for the week after his trial period ended. He expressed interest that he wanted to walk around Disney as much as he could instead of being pushed through the park in his wheelchair.

Due to the improvements in both range of motion and functional mobility that were observed, we continued the standing program. However, he was unable to use the stander for a period of four weeks that coincided with the Disney trip and a break from school. When returning to school, his range of motion measurements were taken again, and all joints had returned to the measurements they were prior to beginning the standing program. He was also ill when returning to school, which further impacted the decreased speed and endurance observed when compared to his levels prior to the four-week break from standing.

He is currently continuing the standing program each day at school, as well as participating in a strengthening program. We are hopeful that we'll see his range of motion, speed and endurance increase and possibly surpass the improvements noted in the initial six-week trial. This data will make a strong case for the need to continue a daily standing

independence continued on page 42

The Lowdown on Low-back Pain

Identifying myofascial trigger points that can cause low-back pain as well as their key perpetuating factors

Mary Biancalana, MS, CMTPT, LMT

KYLE KIELINSKI

Myofascial trigger points are finally becoming an increasingly recognized etiology for (non-visceral) low-back pain. More and more research is pointing to the efficacy of low-cost intervention strategies due to the fact that we now know that many cases of acute low-back pain will resolve with soft-tissue and low-cost manual intervention, according to a July 2011 article in *Spine Journal*. Whether or not the cause of the episode is eliminated, however, can be the difference between chronic, multi-episodic occurrences or a full-function, pain-free life with minimal flare-ups. Considering the impact of muscular, postural and occupational perpetuating factors on the development of trigger points can improve clinical outcomes.

Doing a History

Our case scenario is a 53-year-old male who reports 2-3 times per year crippling low-back pain episodes. He reports that the pain runs up and down his back and into his upper buttocks. Imaging studies are unremarkable.

The report in the patient's own words often sounds like this: "My back just 'goes out' and I'm stuck crawling on all fours to go to the bathroom. There is no rhyme or reason, it just grabs me and I'm off work for a week flat on my back, in bed; it's too painful even to roll over and get up. This time, all I did was bend down to pick up a tissue I dropped. Not a heavy box or anything! Then on my way to stand up, pain shot into my low back, I was so mad and fearful, I just crawled into bed and stayed there."

Upon further investigation we learn more about this patient. He is a stressed-out accountant, he has a 45-minute commute to and from work in a car with bucket-style seats, he weighs 250 pounds, and is 5'10". He sleeps in the fetal position, and is so busy at work slouching over his computer that he does not get up for lunch. He watches 2.5 hours of TV in his favorite recliner each night, loves his coffee and drinks at least 6-8 cups per day, drinks 2 ounces of water per day when he takes his medicine in the morning, and has not been to an exercise class since college in 1980. His standing torso extension is minus 5 degrees and his sidelying hip extension measures 12 degrees with discomfort into the low back at end range. What we have is a classic case of chronically shortened iliopsoas and rectus abdominis muscles.

Within this history, we uncover what I like to call the "super six" — the most important key factors that perpetuate myofascial dysfunction and set us up for acute or chronic myofascial pain in the low back:

1. Poor sleep posture (stomach position is the worst, followed by fetal position);
2. Great length of time spent sitting per day (shortens hamstrings, hip flexors and abdominals);
3. Poor occupational posture;
4. Low amounts of water consumed per day;
5. High amounts of caffeinated or sugary drinks consumed;
6. Low amount of dynamic movement or (full ROM) exercise per day/week/month.

Dr. Janet Travell and Dr. David Simons, co-authors of the seminal work on myofascial dysfunction and trigger points, thought the perpetuating factors to MTrPs (myofascial trigger points) were so important to identify and remediate that they dedicated an entire chapter to them in their books *Myofascial Pain and Dysfunction* and *The Trigger Point Manuals*. Having practiced for more than 13 years in this field, I can attest to the miraculous improvement in treatment outcomes once these factors are identified and, more importantly, eliminated.

Muscles in Front, Pain in the Back

While the super six perpetuating factors may be all but missing in an otherwise healthy person who exercises regularly but still has low-back pain, overtraining the abdominals (iliopsoas, rectus abdominis) can cause trigger points and chronic shortening of those muscles, which then become stuck in a metabolic crisis and chronic myofascial dysfunction. This leads to the potential for acute activation pain after being in the shortened position. We bend down to pick up our toddler, our abdominals passively shorten, and when we stand up, segments of the abdominals remain shortened, and the TrPs in them cause referred pain into the low back. The iliopsoas and rectus abdominis are the most probable muscles implicated in referred pain into the lumbar back.

In our sitting society, they certainly are the muscles that are kept in a shortened position for extended periods of time and rarely are fully stretched. The iliopsoas has a referred pain pattern that runs up and down along the spine, while TrP#2 in the rectus abdominis has a referred pain pattern that runs horizontally across the low back. How or why these referred patterns follow these predictable patterns is not completely understood, but it is known that the referral patterns are usually segmentally distributed.

Treating the Correct Muscles

In their books, Drs. Travell and Simons divided the body by region and listed the muscles that can refer pain to each particular region. For our purposes, the first step is to identify the muscles that can cause pain in the lumbar back.

In their text, seven muscles are listed that can cause lumbar pain — gluteus medius, lumbar multifidi, iliopsoas, longissimus thoracis, rectus abdominis, iliocostalis thoracis, and iliocostalis lumborum. Next, range of motion assessment for each of the 13 muscles can be done, along with palpatory investigation.

We are looking for uncomfortable taut bands of many thousands of myofibril bundles involved in the trigger point dysfunction, not individual microscopic trigger points. If

a muscle displays limited or painful range of motion, then it requires further treatment.

Range of motion assessment for the iliopsoas muscle (and hip flexors) may include measurement of supine hip extension or sidelying hip extension. Reduction in passive hip extension and/or a reported feeling of discomfort or pain in the low back bodes positive for trigger points in the iliopsoas muscle.

Manual Treatment of Iliopsoas

Manual treatment of the iliopsoas or rectus abdominis usually begins with the treatment of the antagonist erector spinae group. This will reduce the chances of them contracting on the passive short when we place the patient in supine hip extension. The left leg is kept bent, while the right hip is in extension with the right iliopsoas and rectus abdominis on a moderate degree of stretch, supported on a chair. This stretch position should be maintained for short duration and can be increased as treatment progresses. Trigger point pressure release should be applied in all three iliopsoas locations as well as Trp#2 for rectus abdominis. Treatment should also continue along the full length of the muscles. For the central iliopsoas Trp, pressure is first exerted downward at the lateral border of the rectus abdominis, then angles medially under the rectus abdominis, compressing the iliopsoas against the lumbar spine. It is best to finish this treatment by placing the patient sidelying and hip-flexed, allowing the psoas and abdominals to relax, and the erectors to be stretched.

back pain continued on page 42

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Wide Range, Close Knit

Therapists in the Northeast Region keep professional and social ties

By Sarah Long

States in the Northeast Region may vary in geography and population density, but no matter what the location, the physical therapists who live and work there say there are abundant opportunities for professional networking, diverse practice settings and a high level of personal satisfaction.

With Vermont being a small state, it's easy to get to know other clinicians, said Justine Dee, PT, MS, a LANA-certified lymphedema therapist at Dee PT in South Burlington, Vt. Many of the clinicians have either gone to school together at the University of Vermont or have gotten to know each other via jobs or through supervision of PT students during their careers.

Dee also appreciates the state's beauty, and enjoys skiing or biking after work, depending on the season. "The therapists at the clinic where I work are very athletic and involved in a variety of sports," she said. "Many of them run, spin or swim before work. This helps to keep me motivated to stay in shape, helps to manage stress, and it demonstrates to patients the positive benefits of exercise."

Dee takes advantage of the resources for community clinicians at the nearby University of Vermont's physical therapy department in the department of rehabilitation in the College of Nursing and Health Sciences. Participating in research being done at the university, such as the work of Sharon M. Henry, PT, PhD, studying treatment of patients with low-back pain, helps keep PTs up to date on what is going on in the physical therapy profession and healthcare community, she said.

At Vermont's university hospital and medical center, Fletcher Allen Health Care (FAHC), there are numerous opportunities to attend grand rounds, annual meetings and lectures by physicians and researchers. "This occurs at the other hospitals around the state, which are smaller than FAHC, but have very good reputations for patient care as well," Dee said.

Some PTs who live in Vermont work at Dartmouth-Hitchcock Medical Center (DHMC), which is located in New Hampshire, just across the eastern border of Vermont, and many Vermonters take advantage of DHMC's continuing education opportunities.

The Vermont chapter of the American Physical Therapy Association (APTA) holds conferences and meetings throughout the year, and has recently started to telecast the conferences to other sites around the state to make it easier for therapists to access the information and stay involved.

Conferences also are held periodically at the University of Vermont. "Dr. Henry has had faculty from Washington University come and teach about the Movement System Impairment examination and treatment, and Karen Westervelt, PT, OCS, and Sonya Worth PT, OCS, both part-time clinical faculty, have arranged and held several different manual therapy courses, bringing in speakers from Australia to teach Mulligan mobilization with movement techniques," Dee said. "They are taking a group of students to New Zealand this summer for a three-week manual therapy course."

The Vermont Lymphedema Network, a nonprofit group, also sponsors annual conferences and networking opportunities.

"There is a variety of work settings to practice in — acute-care facilities, inpatient and outpatient rehabilitation centers, privately owned PT outpatient clinics, skilled nursing facilities, schools, home health — and there does always seem to be openings at different facilities," Dee said.

Outdoor Lifestyle

David Barlow, DPT, OCS, a physical therapist and partner at BE Fit Physical Therapy in Hanover, N.H., lives in Norwich, Vt., and works in Hanover, a border town and five-minute commute.

"Part of working in New Hampshire is the easy commute and outdoor lifestyle. The community I'm in — Upper Valley — is an extremely athletic region so, as a sports and orthopedic PT, I get to work with very motivated and active clientele."

New Hampshire is a direct-access state so individuals can pursue PT with fewer constraints on insurance, and can "access care more quickly than getting bogged down in the healthcare system red tape," Barlow said. "The fact that we are at times the first choice in assessing an individual's injury or pain means that we have to be knowledgeable, stay current on best practice, provide thorough assessments and work well with our colleagues — PCPs, specialists and other practitioners, massage, personal trainers, chiropractors, etc. — to ensure patients get the proper care. This is very rewarding from a practice side, and it is that level of responsibility that makes my work enjoyable."

While some continuing education courses can be found through the New Hampshire chapter of APTA, the Dartmouth-Hitchcock Medical Center and other organizations, most events seem to be held around the Manchester-Concord-Nashua region, Barlow said.

"In general, there are fewer opportunities than the bigger cities and less of the more

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At A Glance

Salary Information in the Northeast Region

	Connecticut	Maine	Massachusetts	New Hampshire
Employed PTs	3,530	1,300	6,880	1,150
Employed PTAs	440	260	2,310	370
Employed PT Aides	570	220	870	130
PT Average salary	$80,490	$74,320	$78,310	$72,260
PTA Average salary	$57,260	$46,720	$54,050	$48,740
PT Aide salary	$26,810	$24,850	$29,180	$28,570
	New Jersey	**New York**	**Rhode Island**	**Vermont**
Employed PTs	6,330	13,490	1,050	660
Employed PTAs	970	3,410	190	120
Employed PT Aides	3,150	2,630	110	—
PT Average salary	$88,270	$78,840	$82,240	$72,110
PTA Average salary	$57,330	$47,810	$51,040	$46,420
PT Aide salary	$25,570	$26,910	$25,680	—

Salary information provided by the U.S. Department of Labor, www.bls.gov. State licensing agencies can be found at www.fsbpt.org/licensing/index.asp

high-profile type of courses that draw in the more experienced or well-known speakers," he said. "We have hosted a course or two at our clinic, which has also been a way to get some desirable speakers to the area in the content we are looking for."

As an owner of a PT practice, Barlow has had trouble attracting PTs to the Upper Valley area. "This is especially true with regard to the more experienced PT sports and ortho population," he said. "This is likely true in other even more rural areas of the state."

Because DHMC and Dartmouth College are nearby, there's a diversity of inpatient and outpatient settings, but jobs are limited.

"Some of the bigger areas such as Concord, Manchester and Nashua may have more opportunities than the smaller towns," Barlow said. "One area in our region that's truly underserved is neuro rehab, both from a medical side and PT side."

Like Vermont, Rhode Island's small geographical footprint makes professional networking easy. It's easy to get involved with the state chapter of APTA at any level, said Jennifer Audette, PhD, PT, clinical assistant professor at the University of Rhode Island (URI). "The people involved are welcoming and open to ideas," Audette said. "I like that we are pretty close-knit. Many of us have lived and worked

in the state for a very long time." Job opportunities exist in all practice settings. "Any PT I know who wants to be working is working," she said.

Michelle E. Collie, PT, MS, DPT, OCS, owner and director of Performance Physical Therapy, which has offices in Smithfield, Barrington, Pawtucket, Providence and Riverside, R.I., echoed Audette's sentiment.

"The state is small so it's great to easily be able to have professional relationships with PTs throughout the state, the one PT program at URI, plus other healthcare providers, and legislators at a state and federal level," she said. "Everyone knows each other, which is great. It means word of mouth gets out quickly when a PT or a practice is not so great so it keeps the overall standard of care high."

PTs can pursue continuing education through the Rhode Island chapter of APTA, and through URI and Warren Alpert Medical School of Brown University in Providence. "A number of private practices now offer residency programs," Collie said. "There are plenty of great opportunities in hospitals, home care, schools and private practice."

On the opposite end of the population spectrum is New York, which Daniel J. Rootenberg, PT, DPT, CSCS, president of SPEAR Physical Therapy Centers in New York, N.Y., deemed "a great place to work."

"The energy of the city creates an environment of highly motivated and highly educated patients that challenge us as professionals to be at our best," he said. "The adage of 'if you can make it here you can make it anywhere' rings true. You have to bring your 'A' game every day regardless of what else may be going on."

The opportunities to network both with colleagues and physicians are abundant due to the many hospital groups in the area.

"I find that hospitals and physicians are reaching out to physical therapists in ways that were not there in the past as we all realize that we're on the same side of the equation," Rootenberg said. "Due to the population density, there are plenty of jobs, especially for motivated PTs who have passion for their profession." ■

Sarah Long is a freelance writer.

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PT and the City

Lisa Mueller earned her DPT in 2009. Since that time, she spent more than two years working in an acute intensive care unit and has recently transitioned into an outpatient orthopedic setting in Milwaukee. She also has experience in lecturing for physical therapy students.

Toni Talks about PT Today

Toni talks about the PT world the way she sees it as a veteran of the field and recent graduate from a transitional DPT program. She welcomes comments and responses – anything is fair game!

The Busy PT's Guide to Finding Balance

With a husband, four children and a dog, Janey Goude finds maintaining balance is as essential as it can be elusive. Join her as she shares strategies that make life a better, balanced place.

PTA Blog Talk

With more than 15 years of PTA experience behind him, Jason Marketti is still learning and growing every day. He invites you to join him on his journey through the therapy profession and as a husband and father of three children.

PT and the Greater Good

Dean Metz has been in clinical practice for more than 20 years as a physical therapist in New York, Florida and most recently the National Health Service of England. He's now working for the largest home care agency in the United States, training and implementing a healthcare plan to address the holistic needs of the frail elderly in New York.

Physical Therapist in Transition

Karen Schiff is working full-time in Florida as a physical therapist and acting interim director of another facility while pursuing her transitional doctoral degree. In addition, she's a single mother of two teenage daughters and is active in her community.

Journey of a DPT Student

Follow Lauren Rosso as she navigates her way through the DPT program at the University of Pittsburgh and looks forward to her future physical therapy career.

ADVANCE Perspective: Physical Therapy

The *ADVANCE for Physical Therapy & Rehab Medicine* editorial staff discusses important issues in the PT profession as well as other current events in health care.

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ON-SITE SEMINARS

APRIL 5-6, 2013 — **SAVANNAH, GA**

Physical Therapy Assoc of Georgia Annual Spring Meeting

PTAG will host the 2013 Spring Meeting at The Armstrong Center in Savannah, GA on April 5-6, 2013. The educational meeting will feature educational programs for PTs & PTAs. Athletic Trainers may also earn educational credits at PTAG meetings. PTAG is offering (19) nineteen contact hours of continuing education in the following topics: Ethics and GA Jurisprudence for the PT Practice, Differential Diagnosis of Leg Pain, Fascial Manipulation, The Three I's: Imaging and Issues in the Neuro ICU, Shoulder Pain, Posture - Let's Get Vertical with Pilates Principles. **Contact:** 770-433-2418; www.ptagonline.org for more information.

APRIL 11-14, 2013 — **SAN DIEGO, CA**
APRIL 18-21, 2013 — **CHICAGO, IL**
MAY 2-5, 2013 — **BALTIMORE, MD**

Intro to NDT Part I Improving Gait Faster Part II

Achieve functional outcomes for adults with hemiplegia. Content includes the principles of NDT, facilitation of sit-to-stand, use of the LE in functional activities, transfers, UE weight-bearing, remediation of pain and subluxation of the hemiplegic shoulder. Bed mobility will be demonstrated. Treatment ideas and a framework to document goals based on functional outcomes using NDT will be provided. Get to results faster when improving gait. Increased clinical reasoning will enable you to know what to expect and what to predict. You will be able to assess the cause of the problem and have more immediate influence. You will have a better understanding of the normal components of gait and then understand why your patient with hemiplegia has tendencies in gait. You will practice with "hands-on" how to increase ROM of the hip and foot. Concepts for use of a self-exercise program and use of orthotics will be discussed. Additional treatment ideas related to gait and more examples of documentation will be provided. Both parts include client intervention videos & "hands-on" experience. Cathy Runyan, OTR/L, & Peggy Miller, PT, Recovering Function NDT Instructors. Audience: PTs, PTAs, OTs, COTAs. Contact hours: 30. **Contact:** Recovering Function, 408-268-3691; or www.RecoveringFunction.com for a complete brochure of introductory, advanced, and certification courses as well as information about additional course dates/locations, group rates & free registrations when hosting courses at your facility.

APRIL 12-13, 2013 — **URBANA, IL**
APRIL 27-28, 2013 — **STATEN ISLAND, NY**
AUGUST 16-17, 2013 — **WEYMOUTH, MA**

Movement, Rhythm and Sequencing - Getting the Beat

This intensive conference will provide clinicians with dynamic state of the art intervention strategies that support integration of sensation in children with sensory, emotional and motor challenges. Presentation of current neurobiology of the vestibular system's central role in sub-cortical and cortical intercommunication and related research are reviewed. Assessment strategies and intervention methods to: Improve sensory modulation, Enhance vestibular function and postural skills, Optimize social readiness, Synchronize the organization and sequencing of motor skills and behavior as needed for optimal function in time and space. Instructor: Lise Gerard-Faulise. **Contact:** Education Resources, Inc., 508-359-6533; 800-487-6530 (outside MA); www.educationresourcesinc.com

APRIL 13-14, 2013 — **TAMPA, FL**
APRIL 20-21, 2013 — **ATLANTA, GA**

Complete Wound Care Prevent-Assess-Debride-Treat

The intensive two-day course covers topics ranging from physiology of wound healing and modalities in wound care to documentation & risk management. Through a combination of interesting lecture & extensive hands-on labs (including compression dressings, Doppler, sharp debridement, ultrasound & electrical stimulation), this course strives to provide individualized attention. After years of presentation, when given a choice of Excellent, Good, Fair, or Poor, over 80% of attendants rated this course Excellent, all others rated it Good. Cost: Only $350 for 16 hours. Please call for group discounts. **Contact:** JVB Enterprises, Inc., 888-328-6755 (toll-free); or www.teachtx.com

APRIL 13-14, 2013 — **NEW YORK CITY, NY**
APRIL 26-27, 2013 — **PORTLAND, OR**
JUNE 21-22, 2013 — **ORLANDO, FL**

Dr. Carol B. Lewis Presents: Clinical Geriatric Neurology

Carole B. Lewis, PT, DPT, GCS, MSG, MPA, PhD, FAPTA presents Geriatric Neurology. This entertaining lecture provides take home information on cutting edge assessment and treatment of older clients with Parkinson's disease, stroke, gait, balance disorders, and pain problems with a 300+ page handout with over 5,000 current medical references. Use these treatment techniques and evaluation tools to work smarter not harder. **Contact:** Great Seminars and Books, 877-794-7328 (toll-free); or www.greatseminarsandbooks.com

APRIL 13-14, 2013 — **STATEN ISLAND, NY**
JUNE 1-2, 2013 — **KALAMAZOO, MI**
OCT. 26-27, 2013 — **HOLLYWOOD, FL**

Diagnosis/Treatment: Movement Impairment Syndromes

The concepts and principles of the movement system impairment (MSI) theory as developed by Shirley Sahrmann, PT,

(Continued on next page)

(Continued from previous page)

PhD, FAPTA, and its relationship to alteration in neuromusculoskeletal function will be presented. This course will enable the clinician to identify impairments in alignment, muscle length, and pattern of movement and their relationship to musculoskeletal pain syndromes. The signs and symptoms of syndromes to be diagnosed by the therapist will be described. Discussion will focus on developing a precise therapeutic exercise program to correct faulty posture and movement associated with functional activities. Instructor: Mary Kate McDonnell. **Contact:** Education Resources, Inc., 508-359-6533; 800-487-6530 (outside MA); www.educationresourcesinc.com

APRIL 13-14, 2013 — **LAS VEGAS, NV**
JUNE 22-23, 2013 — **CHERRY HILL, NJ**
AUG. 17-18, 2013 — **SAN JOSE, CA**

Rehabilitation For Osteoporosis

Speaker: Sherri Betz, PT, GCS, CEEAA, PMA-CPT. This informative 20 hour seminar places an emphasis on postural awareness, neuromuscular re-education for trunk control, balance, spinal extension & lower extremity strength as applied to fall and fracture prevention of the hip and vertebral bodies. Learn innovative & creative Pilates-based models and evidence-based treatment ideas. Discover how to use the FRAC fracture risk assessment tool & how to introduce alignment, breathing and core control. Exercise classes presented will be appropriate for the fit or frail osteoporotic patient. **Contact:** Great Seminars and Books, 877-794-7328 (toll-free); or www.greatseminarsandbooks.com

APRIL 18-19, 2013 — **OCONOMOWOC, WI**

WI Physical Therapy Association Spring Conference

The Wisconsin Physical Therapy Association (WPTA) will host its Spring Conference April 18-19, 2013 at the Olympia Resort & Convention Center, Oconomowoc. The conference will feature hands-on labs, lectures, discussions, expert panels and a professional issues forum. Attendees will receive contact hours qualified as continuing education by the Wisconsin DSPS for courses attended in their entirety. Registration includes continental breakfasts, morning & afternoon breaks, luncheons, Welcome Reception, Business Meeting, Awards Dinner and conference materials. All classes are held on a first-come, first-served basis. Sign up early! **Contact:** WPTA office, 608-221-9191; wpta@wpta.org for more information or www.wpta.org to download a registration form or register online.

APRIL 19-20, 2013 — **LAS VEGAS, NV**

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Stanley V. Paris, PT, PhD, FAPTA

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S1 - Spinal Evaluation & Manipulation
Impairment Based, Evidence Informed Approach
35 Hours, 3.5 CEUs (No Prerequisite)
$895

Little Rock, AR	Furto	Apr 17 - 21
Charleston, SC	Yack	Apr 18 - 22
New York City, NY	Yack	May 1 - 5
Kalispell, MT	Yack	May 17 - 21
Boston, MA	Yack	Jun 19 - 23
Orlando, FL	Furto	Jul 17 - 21
Austin, TX	Yack	Aug 14 -18
St. Louis, MO	Furto	Sep 11 - 15
Atlanta, GA	Yack	Sep 18 - 22
St. Augustine, FL	Viti	Oct 9 - 13
Harrisburg, PA	Furto	Nov 6 - 10
Baltimore, MD	Smith	Nov 7 - 11
Indianapolis, IN	Yack	Nov 13 -17

S2 - Advanced Evaluation & Manipulation of Pelvis, Lumbar & Thoracic Spine Including Thrust
21 Hours, 2.1 CEUs (Prerequisite S1)
$595

Chicago, IL	Yack	Apr 12 - 14
St. Augustine, FL	Irwin	May 3 - 5
Atlanta, GA	Yack	May 31 - Jun 2
Denver, CO	Yack	Jun 7 - 9
New York City, NY	Yack	Jul 12 - 14
St. Augustine, FL	Irwin	Sep 13 - 15
Houston, TX	Irwin	Oct 18 - 20
Birmingham, AL	Irwin	Oct 25 - 27
Little Rock, AR	Irwin	Dec 6 - 8
Orlando, FL	Yack	Dec 6 - 8
San Marcos, CA	Yack	Dec 13 - 15

S3 - Advanced Evaluation & Manipulation of the Cranio Facial, Cervical & Upper Thoracic Spine
27 Hours, 2.7 CEUs (Prerequisite S1)
$795

Chicago, IL	Viti	Jun 6 - 9
St. Augustine, FL	Smith	Jun 13 - 16
Denver, CO	Smith	Jul 25 - 28
New York City, NY	Smith	Aug 1 - 4
Birmingham, AL	Irwin	Aug 15 - 18
Baltimore, MD	Smith	Sep 13 - 16
Ft. Lauderdale, FL	Irwin	Nov 7 - 10
St. Augustine, FL	Smith	Dec 6 - 9

S4 - Functional Analysis & Management of Lumbo-Pelvic-Hip Complex
15 Hours, 1.5 CEUs (Prerequisite S1)
$545

Ft. Lauderdale, FL	Lonnemann	Jun 1 - 2
Virginia Beach, VA	Nyberg	Jun 22 - 23
San Marcos, CA	Grant	Aug 17 - 18
Denver, CO	Grant	Aug 24 - 25
Charleston, SC	Nyberg	Sep 14 - 15
New York City, NY	Nyberg	Oct 12 - 13
St. Augustine, FL	Grant	Nov 2 - 3
Houston, TX	Nyberg	Nov 16 - 17
Chicago, IL	Nyberg	Dec 7 - 8

E1 - Extremity Evaluation and Manipulation
30 Hours, 3.0 CEUs (No Prerequisite)
Also Available to OTs
$745

Austin, TX	Turner	Apr 25 - 28
Orlando, FL	Naas	Apr 25 - 28
Atlanta, GA	Busby	May 2 - 5
San Marcos, CA	Turner	May 30 - Jun 2
Washington, DC	Naas	Jun 20 - 23
Boston, MA	Busby	Jul 18 - 21
St. Augustine, FL	Busby	Jul 25 - 28
Asheville, NC	Naas	Aug 8 - 11
Columbus, OH	Naas	Sep 12 -15
Kalispell, MT	Busby	Sep 19 - 22
Las Vegas, NV	Turner	Oct 3 - 6
New York City, NY	Busby	Oct 3 - 6
Ft. Lauderdale, FL	Naas	Oct 10 - 13
Chicago, IL	Busby	Oct 24 - 27
Charleston, SC	Busby	Nov 14 - 17

E2 - Extremity Integration
21 Hours, 2.1 CEUs (Prerequisite E1)
$595

St. Augustine, FL	Patla	May 3- 5
Birmingham, AL	Patla	Jun 28 - 30
San Marcos, CA	Patla	Jul 19 - 21
Orlando, FL	Patla	Aug 2 - 4
Houston, TX	Patla	Sep 13 - 15
Virginia Beach, VA	Patla	Sep 20 -22
New York City, NY	Conrad	Nov 8 - 10
St. Augustine, FL	Patla	Nov 15 - 17

MF1 - Myofascial Manipulation
20 Hours, 2.0 CEUs (No Prerequisite)
$595

St. Augustine, FL	Grodin	Apr 19 - 21
Birmingham, AL	Cantu	Apr 26 - 28
San Marcos, CA	Stanborough	Apr 26 - 28
Atlanta, GA	Grodin	May 17 - 19
Little Rock, AR	Cantu	Jun 28 - 30
New Orleans, LA	Cantu	Aug 23 - 25
Chicago, IL	Cantu	Sep 20 - 22
Las Vegas, NV	Grodin	Oct 4 - 6
Ft. Lauderdale, FL	Cantu	Oct 25 - 27
Columbus, OH	Cantu	Nov 8 - 10
New York City, NY	Grodin	Dec 6 - 8
St. Augustine, FL	Cantu	Dec 6 - 8
Washington, DC	Stanborough	Dec 13 - 15

MANUAL THERAPY CERTIFICATION Preparation and Examination
32 Hours, 3.2 CEUs
(Prerequisites: S1, S2, S3, S4, E1, E2, MF1)
$995

St. Augustine, FL		Jun 10 - 15
San Marcos, CA		Jul 15 - 20
St. Augustine, FL		Sep 30 - Oct 5

Advanced Manipulation Including Thrust of the Spine & Extremities
20 Hours, 2.0 CEUs (Prerequisite: Completion of MTC Certification)
$775

St. Augustine, FL	Yack	Apr 26 - 28
Austin, TX	Irwin	Sep 27 - 29

Additional Seminar Offerings

Applied Musculoskeletal Imaging for Physical Therapists
21 Hours, 2.1 CEUs (No Prerequisite)
$545

St. Augustine, FL	Agustsson	May 17 - 19
San Marcos, CA	Agustsson	Aug 23 - 25
Austin, TX	Agustsson	Nov 1 - 3

Caregiver Training 1: Assessment and Treatment of Dementia
12 Hours, 1.2 CEUs (No Prerequisite)
Open to OTs, PTs, COTAs, PTAs and other health professionals
$445

Atlanta, GA	Hubbard	Apr 20 - 21
St. Augustine, FL	Hubbard	Aug 3 - 4

Exercise Strategies and Progression for Musculoskeletal Dysfunction
15 Hours, 1.5 CEUs (No Prerequisite)
Open to OTs, PTs, COTAs, PTAs
$545

St. Augustine, FL	Chaconas	Apr 13 - 14

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A $100 non-refundable deposit must accompany registration form. A 50% non-refundable, non-transferable deposit is required for Certification. Balance is due 30 days prior to start date of the seminar. Balance can be transferred or refunded with 2 week written notice. Notice received after that time subject to only 50% refund. No refunds or transfers will be issued after the seminar begins.

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(Advanced notice and full payment required, does not apply after the first day of a seminar.)

Multiple Seminar Discount - Register and pay in full for two or more seminars at the same time and receive a 10% discount.
(May not be combined with any other discounts or previous registrations.)

ADV 4-13

Seminar dates, locations, and tuition are subject to change, please call before making any non-refundable reservations.

APRIL 19-20, 2013	TALLAHASSEE, FL
APRIL 26-27, 2013	SCOTTSDALE, AZ
SEPT. 20-21, 2013	TUSCALOOSA, AL

Mobilizing the Medically Complex Acute Care Patient

Therapists are often challenged when presented with complex acute care patients who may have cardiovascular and/or pulmonary dysfunction or complications in addition to other medical conditions. Mobilizing these complex patients safely requires integration of the implications of lab values, diagnostic test results, patient history, medications and equipment. Signs of patient instability and when and how to modify or terminate treatment will be discussed. Instructor: Ellen Hillegass, EdD, PT, CCS, FAACVPR. **Contact:** Education Resources, Inc., 508-359-6533; 800-487-6530 (outside MA); www.educationresourcesinc.com

APRIL 19-20, 2013	WEYMOUTH, MA
MAY 31-JUNE 1, 2013	ANAHEIM, CA
OCT. 4-5, 2013	FORT WORTH, TX

Therapeutic Interventions in the NICU

This course focuses on development and therapeutic interventions in the NICU. It covers assessment and treatment, transition to home, post discharge follow-up and identification of emerging disabilities. Strategies to optimize behavior, development and feeding of the neonate will be offered in addition to practical approaches to facilitating teamwork and caregiver engagement. Instructor: Tracilyn Watson-Urruela. **Contact:** Education Resources, Inc., 508-359-6533; 800-487-6530 (outside MA); www.educationresourcesinc.com

APRIL 20-21, 2013	KNOXVILLE, TN
APRIL 20-21, 2013	LITTLE ROCK, AR
MAY 10-11, 2013	MISSOULA, MT

Kinesio Taping® Fundamentals and Advanced

Many more KT1/KT2 dates and locations, and Kinesio Taping® KT3 courses listed online. KTA approved seminars. Learn the fundamental and advanced concepts, corrective techniques of the Kinesio Taping® Method, and the unique properties and use of Kinesio Tape. Lab sessions provide ample time to practice kinesiotaping skills for upper and lower body applications. Hosting opportunities available for 2013 and 2014. **Contact:** Rehab Education, LLC, 845-368-2458 for questions; info@RehabEd.com or www.RehabEd.com for details and registration.

APRIL 20-21, 2013	NEWARK, NJ
MAY 18-19, 2013	CHICAGO, IL
JUNE 8-9, 2013	ATLANTA, GA

Starting and Running a Pediatric Therapy Practice

This seminar presented by entrepreneur Vincent Mullins, MOT, OTR, will provide clear steps to open and run a pediatric OT/PT/ST private practice. All aspects of start-up and growth of the practice will be presented through personal experience and years of research and development. Both therapy and business portions will be discussed. 11 CE hours. Live video available for those unable to attend. **Contact:** 940-300-2299; or www.THERAPYSEMINARSLLC.com to register online.

APRIL 20-21, 2013	AUSTIN, TX
JUNE 22-23, 2013	CHARLESTON, SC
AUG. 17-18, 2013	BOISE, ID

Safe Steps: Making Gait, Balance Assessment & Treatment

Speaker James C. Wall, BSC, MSc, MEd, PhD, presents Safe Steps: Making Gait and Balance Assessment and Treatment Worth It. This seminar reviews the major changes commonly seen in the elderly, which can contribute to problems with gait, balance, and subsequent loss of independence.

Evaluations tools, objective techniques to measure functional mobility tasks and evidence-based treatment strategies will be covered. **Contact:** Great Seminars and Books, 877-794-7328 (toll-free); or www.greatseminarsandbooks.com

APRIL 20-21, 2013 — **LINCOLN, NE**
AUG. 17-18, 2013 — **TOMS RIVER, NJ**
NOV. 2-3, 2013 — **NEWPORT NEWS, VA**

Home Health Rehabilitation

Speaker: Carol Schunk, PT, PsyD. Home Health is a unique physical therapy practice setting. Not only are there clinical issues but being in the patient's home environment makes the delivery of service very different than in an outpatient or inpatient facility. This course will provide both clinical information relevant to those being treated in their home as well as the psychological aspects of dealing with families and caregivers including evaluation tools for balance, function, cognitive ability and environmental hazards presented to allow the therapist to develop an appropriate plan of care. **Contact:** Great Seminars and Books, 877-794-7328 (toll-free); or www.greatseminarsandbooks.com

APRIL 20-21, 2013 — **NEW ORLEANS, LA**
SEPT. 21-22, 2013 — **TACOMA, WA**
OCT. 18-19, 2013 — **BILLINGS, MT**

Comprehensive Rehabilitation Strategies

Speaker: Doug Dillon, PT, GTC, CSST. Rehabilitation for our geriatric population is changing rapidly. Payment changes make it more challenging to deliver quality care for the rehabilitatively and medically complex older patient. This seminar, with its 350 page handout and 5000 references, provides a thorough approach to therapeutic strategies and goals, thereby preparing therapists with cutting-edge information, evaluation tools and treatment protocols for the complex geriatric patient. **Contact:** Great Seminars and Books, 877-794-7328 (toll-free); or www.greatseminarsandbooks.com

APRIL 21, 2013 — **LAS VEGAS, NV**

Advanced Billing, Coding, Collections and Audit-Proofing

There are more requests for refund, denials, audits, and reimbursement issues than ever before in the history of our profession. Also, are your therapists billing only 3 units while spending over an hour with patients? Is your documentation making you vulnerable? This course will help solve many of the problems confronted by most PT/OT practices today. Get the secrets to quicker payment, better reimbursement, appealing denials, audit-proofing, and more. TESTIMONIALS: "This is the best course I've ever attended on billing, and I've attended over 100. Take It!" 100% No-Risk Guarantee. **Contact:** 800-801-4511; or www.IndeFree.com

APRIL 21-22, 2013 — **NEW YORK, NY**

Taping for Alignment, Strength & Function in Children

Enhance therapy outcomes in your pediatric clients by utilizing a combination of taping and strengthening techniques that will be presented in this course. You will practice with a variety of materials on other class participants. Strengthening strategies will be presented and practiced to enhance the new alignment achieved through taping. Examples of intervention with children through videotape and case studies will reinforce learning. This course is applicable for pediatric therapists of any level and provides techniques that can be used throughout the life span. Group size is limited. Instructor: Jacqueline Grimenstein, PT. **Contact:** Therapeutic Services, 718-692-1929; 888-7-THERAPY; 718-338-3393 (fax); www.therapeuticservicesinc.com

APRIL 26, 2013 — **DENISON, TX**
MAY 17, 2013 — **COON RAPIDS, MN**
SEPT. 20, 2013 — **FAIRFIELD, CT**

Geriatric Strength Building for Function

Muscular weakness in aging adults is effectively treated when using the proper exercise protocols. This heavily evidence-based seminar will provide you with the information needed to deliver safe and highly effective optimal strength exercise to aging adults in any clinical setting. This course is designed to enable you to immediately and efficiently incorporate the learned material into your treatments to help you get great treatment results and to comply with reimbursement and regulatory challenges. Instructor: Mark Richards. **Contact:** Education Resources, Inc., 508-359-6533; 800-487-6530 (outside MA); www.educationresourcesinc.com

APRIL 26-27, 2013 — **TEMPLE, TX**
JUNE 14-15, 2013 — **BURLINGTON, NC**
SEPT. 20-21, 2013 — **MANCHESTER, NH**

Neurorehabilitation Across the Continuum of Care

Does what's going on in the nervous system really matter to therapy practice? This course will provide therapists with a new perspective for improving outcomes in their patients with neurologic deficits. Participants will learn an evidence-based approach to selecting the most appropriate interventions based on functional prognosis and learn when and how to facilitate recovery versus facilitate compensation. Participants will be able to perform a comprehensive neurological examination, correlating findings to symptoms, neuropathology and prognosis as well as skillful documentation. Speaker: Roseanne Thomas. **Contact:** Education Resources, Inc., 800-487-6530; 508-359-6533; www.educationresourcesinc.com

APRIL 26-27, 2013 — **LOS ANGELES, CA**
OCT. 25-26, 2013 — **MAITLAND, FL**
NOV. 22-23, 2013 — **WASHINGTON, DC**

Treatment of the Child with CP & Other Neurological Disorders

Therapists are bombarded with new information on brain function and new techniques to improve functional mobility. This course will help therapists select and prioritize the most appropriate treatment strategies for infants, toddlers & young children with neurologic challenges and other special needs. They will become familiar with and select from new approaches including: MOVE, Conductive Education, Compression Garments, MEDEK and TAMO. Focus will be on children with cerebral palsy and children with severe motor impairments as well as others with positioning and mobility challenges. Evidence-based interventions will be emphasized to achieve measurable functional goals. Instructor: Ginny Paleg. **Contact:** Education Resources, Inc., 508-359-6533; 800-487-6530 (outside MA); www.educationresourcesinc.com

APRIL 27-28, 2013 — **BRIDGEWATER, NJ**
MAY 4-5, 2013 — **LOS ANGELES, CA**
JUNE 1-2, 2013 — **FT. LAUDERDALE, FL**

Edema-Differential Diagnosis & Treatment

This intensive two-day course is designed to teach clinicians to differentiate between various edema etiologies and design effective treatment programs based on those findings. Topics include the evaluation of the arterial, venous, and lymphatic systems. Numerous treatment techniques will be covered, such as compression bandaging as well as a hands-on introduction to manual lymphatic drainage. Over 80% of attendants rated this course Excellent, all others rated it Good. Cost: Only $350 for 16 hours. Please call for group discounts. **Contact:** JVB Enterprises, Inc., 888-328-6755 (toll-free); www.teachtx.com for other courses offered in your area or for more information.

APRIL 27-28, 2013 — **HARRISBURG, PA**
MAY 4-5, 2013 — **ROYAL OAK, MI**
JUNE 22-23, 2013 — **RALEIGH, NC**

Acute Care Rehabilitation

Speaker: Mark Nelson, MPT. This dynamic seminar provides the latest information on cardiac, pulmonary and geriatric rehabilitation in the acute care setting. As in all practice settings, acute care rehabilitation is continuously evolving. From the various entry points into the acute care setting to discharge, rehabilitation plays an integral role. Therapists are being increasingly relied upon to make significant contributions to the medical team and frequently are the determining factor in hospital length of stay. This high tech seminar will provide therapists with clinical information, practical tips and high level problem solving skills by utilizing lecture and case studies to discuss the role of therapists in this challenging environment. **Contact:** Great Seminars and Books, 877-794-7328 (toll-free); or www.greatseminarsandbooks.com

APRIL 27-28, 2013 — **TAMPA, FL**
JUNE 1-2, 2013 — **SAN DIEGO, CA**

Clinical Use of Graded Motor Imagery for Rewiring the Brain

Are your patients not responding to therapy? How can you maximize treatment outcomes despite limited visits? Try Graded Motor Imagery (GMI), in the clinic and with a home program, to improve movement and range of motion in preparation for a functional training program. The GMI program helps identify patients who are not responding to conventional therapies and helps improve clinical efficiency and compliance with a home program. GMI is an emerging treatment technique designed for clinicians who treat orthopedic and neuro patients with pain and limited movement. It has been successful in treating peripheral nerve injuries and

central nervous system injuries through the use of a sequential 3-stage process consisting of right and left identification, visual imagery and mirror therapy. Instructor: Susan W. Stralka, MS, PT, DPT. Hosting opportunities available for 2013 and 2014. **Contact:** Rehab Education, LLC, 845-368-2458 for questions; info@RehabEd.com or www.RehabEd.com for details and registration.

APRIL 27-28, 2013 — **HOLLYWOOD, FL**
JUNE 1-2, 2013 — **FORT WORTH, TX**

ICU and Acute Care Update

Therapists working with patients in ICU face a complex challenge. These patients have limited mobility due to life support, monitoring equipment, multiple medical problems and muscle weakness. Early mobility and walking enhances functional outcomes by optimizing cardiopulmonary and neuromuscular status. It can lead to an increase in the patient's quality of life and higher functional capability, and potentially reduce length of hospital stay. Case reports will be presented to demonstrate how the early mobility and walking program in ICU can positively impact the recovery of selected patients. Instructor: Christiane Perme. **Contact:** Education Resources, Inc., 800-487-6530; www.educationresourcesinc.com

APRIL 27-28, 2013 — **PALM SPRINGS, CA**
JUNE 22-23, 2013 — **IDAHO FALLS, ID**

G-Code Know How: Becoming Proficient in Functional Assessment

Speaker Dr. Dale Avers provides the most current functional tools in PT practice and information about CMS's policy for the use of documenting physical function. This course with both lecture and lab where functional tools and their purposes are discussed and practiced in a case format. Directions and references for over 20 tests provided in a written format. **Contact:** Great Seminars and Books, 877-794-7328 (toll-free); or www.greatseminarsandbooks.com

APRIL 27-28, 2013 — **PEMBROKE PINES, FL**
JULY 26-27, 2013 — **NEW BRUNSWICK, NJ**

Treatment of The Clumsy Child

Many school-age children struggle with motor skills. This lab course will provide practical and effective intervention strategies for these "clumsy" children. Underlying etiologies of clumsiness (developmental coordination disorders) as well as newer concepts of motor control and motor learning will be discussed in relationship to other neurophysiologic concepts. This course will discuss evaluation tools to isolate the roots of the problem and treatment techniques and suggestions for the classroom utilizing an integrated approach. Functional outcomes and clinical effectiveness will be emphasized. Instructor: Barbara Connolly. **Contact:** Education Resources, Inc., 508-359-6533; 800-487-6530 (outside MA); www.educationresourcesinc.com

APRIL 27-28, 2013 — **ATLANTA, GA**
OCT. 12-13, 2013 — **BOSTON, MA**

Simplifying Management of The Wrist and Elbow

Focus on the management of the wrist, carpals and elbow in this intermediate to advanced level course. Designed to enhance your understanding of the complexity of the wrist and elbow joints, and the assessment and management of various conditions affecting them. Gain confidence in problem solving and designing treatment programs for a variety of upper extremity conditions. Instructor: Shrikant J. Chinchalkar, OTR, CHT. Hosting opportunities available for 2013 and 2014. **Contact:** Rehab Education, LLC, 845-368-2458 for questions; info@RehabEd.com or www.RehabEd.com for details and registration.

MAY 2-10, 2013 — **INDIANAPOLIS, IN**
MAY 3-11, 2013 — **MINNEAPOLIS, MN**
JULY 19-27, 2013 — **BOSTON (CHELMSFORD), MA**

Lymphedema Therapy Certification Vodder MLD & Foeldi CDT

Klose Training offers the highest-quality lymphedema certification course in the US. It's the most efficient & cost-effective way to become certified. 45 hrs of online home study + 90 hrs of classroom (lab) instruction. (Fewer days away from work; lower travel costs). UE-only option: 90 hrs. Pathophysiology, diagnosis, & DD are taught by an expert lymphedema physician. Lab instructors are the most experienced in the field. Approved for CEUs. Meets requirements to take the LANA exam. Free post-graduate services. Program est. 1990 by Guenter Klose, Certified Instructor. **Contact:** Klose Training, 303-245-0333; info@klosetraining.com or www.klosetraining.com

MAY 3-4, 2013 — **CANTON, MA**
AUG. 17-18, 2013 — **WASHINGTON, DC**
SEPT. 7-8, 2013 — **KALAMAZOO, MI**

Integrating NDT, SI and Motor Learning in Children

Are the goals you are setting for the children you treat, realistic? Is the treatment approach the most effective to achieve the outcome you want? This workshop will enhance critical thinking skills to enable therapists to use a systematic approach to treating children with developmental challenges. Focus will be on problem solving to gain function for children with motor control, sensory processing and behavioral compromise. The unique approach will help therapists set realistic measurable goals, set priorities and determine frequency of treatment and exit criteria. Instructor: Lezlie Adler. **Contact:** Education Resources, Inc., 508-359-6533; 800-487-6530 (outside MA); www.educationresourcesinc.com

MAY 3-5, 2013 — **MYRTLE BEACH, SC**

SCAPTA Annual Conference

The South Carolina Chapter of the American Physical Therapy Association (SCAPTA) will host its next Annual Conference, May 3-5, 2013 at the Sheraton Myrtle Beach Convention Center Hotel, Myrtle Beach, SC. The conference will feature expert presentations on navigating the reimbursement process, new functional limitation reporting requirements, and health care reform; management of lumbar spine dysfunction; and techniques for identifying and treating vestibular and central nervous system disorders related to balance dysfunction for persons of all ages. The conference will also include a course for students, job fair, exhibitors, poster presentations, and fun events. **Contact:** www.scapta.org to register by April 1 to take advantage of early bird rates.

MAY 3-5, 2013 — **PLANTATION, FL**
JUNE 7-9, 2013 — **PORTLAND, OR**
NOV. 8-10, 2013 — **LAS VEGAS, NV**

Three Day Intensive on Treating The Child with Hypotonia

This three day intensive workshop on treating the child with hypotonia will focus on specific strategies to improve motor control in this population. Techniques to improve proximal control, sustained postural movements against gravity, and symmetrical alignment will be demonstrated through use of videotapes, as well as 3 patient demonstrations and practice labs. Lecture and video material will cover key deficits in the motor and sensory development of the hypotonic child. Instructor: Barbara Hypes. **Contact:** Education Resources, Inc., 508-359-6533; 800-487-6530 (outside MA); www.educationresourcesinc.com

MAY 4-5, 2013 — **WEST ORANGE, NJ**
JUNE 14-15, 2013 — **NEWPORT NEWS, VA**
SEPT. 27-28, 2013 — **DURHAM, NC**

Geriatric Neurology in The Medically Complex Client

Learn evaluation tools and treatment protocols for medically complex older persons with neurological dysfunction. Evidence-based information on assessment and treatment of clients with Parkinson's Disease, Stroke, Alzheimer's balance and gait disorders, neurosensory pathologies and pain will be provided. The changes associated with aging as well as pathological manifestations that affect the neurosensory system and result in problems with coordination, mobility, proprioception and kinesthesia, balance and falls, weakness and pain will be presented. Instructor: Jennifer Bottomley. **Contact:** Education Resources, Inc., 508-359-6533; 800-487-6530 (outside MA); www.educationresourcesinc.com

MAY 4-5, 2013 — **ATLANTIC CITY, NJ**
JULY 20-21, 2013 — **LOS ANGELES, CA**
SEPT. 21-22, 2013 — **DENVER, CO**

Taking Balance To the Limits

Speaker Janene Barber PT, GTC has taught and treated extensively in this area with astounding results. This course goes beyond all you have learned about the effects of speed, strength and range of motion limitations as causes for balance dysfunction. You will leave with an in depth knowledge and skill in postural dyscontrol, somatosensation and vestibular arenas. Take home innovative useable evaluation and treatment techniques that will dramatically change your practice. **Contact:** Great Seminars and Books, 877-794-7328 (toll-free); or www.greatseminarsandbooks.com

MAY 4-5, 2013 — **CHEYENNE, WY**
JULY 27-28, 2013 — **SEATTLE, WA**
SEPT. 21-22, 2013 — **DUBUQUE, IA**

Rehabilitation for The Frail Elderly

Speaker: Robert Thomas, MS, PT. Learn the latest information on 30 assessment tools and treatment protocols for working with the frail older population. Information on the effects of institutionalization, medical and cognitive pathologies that affect the frail population, pharmacological management, and the impact of reimbursement models will be presented. Specific evaluations and creative treatment protocols for gait, balance, strength, flexibility, and endurance will be provided. **Contact:** Great Seminars and Books, 877-794-7328 (toll-free); or www.greatseminarsandbooks.com

MAY 4-5, 2013 — **BOSTON, MA**
AUG. 17-18, 2013 — **INDIANAPOLIS, IN**
NOV. 2-3, 2013 — **MIAMI, FL**

Cancer Rehabilitation

Speaker: Nicole Stout MPT, CLT-LANA. Current evidence-based rehabilitation interventions for individuals undergoing treatment for cancer, survivorship from cancer, or facing metastatic disease will be highlighted. Exercise prescription, contradictions and precautions with exercise & modalities. A unique, problem based format, with group interaction, utilizing case studies for client evaluation and development of plan of care. **Contact:** Great Seminars and Books, 877-794-7328 (toll-free); or www.greatseminarsandbooks.com

MAY 5, 2013 — **NEW YORK, NY**

Using Nutrition to Improve Biochemistry of Development

This course is designed to help therapists and teachers improve clinical outcomes by identifying children who are not reaching

their potential because of poor diet or insufficient nutrients for cognitive development. Youngsters can be eating foods that are irritating the system or missing nutrients needed to create neurological connections. Learn how to recognize nutritional problems that may be slowing down progress. Discover creative strategies for low muscle tone, cognitive enhancement, and improving classroom function. Nutritional strategies that support speech, occupational, and physical therapies will be discussed. Instructor: Kelly Dorfman, MS, LND. **Contact:** Therapeutic Services, 718-692-1929; 888-7-THERAPY; 718-338-3393 (fax); www.therapeuticservicesinc.com

MAY 16-19, 2013 — **PHILADELPHIA, PA**
JUNE 8-11, 2013 — **LOUISVILLE, KY**
JUNE 20-23, 2013 — **WEST ORANGE, NJ**

Recovering Function NDT Courses Intro, Advanced, Cert

Recovering Function's series of "hands-on" NDT courses provides you with a step-by-step framework or problem-solving strategies and manual cues for assessing potential and individualizing functional outcomes when implementing interventions for your adult clients with hemiplegia. Audience: OTs, COTAs, PTs, PTAs. Cathy Runyan, OTR/L, & Peggy Miller, PT, Recovering Function NDT Instructors. Offered nationwide. **Contact:** Recovering Function, 408-268-3691; or www.RecoveringFunction.com for a complete brochure of intro, advanced, and cert courses as well as information about additional course dates/locations, group rates & free registrations when hosting courses at your facility.

MAY 18-19, 2013 — **HARTFORD, CT**

Orthopedic Therapy of the Shoulder: Examination & Intervention

Evidence-based approach to evaluation and manual treatment of shoulder pathologies includes in-depth presentation, anatomechanics, non-operative, surgical and post-operative interventions for common shoulder problems, and extensive hands-on lab sessions. Instructor: Martin J. Kelley, PT, DPT, OCS. Hosting opportunities available for 2013 and 2014. **Contact:** Rehab Education, LLC, 845-368-2458 for questions; info@RehabEd.com or www.RehabEd.com for details and registration.

MAY 18-19, 2013 — **JACKSON, MS**
AUG. 17-18, 2013 — **RICHMOND, VA**
SEPT. 21-22, 2013 — **LOGAN, UT**

Put Some Muscle Into Ther Ex

Speaker: Wendy K. Anemaet, PT, PhD, GCS, CWS, GTC, COS-C; Strength loss begins in the 30's - but what's next? MMT's unreliable - what other options exist? Which muscles matter most to ADL? Join us for an intensive, fun, 2-day tune up to strengthen your outcomes and change the way you prescribe Ther Ex on Monday morning! Explore the current scoop on geriatric resistance training, practice evaluative techniques and exercises, and learn about parameters of strengthening for a range of medical and rehab diagnoses. Put Some Muscle into Ther Ex offers the essential tools and knowledge to design, implement, evaluate and modify effective resistance training programs for the older populations. **Contact:** Great Seminars and Books, 877-794-7328 (toll-free); or www.greatseminarsandbooks.com

MAY 19-20, 2013 — **NEW YORK, NY**

Current Concepts in Pediatric Gait and Orthoses

This workshop will review typical gait and lower extremity development as well as common pediatric orthoses, their indications and contraindications. Evidence for the efficacy of orthoses will be reviewed and critically analyzed. Current philosophy and newer trends will be explored. Orthoses specifically for children with hypotonia, with an emphasis on Down syndrome, will be discussed in more detail. Techniques for documentation of gait and alignment will also be presented. The workshop will include lecture, case study and video discussion, along with group discussion of concepts presented. Instructor: Kathy Martin, PT, DHS. **Contact:** Therapeutic Services, 718-692-1929; 888-7-THERAPY; 718-338-3393 (fax); www.therapeuticservicesinc.com

JUNE 1-2, 2013 — **CHICAGO, IL**
SEPT. 21-22, 2013 — **WEYMOUTH, MA**

Best Practices in Home Health Care

Home health care assessment and treatment has become more complex and requires specialized, advanced skills. Do you have the skills to provide your patients with the safest, best possible care? This course is designed to provide physical & occupational therapists with up-to-date, evidence-based techniques for assessment & treatment of the medically complex geriatric home care patient. Instructor: Suzanne Clark. **Contact:** Education Resources, Inc., 800-487-6530; 508-359-6533 (within MA); www.educationresourcesinc.com

JUNE 2, 2013 — **BROOKLYN, NY**

Torticollis: Assessment & Treatment in Infants/Children

One-day course for novice & experienced clinicians explores possible effects of torticollis, sleep posture & increased use of positional devices on infant postural development, w/ implications for management. Functional, clinically oriented evaluation & evidence based treatment strategies provided.

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Clinical management of infant head shape, diagnostic procedures, surgical intervention discussed. Home exercise programs, effective strategies to team w/parents when establishing individualized goals. Lecture & video review. 9.6 NYPTA CEUs, 8 NJBPTE CEUs, 8 NBCOT PDUs. Highly Qualified, Experienced Instructor: Cindy Miles, PT, MEd, PCS. **Contact:** Angela, 718-851-3300 x157; challenge-ei.com or email: shoshana.challenge@thejnet.com

JUNE 2, 2013 — **NEW YORK, NY**

Parkinson's Disease: Tools for Rehab Management

It is possible for people with Parkinson's disease to live longer and better with the help of therapy and exercise. No longer are individuals with Parkinson's only receiving medication to treat their disease, but also quality, evidence-based rehabilitation services. This course will educate therapists on practical approaches to providing comprehensive, evidence-based evaluation and treatment strategies for individuals with Parkinson's disease. We will review current studies and discuss cognitive changes, motor-learning, and the principles of neuroplasticity as they relate to Parkinson's and rehabilitation. A short portion of the lecture will focus on the Atypical Parkinsonisms and the role of therapy as well. Keynote: Heather J. Cianci, PT, MS, GCS. **Contact:** Therapeutic Services, 718-692-1929; 888-7-THERAPY; www.therapeuticservicesinc.com

JUNE 7-8, 2013 — **WILKES-BARRE TWP, PA**
AUG. 23-24, 2013 — **BAYSIDE, NY**
OCT. 18-19, 2013 — **TBA**

Yoga and Pilates Therapy for The Child with Special Needs

Learn how to integrate pilates and yoga exercise techniques in to your therapeutic intervention. These techniques will be applied to the child with special needs from birth to school age with the diagnosis of sensory impairments, tone issues, autism, ADHD and spina bifida. Instruction will be completed on how to include these techniques into your everyday practice in pediatric rehabilitation. You will be able to design family friendly home programs for your clients and participate in labs so that you can better appreciate the use of these techniques. Instructor: Angelique Micallef-Courts. **Contact:** Education Resources, Inc., 508-359-6533; 800-487-6530 (outside MA); www.educationresourcesinc.com

JUNE 8-9, 2013 — **HOUSTON, TX**

Schroth Method to Treat Scoliosis at all Ages

Instructors: Hagit Berdishevsky, Advanced Clinical Specialist. Location: Texas Children's Feigin Center. **Contact:** Mitzi Wiggin, 832-826-6107 for more information; e-mail: mmwiggin@texaschildrens.org; or register on-line: www.texaschildrens.org/pmr and click on continuing education.

JUNE 12-14, 2013 — **TAMPA BAY, FL**
OCT. 16-18, 2013 — **TAMPA BAY, FL**

Vestibular Rehabilitation Therapy

This 3-day workshop provides "hands-on" training and includes an overview of vestibular anatomy and physiology, extensive training materials for therapy programs, as well as direct patient observation. The American Institute of Balance has successfully trained thousands of therapists from around the world and is one of the few institutions that provide certification. Course Director: Richard E. Gans, PhD, nationally known expert in Vestibular Testing and Rehabilitation and author of Vestibular Rehabilitation: Protocols & Programs. Workshops in Vestibular Assessment or Vestibular Assessment & Management are also available. **Contact:** Sherry Tribby, 800-245-6442 for program questions; or www.dizzy.com to register.

JUNE 14-15, 2013 — **PHILADELPHIA, PA**
OCT. 11-12, 2013 — **KANSAS CITY, MO**

Vestibular Rehab: Treatment Intensive

Recognizing, assessing and treating vestibular disorders with an appropriate plan is dependent on careful differential diagnosis. Successful vestibular interventions must be based on understanding the complexities of the vestibular, oculomotor, or sensory systems they are targeting. This lab course covers treatments across the age spectrum, including childhood paroxysmal vertigo, BPPV, Meniere's disease, ototoxicity, bilateral disorders, mal de debarquement, migraine associated vertigo, traumatic vertigo, acoustic neuroma, central vertigo, and disequilibrium of aging. Instructor: Gaye Cronin. **Contact:** Education Resources, Inc., 508-359-6533; 800-487-6530 (outside MA); www.educationresourcesinc.com

JUNE 21-22, 2013 — **JACKSONVILLE, FL**
SEPT. 7-8, 2013 — **SCOTTSDALE, AZ**
OCT. 5-6, 2013 — **GROVE CITY, PA**

Geriatric Neurology: Falls Prevention and Balance

Are the interventions you are using to improve balance in geriatric and neurologic patients the most effective, up-to-date and relevant for your individual patient? This course will teach you to select and use the most appropriate tools to assess the risk for falls, evaluate function and assess balance. Therapists will learn to differentiate normal aging from pathology and develop effective evidence-based treatment strategies to improve functional balance outcomes to optimize the environment. (Medically complex patient - Stroke - Dementia - Balance & Frail Elderly) Instructor: Carole Burnett. **Contact:** Education Resources, Inc., 508-359-6533; 800-487-6530 (outside MA); www.educationresourcesinc.com

JUNE 21-23, 2013 — **MINNEAPOLIS, MN**
JULY 20-21, 2013 — **LOUISVILLE, KY**
AUG. 17-18, 2013 — **MILWAUKEE, WI**

Geriatric Therapeutic Exercise

Speaker: Mark Traffas, PT, GTC. Exercising geriatric patients presents a unique challenge to therapists. This course will demonstrate different, evidence-based exercise techniques and innovative interventions for all of the body's major joints as well as for the most common diagnoses seen in older patients (i.e. stroke, Parkinson's disease, gait and balance deficits). You will learn how to use functional tools to establish and guide exercise programs. Don't miss this opportunity to enlarge your arsenal of treatment ideas. **Contact:** 877-794-7328 (toll-free); www.greatseminarsandbooks.com

JUNE 22-23, 2013 — **HONOLULU, HI**

Biomechanics of the Hand: Analytical Approach to Hand Rehab

A great hand therapy review course for the hand therapy certification exam! Comprehensive course provides an analytical approach to hand rehabilitation. Enhance your theoretical knowledge to be better able to problem solve and design treatment programs for a variety of upper extremity conditions. Includes video presentation of pathomechanics, treatment, cadaver dissection, and surgery. Instructor: Shrikant J. Chinchalkar, OTR, CHT. Hosting opportunities available for 2013 and 2014. **Contact:** Rehab Education, LLC, 845-368-2458 for questions; info@RehabEd.com or www.RehabEd.com for details and registration.

JUNE 22-23, 2013 — **SOUTH BEND, IN**
SEPT. 21-22, 2013 — **ALBUQUERQUE, NM**
OCT. 19-20, 2013 — **CHARLOTTE, NC**

Rehab of Persons with Common Medical Pathologies

Speaker: Steven Tepper PhD, PT. This entertaining lecture provides take home information on rehabilitation of MI/CHF, COPD, Diabetes, Renal Failure, Obesity, Peripheral Arterial Disease and Deep Vein Thrombosis seen in a wide variety of settings: acute, subacute, long-term care, home health, cardiac and pulmonary rehabilitation and fitness/wellness clinics. Specific evaluations, functional tools, interventions and limitations to functional activities, will be covered in a case study format and lab sessions utilizing the Guide to Physical Therapy Practice. Stay up to date with the latest research findings with this dedicated and talented educator. **Contact:** Great Seminars and Books, 877-794-7328 (toll-free); or www.greatseminarsandbooks.com

JUNE 22-30, 2013 — **ST. LOUIS, MO**
JULY 13-21, 2013 — **LOS ANGELES, CA**
JULY 27-AUG. 4, 2013 — **DURHAM, NC**

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(Continued on next page)

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AUG. 17-18, 2013 — **OMAHA, NE**
OCT. 19-20, 2013 — **GREEN BAY, WI**
NOV. 1-2, 2013 — **SPOKANE, WA**

Manual Therapy for The Geriatric Patient

Speaker - James Gose, PT, DPT, OCS, Cert MDT, COMT, CMP: Using concepts of Robin McKenzie, Geoffrey Maitland and Brian Mulligan this course presents the evidence-based rational for using manual therapy with geriatric patients & demonstrates how manual therapy can safely & effectively be applied to this population. With over 120 manual techniques demonstrated and practiced the philosophical, evaluative and treatment concepts of each approach will be compared and contrasted. The perfect course if you see geriatric patients. **Contact:** Great Seminars and Books, 877-794-7328 (toll-free); or www.greatseminarsandbooks.com

OCT. 19-20, 2013 — **KISSIMMEE, FL**
NOV. 1-2, 2013 — **ALBANY, NY**

Rehab for Persons w/ Dementia: Making Therapy Worth It

Speaker: Susan Staples, PT, GCS. This seminar provides participants with specific evaluation and treatment strategies that are critical to improve outcomes for this challenging and rapidly growing patient population. Included are strategies for gait, balance and falls, mobility, hip fractures, strength/ROM, cardiopulmonary and pain issues, seating and positioning, restraints, and behavioral problems. Participants will also gain a thorough understanding of the different types of dementia with specific communication and approach strategies for success. The speaker provides an evidence-based seminar with an extensive handout. **Contact:** Great Seminars and Books, 877-794-7328 (toll-free); or www.greatseminarsandbooks.com

[CLASSIFIED MARKETPLACE]

[LOW-BACK PAIN]

back pain continued from page 26

Supporting Work at Home

Teaching the patient a home stretching routine has been standard for physical therapy practice. In the trigger point therapy model, however, self-applied compression for the above-named muscles is added to the stretch and range of movement home program to ensure full pain-free muscle lengthening and to continue to normalize the contracted muscle tissue.

Various tools can be employed, such as body rolling balls of various diameters as well as "S"-shaped compression tools. Pressure is applied to the full length of the muscles. Changing or varying sitting posture during the day is an easy way to stretch the iliopsoas and abdominals. The greatest in-clinic soft-tissue interventions can be completely undone if the patient goes home and sleeps all night in a poor position, or continues to sit all day without breaks. A full protocol of remediating negative postural influences, added home compression on key identified muscles that are referring pain to the area, stretching and full range of motion exercises is critically important in improving outcomes. ■

Mary Biancalana is owner of Trigger Point Sports Performance and Muscle Health Inc., Chicago, Ill. She is a board-certified myofascial trigger point therapist with more than 12 years of clinical experience working with people in chronic and acute pain due to myofascial dysfunction, including members of the Chicago Bears football team and collegiate athletes. She is co-author of Trigger Point Therapy for Low Back Pain *(New Harbinger, 2010).*

[MOBILITY]

independence continued from page 24

program during those times that he will be on prolonged breaks from school.

This case demonstrates the changes that can be made in range of motion in an independent ambulatory adolescent through the use of a daily standing program. This student was working on range of motion of the same joints we targeted with standing when he was performing passive stretching exercises. Using a stander with this student resulted in improved functional mobility as well as a change in attitude that I'm hopeful will continue to assist him with improvements in his independent functional mobility skills. ■

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Amy Marso is a physical therapist in the Hiawatha Valley Education District in southeastern Minnesota. Her main focus has been on school-based physical therapy services for the past eight years working for the St. Paul Public Schools in St. Paul, Minn.

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1. Actigraphy-Measured Sleep Characteristics and Risk of Falls in Older Women *Arch Intern Med.* 2008; 168(16):1768-1775.

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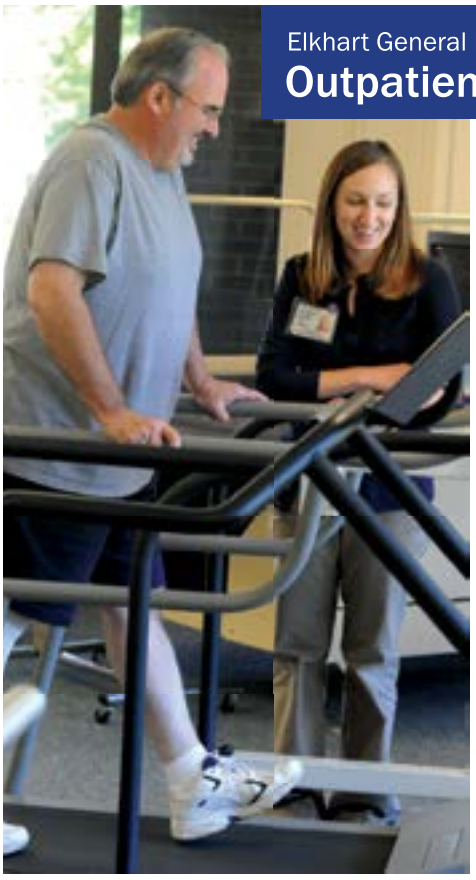

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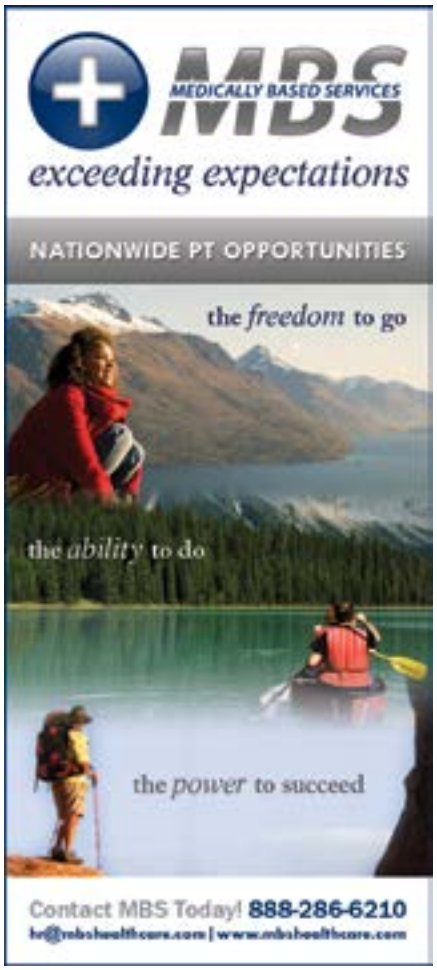

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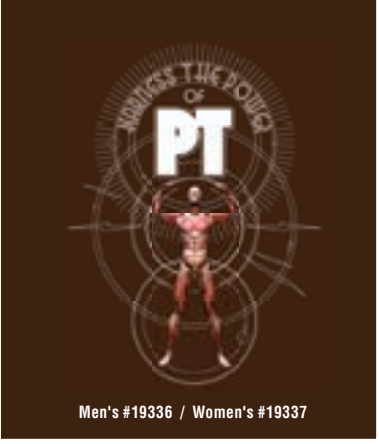

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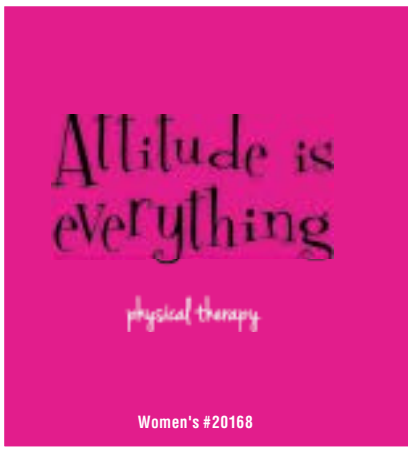

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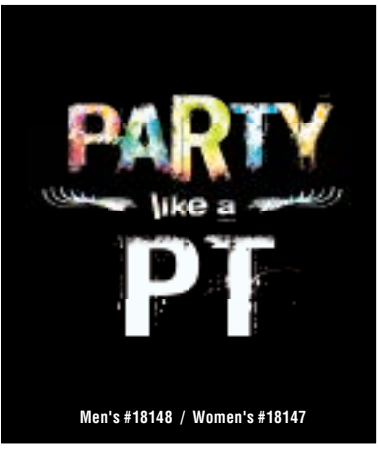

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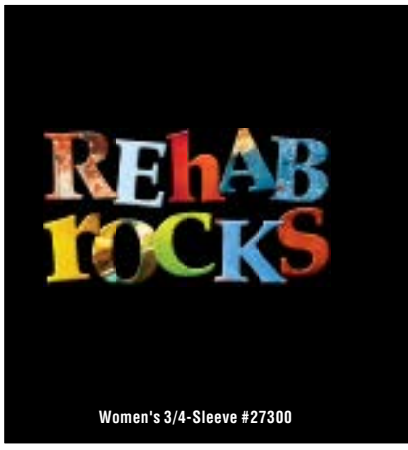

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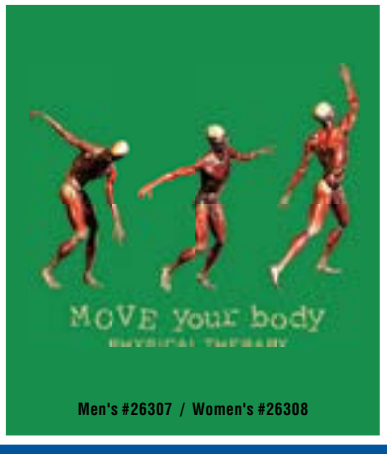

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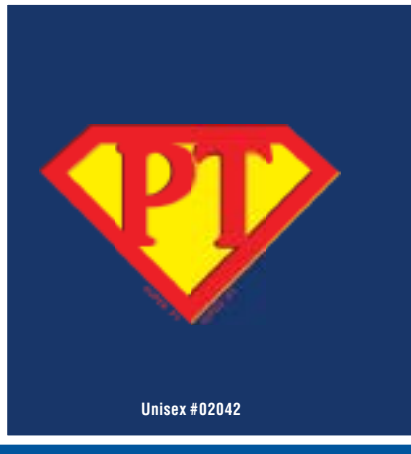

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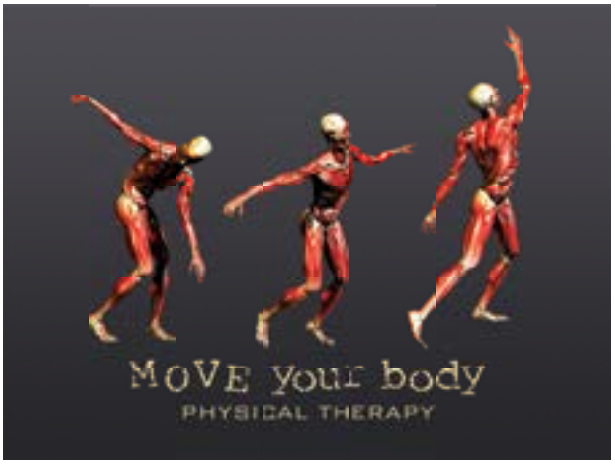

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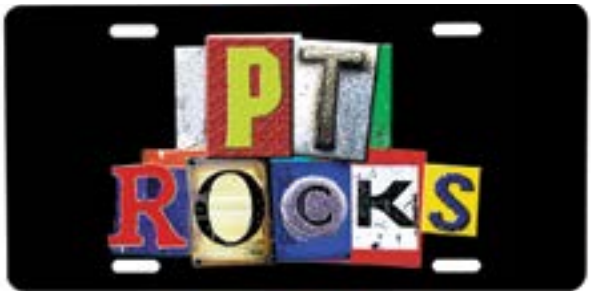

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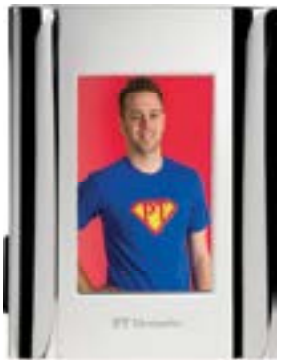

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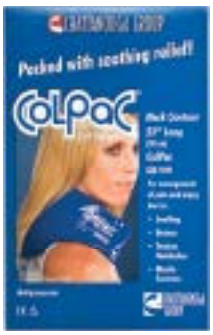

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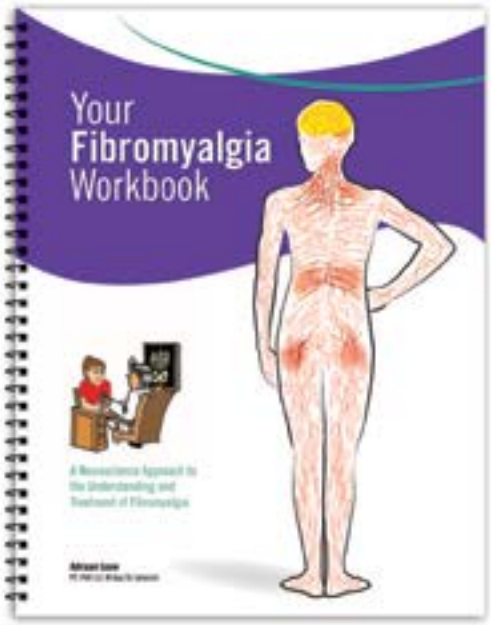

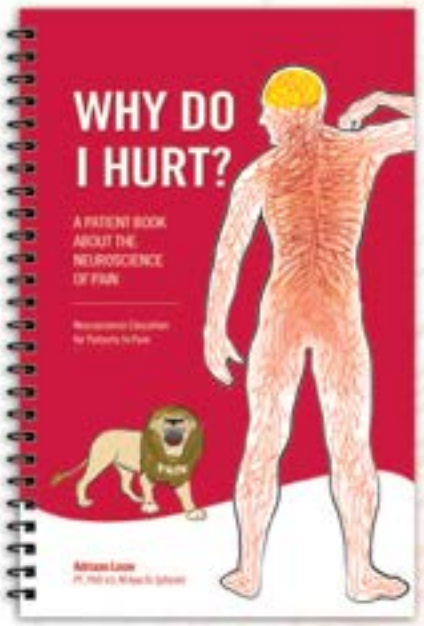

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