SUMMER 2017

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Federal Physical Therapy

SECTION

Quality physical therapy care across federal medical facilities.

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Chris Barrett, PT, DPT, CLT

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Federal Physical Therapy

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www.federalpt.org

CSM APTA Combined Sections Meeting

New Orleans • February 21–24, 2018

Save the Date!
President’s Message
Mark Havran DPT, LAT, CSCS
President, Federal Physical Therapy Section, APTA

2017 marks another year of growth. Input that you have given and participated in has led to further pursuit of collaborations. The board hopes the monthly blasts have helped keep you abreast of information in a timely basis. The board has been looking at how we can strategically partner with APTA services as a whole. This includes educational offerings, sharing of best practices, engagement with Chapters, and continued support for students and early career therapists.

Membership has continued to grow, membership in the Amputation SIG grows and creates transparency between sections. This year the board will take up the challenge to create an updated strategic plan that will focus on outreach to new and current members to fully define what the Federal PT section is - and how our practices and knowledge will shape future healthcare as it relates to Access, Education, and sharing of best practices.

I hope this finds your summer going well! Please take time to read about current happenings within the services and people affiliated with the Federal PT Section.

For those of you reading this not familiar with our section, I hope the below brief description will inform you. The Federal PT Section incorporates physical therapists, physical therapy assistants, and students that are wanting to learn and share knowledge internal and external to the Federal Government. Membership includes those that work in the government that include: Veterans Affairs, military uniformed services (Army, Navy, Air Force, Marines), the US Public Health Service (Indian Health Services, Bureau of Prisons, Coast Guard), and private sector.

Please visit our website or contact us on how you can be involved.

Tricare Update

On June 28th, the House Committee on Armed Services marked up the FY18 National Defense Authorization Act (NDAA). APTA has been working with several Congressional offices to include language that would compel TRICARE to recognize physical therapist assistants and occupational therapy assistants. After negotiations between Representatives Ralph Abraham (R-LA), Ruben Gallego (D-AZ), and the committee staff, report language was drafted and passed as part of an en bloc package of amendments and added to the NDAA legislation.

The language directs the Secretary of Defense to submit a report to the committee outlining the process used by the departments to include para health professionals as healthcare providers in the military health system by April 1, 2018. This review shall determine how to incorporate PTAs, OTAs, and other para health professionals. This move is an important first step forward that we hope will ultimately lead to coverage of PTAs under Tricare.

We expect the Senate to work on their version of NDAA later this year. We will continue to educate Senators and their staff on this issue to make sure that this language is included in the Senate version. If you have any questions please email Michael Hurlbut.
Section Delegate Report  
*Carrrie Hoppes, PT, DPT, NCS, OCS*

Over 400 members of the House of Delegates gathered in Boston to consider 14 different motions this week. Important motions that passed included rescinding the current APTA mission statement, adopting a new scope of practice, committing to increasing diversity within our profession, and most importantly to our Section, allowing uniformed services personnel to select their chapter of membership.

The House voted, with support from the Federal Section, to pass RC 1A-17 Rescind the Mission Statement of APTA, as the mission statement was considered "stale, outdated, [and] uninspiring." Passing of RC 1A-17 will allow the Board to craft a new mission statement.

With a unanimous vote, and the support of the Federal Section, the House adopted a new scope of physical therapist practice. It includes wording that includes professional, jurisdictional, and personal scopes of practice. Additionally, it states our role in public health and population health. This was a momentous occasion in the House.

RC 11-17 Increasing Professional Diversity charges the APTA to implement strategies to advance diversity and inclusion within our profession. This motion will help to create a more diverse physical therapy profession by increasing the number of underrepresented minorities.

And the most relevant motion to our section passed with more than 2/3 vote. RC 1A-17 will allow uniformed services personnel, spouses, and partners to choose their chapter of membership. This will allow these members to remain in a chapter of their choosing, which is meant to encourage and facilitate greater participation and long-term engagement.

As your Federal Section Delegate, I very much appreciate the feedback I received from our members on the wording of RC 13-17. Additionally, I would like to thank the Federal Section Board Members for their mentorship and guidance as I prepared for and participated in my first House of Delegates meeting.

Federal Affairs Update  
*Amanda Simone, DPT, CLT-LANA*

As you likely have heard in the news, there is a great deal of activity on Capitol Hill related to healthcare. Staff members at APTA continue to work tirelessly in advocacy for our profession and full details of their work is available [HERE](#). APTA is currently monitoring several regulatory items including the recent push back of mandatory Medicare bundling for cardiac care and expansion of the current Comprehensive Joint Replacement model to January 2018. More information on this is available [HERE](#). There is also a change to the 21st Century Cures Act which allows outpatient physical therapy services furnished in certain rural areas to be billed under reciprocal billing and fee-for-time compensation arrangements in the same manner for physicians. This new policy went into effect June 13, 2017. More information on this is available [HERE](#).

Congressionally the primary focus has recently been on AHCA. APTA is continuing to express concerns with changes to the Essential Health Benefits and to the Medicaid program. They have been working hard to ensure the impact of this on provision of Physical Therapy services is known. They will continue to update the membership as they learn more. Strong efforts also continue regarding repeal of the Medicare therapy cap legislation (H.R. 807/S. 253). Another current piece of legislation with significant potential benefit to Physical Therapists is the PT workforce bill (H.R. 1639/S. 619) which would make Physical Therapists eligible to apply for the National Health Service Corps Student Loan Repayment if it is passed. There is also pending legislation regarding chiropractors in the USPHS (HR 2202). Little information is available regarding this at this time however we are working with APTA to arrange a meeting and will share information as it becomes available. APTA is also tracking the Lymphedema Treatment Act (HR 930) as well as legislation from last year and not yet re-introduced this year on telehealth.

Downloading the APTA Action App is a simply way to keep up to date with legislation impacting Physical Therapists and opportunities to get involved. It is available [HERE](#). There are great opportunities for federal PTs to be involved with professional advocacy as long as the boundaries of the Hatch Act and the federal employee code of conduct are maintained. The federal section FAL, Amanda Simone, is available to assist anyone interested in getting more involved. Email her [HERE](#).
CSM 2017 – FPTS Annual Business Meeting

Outgoing service reps were recognized for their service.

Below: FPTS President Mark Havran stands behind (L-R) Holly Roberts, Ru Gakhar, and Eric Bradford

Not pictured: Robert Wiederien and Marc Weishaar

Below: Ian Lee was also recognized for his service as the Section Delegate

Picture below is of Outgoing Section Delegate Ian Lee with incoming Section Delegate Carrie Hoppes
Federal Section Sessions:

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<td>Moving Patients to Health: Integrating Holistic Health and Fitness into Practice</td>
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<td>Mindful Awareness Training for Veterans with Comorbid Chronic Pain and PTSD</td>
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Physical Therapists in the U.S. Air Force

Air Force physical therapists use state-of-the-art technology to practice comprehensive orthopedic and sports medicine in military hospitals and clinics throughout the world. They treat patients and engage in ergonomic evaluations and preventive medicine activities involving Airmen serving in every Air Force career from those working on the ground to those in the air. The majority of Air Force recruits are from the civilian economy as only two seats in the Army Baylor Physical Therapy Program are reserved for the Air Force. There are no dedicated ROTC physical therapist slots, but ROTC is another accession option. The primary way the Air Force acquires their physical therapists is through a Healthcare Professions Recruiter. You can visit the Air Force’s main website to find a local Healthcare Professions recruiter in your area. Upon acceptance, physical therapists go through Officer Candidate School where they learn the ins and outs of being an Officer in the Air Force.

As in all military services, active duty physical therapists may be competitively selected to pursue advanced degrees with tuition and fees paid while incurring an active duty service obligation based on the program length. The primary programs the Air Force has provided are the Sports/Orthopedic Manual Physical Therapist Doctor of Science Program, Sports Medicine Physical Therapy Doctor of Science Program, and Special Tactics Physical Therapy Fellowship. Opportunities exist for civilians to work in government service and contract positions and the Air Force is currently recruiting to fill those vacancies. At the present time there are no loan forgiveness opportunities for Air Force physical therapists.

In the Air Force, most physical therapists work in MTFs and care for patients with orthopedic problems. More generally, physical therapists evaluate, treat and prevent orthopedic (e.g., sprains, strains, fractures), neurologic (e.g., multiple sclerosis, spinal cord injuries, cerebral palsy), and cardiopulmonary disorders (e.g., heart disease).

Finally, here’s what the personnel command says a physical therapist does, “Plans, develops, and manages physical therapy programs and activities. Implements research activities. Provides and conducts training in physical therapy. Evaluates patients and treats disabilities requiring physical therapy.”

BRANDON O. WIELERT, Capt, USAF, BSC, DPT
Staff Physical Therapist Wilford Hall Physical Therapy Department
JBSA, San Antonio, Texas

U.S. Public Health Service Physical Therapists’ Role in Decreasing the Opioid Abuse Epidemic

CDR Tracy Gualandi, DPT, CWS, CCS (U.S. Public Health Service Therapist) with contributions by: CDR Jessica Feda, DPT, OCS, CWS (Bureau of Prisons) and LCDR Selena Bobula, DPT, NCS (Indian Health Service)

According to a 2006 American Academy of Pain Medicine report, chronic pain affects approximately 76 million individuals in the United States. Despite prolific research and innovative attempts across the pain management field to target and treat chronic “pain generators,” effective management of chronic pain conditions remains a challenge for clinicians. One strategy to help manage chronic pain has been the utilization of opioid prescriptions as a pain relieving medication, which has led to prescription opioid sales quadrupling from 1999 to 2010. While the use of these medications to manage chronic pain may be appropriate for some individuals, it appears that overreliance on their use has been one of the precipitating factors leading to the opioid epidemic in the United States. According to the Office of the Surgeon General, 78 Americans die every day from an opioid overdose. In response to this public health crisis, the 19th Surgeon General, Dr. Vivek H. Murthy, released a “Call to Action” for healthcare providers to address the opioid epidemic through the “Turn the Tide” campaign. In a letter to healthcare providers, he called for them to become more aware of the opioid problem and to seek evidence-based treatment strategies to treat chronic pain conditions. This included Dr. Murthy recommending patients with low back pain, one of the leading chronic pain diagnoses and the leading cause of disability among adults under age 45 years in the United States, be encouraged to remain active and seek non-pharmacological treatments, such as exercise, cognitive behavioral therapy, and interdisciplinary rehabilitation. Current Department of Health and Human Secretary, Dr. Thomas Price has expressed a continued desire to battle the Opioid Epidemic and has stated his administration is committed to fighting the crisis making it a top priority for the Department of Health and Human Services.

Physical and occupational therapists utilize many evidence-based, non-pharmacological treatment strategies to address both acute and chronic pain conditions. To effectively treat chronic pain, the clinician not only needs to address the physical pain, but also needs to address the biopsychosocial constructs of pain development. An integrative approach to pain rehabilitation is necessary to transition the patient from a reactive pattern of healthcare usage to manage their pain to understanding the multidimensional aspects of pain.
which can give them a sense of control over their symptoms. There are a variety of treatments and modalities therapists utilize to treat pain, such as: manual therapy; soft tissue mobilization; exercise therapy; postural education; functional training; and, the use of physical modalities, including electrical stimulation, laser therapy, ice, and heat. Each plan of care should be evidence-based and patient-centered to achieve the best outcomes and incorporate the patients’ values, beliefs, and goals. Through the use of these conservative interventions, acute and chronic pain conditions can be effectively treated and the risk of disability decreased.

An emerging physical and occupational therapy modality showing positive outcomes in case studies at decreasing myofascial pain is the use of trigger point dry needling. According the American Physical Therapy Association, “dry needling is a skilled intervention that uses a thin filament needle to penetrate the skin and stimulate underlying myofascial trigger points, muscular, and connective tissues for the management of neuromusculoskeletal pain and movement impairments.” Studies have shown an improvement in pain, range of motion, and, function when dry needling is incorporated into physical therapy treatment. Many therapists, including those in the U.S. Public Health Service (USPHS) Commissioned Corps, are acquiring certification in dry needling. The Bureau of Prisons (BOP) invited Army Physical Therapist, Major Easterling to instruct an intensive one-week dry-needling certification course at the 2016 BOP Therapist Educational Conference. All BOP Public Health Service (PHS) therapists in attendance were certified in dry needling treatment techniques in an effort to better treat federal prisoners suffering from chronic pain in hopes to decrease the need for opioids in the prison system.

Patient-centered education is also a key component to effectively treating chronic pain. Educating patients regarding chronic pain, pain physiology, and how to manage their symptoms can greatly improve outcomes. In 2015, the USPHS Therapist Category hosted the first Virtual Forum on Chronic Pain. World-renowned Therapeutic Neuroscience educator and Pain Science author, Dr. Adriann Louw, PT, PhD, CSMT, was invited to speak as well as CDR Jessica Feda, DPT, OCS, CW from the Bureau of Prisons (BOP) and LCDR Selena Bobula, DPT, NCS from the Indian Health Service (IHS). They discussed the importance of patient education in the management of chronic pain and chronic pain programs to treat chronic pain conditions through conservative measures. This conference was comprehensive and lasted more than three hours with more than 65 participants around the country attending via webinar. Dr. Adriann Louw discussed the physiology of chronic pain and the latest evidenced-based educational treatment strategies while CDR Feda and LCDR Bobula outlined their chronic pain treatment programs in the BOP and IHS, respectively. CDR Feda and LCDR Bobula presented data from their pain management programs exhibiting positive treatment outcomes in the BOP and IHS pain management programs.

**Chronic Pain Management Program, Federal Medical Center (FMC) Rochester, Bureau of Prisons (BOP)**

*Submitted by: CDR Jessica Feda, Physical Therapist, BOP*

Chronic pain complaints are prevalent within an incarcerated environment. At FMC Rochester, the physicians and formulary are very good at limiting opioid use, however even in an institution that is progressive in limiting narcotic medications; currently 83 inmates are on opioid medications. In 2011, Dr. Allen, Director of Health Programs, developed a multidisciplinary team to begin tackling the chronic pain problem within the BOP. They are developing a clinical practice guideline for use in mainline institutions within the BOP. FMC Rochester has a multi-disciplinary chronic pain management program focusing on integrative pain rehabilitation. The ultimate objective is to empower the inmate dealing with chronic pain so they better understand the origins of pain and how to minimize and stabilize symptoms, while enhancing function. In a correctional institution the inmates may be at an exceptionally high risk for chronic pain development due to a multitude of reasons to include internal and environmental stressors, mental health co-morbidities and diminished insight and understanding of the medical system and the physiology of pain. Whether or not an initial inciting factor becomes chronic and a person develops chronic pain certainly has to do with their genetic sensitivity to activating pain pathways, however it also depends on temperament and mental state. Chronic pain is truly not a physical condition, but it is an impairment in the workings of the central nervous system. The many factors that govern crisis response play an integral role in pain and a person’s ability to manage it. The neurophysiologic basis for chronic pain is extremely complex and continues to be researched from a physiologic, chemical and genetic perspective. However, the current best-supported treatment for chronic pain management although well-established is yet difficult to incorporate.

A multi-disciplinary and multi-faceted program is the most appropriate treatment in the realm of chronic pain management. By understanding the multi-faceted origin and continued pain cycle generated by chronic pain, a program can be developed to address many of the contributing factors and generate true progress in an individual’s condition. That is how the Program at FMC Rochester developed and now has been in effect for over 10 years. This Program institutes the biopsychosocial approach with a pain therapeutic neuroscience education focus. Essentially we focus on the biologic, psychological and social factors that influence the pain cycle. The inmates involved are taught active coping strategies and our goal is to foster their self-efficacy and independent functioning. Through this process, we hope to restructure how an inmate evaluates their pain and replace many of the erroneous and negative thoughts that perpetuate their pain cycle. Ultimately, our goals are to promote self-awareness, self-management, and develop an active learner who is significantly more sufficient in managing their symptoms to reduce medical utilization and improve functionality. Please note that our goal is not to eradicate pain. The central nervous system is difficult to alter, however many of the participants do have reduced pain after completion of the Program as a secondary consequence of conditioning and improved emotional state.

Over the past eight years, clinically and statistically significant improvements have been noted in the areas of physical and emotional functions, reducing catastrophizing, reduction of fear
avoidance beliefs and significantly less stress related to pain. The current program is twelve weeks in duration with twice weekly educational sessions, once weekly cognitive behavioral pain acceptance and commitment therapy, once weekly meditation training sessions and three times per week exercise sessions. In addition, each inmate participant is evaluated by a physical therapist and other pain modifying techniques are incorporated as appropriate to include dry needling, biofeedback or other specific therapeutic exercise techniques. Most the inmates that have participated in this formal pain management program have elected to be weaned off narcotics at the completion of the program. The Federal Medical Center at Carswell, the only female medical center in the United States, is currently in the process of implementing the successful program developed at FMC Rochester.

Interdisciplinary Chronic Pain Management Group, Piñon Health Center, Indian Health Service (IHS)
Submitted by: LCDR Selena Bobula, Physical Therapist, IHS

Piñon Health Center, in the center of the Navajo Nation, is an isolated-hardship setting serving more than 38,000 residents. This remote area is underserved and often served by temporary primary care providers in hard to fill assignments. The Piñon Health Center identified a high prevalence of opioids prescribed by the providers treating chronic pain conditions and multiple instances of patient medication diversion practices.

To address these concerns 5 years ago, Piñon Health Center (PHC) established an interdisciplinary chronic pain management group who meets on a monthly basis to review patients on chronic opioid therapy. To decrease patient medication diversion, each patient signs a Pain Agreement with a single provider to only obtain prescriptions from the PHS clinic and to be subjected to random urine drug screens while in the clinic. Patients who break the conditions of the contract are no longer eligible to receive narcotics from the PHC. In the first 2 years, 53 patients were identified as candidates of concerns undergoing chronic opioid therapy and subject for review. Of the 53 patients in the first group, 28 continue to be seen at the PHC but are no longer on narcotics. Only 12 patients go to Chinle. Of the 12 patients at Chinle, only 4 of these patients continue to use narcotics. Hydrocodone use has decreased by 24%, Oxycodone use has decreased by 51% and tramadol use has decreased by 24%. This effort is being led by the Pharmacy and Chief Medical Officer at PHC, but involves input from multiple disciplines to achieve the desired outcome of decreasing opioid use and abuse.

Many of the patients that participated in the program have expressed gratitude for the intervention and have personally thanked the pharmacists and providers for weaning them successfully off narcotics to help manage their addiction. While this will not fully solve the problem of diversion, the number of narcotics prescribed from the PHC clinic is decreasing and all patients currently on opioids are required to have positive drug screens. In addition, the Pharmacy department also performs routine screens through multi-state databases determine if patients are obtaining narcotics from other providers, thus violating the pain management contract. Reviewing the narcotic fact sheets with patients and educating patients on the side-effects of narcotic usage has made a positive impact and many patients have opted out of narcotic management to treat their chronic pain. Future endeavors for the committee include discussing naloxone availability to assist in combating the opioid overdose and preventing misuse as further life-saving efforts in our community to offer the best evidence-based and safe care to patients receiving care at the PHC.

Public Health Service Therapists support the Department of
Health and Human Services mission of decreasing opioid abuse by utilizing a variety of non-pharmacological treatment strategies to treat chronic pain in this challenging environment with successful outcomes. Pain management treatment interventions such as rehabilitation and exercise previously recommended by the Surgeon General for the treatment of chronic pain have been established as a “best-practice” treatment strategy. Utilizing evidence-based treatment to manage chronic pain can decrease opioid dependence which in turn, can improve function, and improve the quality of life for patients suffering from chronic pain.

Therapists in the U.S. Public Health Service serving the Bureau of Prisons and Indian Health Service treat very challenging patient populations with a higher than average risk of substance abuse including opioid addiction. Therapists are challenged with the task of utilizing a variety of non-pharmacological treatment strategies to treat chronic pain in this unique environment. Rehabilitation and exercise, recommended by the former Surgeon General for the treatment of chronic pain, is within the scope of practice of physical and occupation therapists and they utilize a variety of evidence-based, conservative treatment strategies to manage chronic pain in their patients. Successfully decreasing a patient’s chronic pain through non-pharmacological treatments can improve a patient’s function and improve their quality of life; therefore, decreasing the need for opioids and supporting the 19th Surgeon General’s “Call to Action” to help decrease the opioid epidemic.

References

Commissioned Corps Distracted Driving Survey Indicates Officers Are at Risk

The National Highway Transportation Safety Administration estimated in 2012 that 3,328 people were killed, and an additional 421,000 people were injured, in motor vehicle crashes involving a distracted driver. This means that each day an average of nine people are killed and more than 1,000 are injured in crashes caused by distracted driving. Is texting while driving any better than driving drunk? Using a cell phone—whether it’s hand-held or hands-free—delays a driver’s reactions as much as having a blood alcohol concentration at the legal limit of 0.08 percent.

Driving distractions continue to mount as smart phone use proliferates. In the summer of 2016, the Therapist PAC’s Health Promotions and Disease Prevention Sub-committee asked USPHS officers to participate in a survey about their use of technology while driving. Corps-wide, 331 officers completed the on-line questionnaire. The survey revealed that 67% of USPHS officers in the survey that text while driving. An AT&T Commuter Study found in 2013 that 49% of adults text while driving. The USPHS survey suggests that officers may be texting at a higher rate than the general population—a disturbing proposition. Ninety-nine percent of USPHS Officers in the survey reported that it is not safe to text and drive. Similarly, 98% of participants in the AT&T study report they know it is unsafe to text and drive.

While it is convenient to stay connected on the road, texting while driving is considered the most dangerous form of distraction because it involves the eyes, the hands and the mind.

Important statistics to consider from the USPHS Distracted Driving Survey:

- Ninety-five percent of participants use smart phones.
- Participants who send emails while driving:
  - Yes - 36%  No - 64%.
- Participants who access the internet while driving:
  - Yes - 35%  No - 65%.

Ninety-seven percent of participants were less likely to use their phones while driving with a passenger in the car.

Researchers at the Virginia Tech Transportation Institute found that sending or receiving a text takes a driver’s eyes off the road for an average of 4.6 seconds—about as long as it takes to drive the length of a football field at 55 mph. The researchers found that drivers are 23 times more likely to have an accident when texting and driving. Ask yourself: is the convenience of texting worth the risk of killing another driver or yourself?

The simple way to stop distracted driving is to never text and drive at the same time. Need assistance kicking the habit? Download one of the following apps to assist you: SafeCell, DriveSafely, OneProtect, Textecution and AT&T DriveMode. Find the one that is right for you. The AT&T app is...
Many USPHS Officers are USAA members. USAA has teamed up with AT&T on the “IT CAN WAIT” campaign. Check out this website with your family and discuss the importance of safe driving behavior. Click HERE to get information and take the pledge to keep your eyes on the road, not your phone. Officers we have an opportunity to set the standard for driving safety with technology. Join the pledge to put an end to texting and driving. Let’s get on board!

This vehicle was driven by a driver texting on his phone. He hit Michelle Brenner, the wife of CAPT Alex Brenner, who was stopped at an intersection for a red light. Police estimate he was going 45 mph at moment of impact. Mrs. Brenner sustained neck and back injuries.

**Author Information:**

LCDR Scott McGrew works as a clinical physical therapist at Whiteriver Indian Hospital in Whiteriver, AZ.

As a youth, he witnessed a fiery drunk driving accident that took the lives of two young adults and he is passionate about distracted driving education. Contact info: scott.McGrew@IHS.GOV (928) 594-4788.

In recent years, the profession of Physical Therapy (PT) has become increasingly recognized as an asset in a wide range of clinical settings. Physical Therapists bring a specialized skill set in areas of differential diagnosis and hands on clinical examination. These tools along with a robust understanding of pathophysiological dysfunction within the human body and the potential for human healing and growth, position physical therapists perfectly to contribute to interdisciplinart teams. Application of PT skills sets in Emergency Department practice leads to more comprehensive and effective care, and can create excellence in patients’ experiences, in otherwise very distressful situations.

At the Cincinnati Veterans Affair Medical Center (CVAMC), Physical Therapy services have been incorporated in to Emergency Department services using a comprehensive collaborative model to utilize PT as an active participant in Emergency Department service delivery. Introduction of PT services in ED began approximately five years ago on a trial basis to determine the viability of such a partnership. At that time, with little in the way of implementation guidelines, champions from PT, Rehabilitation Care Line leadership, and Ambulatory Care leadership worked closely together to better understand CVAMC needs and to solve obstacles impeding truly integrative ED-PT service. In doing so over the last 6 years, a greater level of understanding between services has emerged with the identification of predictable obstacles and ways to avoid their complications, or at least anticipate them.

**Culture – You Don’t Know What You Don’t Know**

Culture is key. Imagine setting aside your own personal bias, as most therapists readily do, to better understand your patient from another country or another geographic area. Not to do this, would undoubtedly lead to complications in understanding key education, in evaluation, or even in the history taking process. While developing a practice model novel to a facility, or even a geographic area, it is important to remember the impact of cultural biases, understanding that many other medical staff may have a vastly different perception of what Physical Therapy is and what a physical therapist has to offer in an Emergency Department. Further, the physical therapist entering into the ED likely has some preconceived notion of what emergency services should like. Making and acting on preconceived ideas inevitably leads to lack of service coordination, poor clinical communication, and ultimately a failure in service integration. On either side, it takes patience and active listening to promote better understanding of existing natural practice biases. A simple acknowledgement of

**Physical Therapy in the Emergency Department: An Evolving Practice**

Stephanie Christman PT, DPT 
Board Certified Orthopedic Clinical Specialist 
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these as both strengths and weaknesses allows for the opportunity to then harness these qualities and to maximize patient care. In the scenario of a physical therapist integrating into an already established team, such as CVAMC, it is advisable that the therapist perform a comprehensive and balanced needs assessment of ED services as well as their own practice after a period of time and practice in the ED setting. Retrospective data and trending has occurred since the inception of the integrative practice, giving extra-ordinary understanding of many aspect of patient care delivery and system design. This ultimately becomes a tool to discuss progress with leadership and in self-assessment.

**Professional Development – Complex Cases Loads Require Advanced-Practice**

Tools, such as the needs assessment, can give the physical therapist better insight and guidance in the direction of personal and professional development. There are skills universally excepted as entry level within the PT profession. These typically will include evaluative and patient management skills addressing various functional deficits and impairments covered in core PT education such as Acute Care, Orthopedics, and Inpatient Rehabilitation, etc. Other supportive tasks to clinic practice may be warranted dependent on facility and setting. However, there are some skills sets often regarded as advanced or post-Doctorate. These tend to be highly specialized and or involving complex practice patterns and procedures. ED PT practice should be considered within this group. The therapist interested in ED practice should understand that standard practice patterns do not adequately cover the comprehensive nature of clinical services delivered in the ED. In a truly integrative model, the physical therapist contributes to differential diagnosis of low back in one moment, moves on to a functional examination for patient safety to discharge to home, followed by a minor trauma case involving ankle sprain-strain and surface abrasions. Throwing in a case of wound care and debridement or BPPV and vestibular differential add to PT ability to contribute even more if his or her skill set extends to these areas. In each situation however, there is an element of direct access and responsibility for all staff to recognize and act on emergent situation or to rule them out. In essence, it is integral to incorporate seasoned physical therapists with readily available advanced skills in place. By initiating practice at this level, sustainability can be built in a mentorship model by which less experienced therapists can offer support to caseload management while building skills that support total ED coverage. Likewise, the veteran therapist is able to sustain PT relationships, receive feedback and the natural challenges of mentorship that inevitable lead to elevated practice patterns and self-improvement.

**Protocol Development – A Means for Consistent PT Utilization**

Collaboration beyond ED staff and clinicians is a strength of PT practice as therapists are often times readily engaging with other specialty services while managing day to day patient care for movement restrictions, medication requests, etc. Partnering with specialty services typically working with ED staff can help strengthen the role of physical therapy service in the ED. By developing formal protocols addressing some or the more commonly seen ED diagnoses increases service delivery efficiency and connects patients with the right services at the right times. With consistent protocol development and utilization by the physical therapist, ED staff can also begin to build trust in PT expertise and ability to identify patients’ risk factors and red flags, leading to safe recommendations for conservative treatment and or appropriate specialty service referral. Multiple practice protocols have been established in the CVAMC ED to address the many musculoskeletal complaints seen in the minor trauma area in collaboration with specialty services addressing minor orthopedic trauma, wound care, and limb salvage. Patients with non-emergent needs no longer are required to be seen by a surgeon but can be managed conservatively through outpatient physical therapy, thereby decreasing a convoluted referral process and allowing patients to connect with conservative management much closer to time of injury.

**Partnerships and Protocols at Cincinnati VAMC ED current and in development:**

- Surgical podiatry
- Orthopedic surgery
- ENT
- Vascular Services
- Wound Care
- Orthotics / Prosthetics

**Staffing Times – Deciding When Coverage is needed**

Identifying high patient flow times has significance for both staffing and manpower. Setting up trending reports that help to capture times and diagnoses seen within the ED needs assessment can and should lead time dedication to ED services. The nature of ED services does not support a scheduled patient case load. This means a covering therapist would optimally be ready and waiting on the next waiting patient reporting to the ED. If ED is having a busy day, then so is the therapist. If the ED is slow, so will the therapist will be. This can be intimidating from an administrative or managerial standpoint. However, if needs assessments are performed and patient flow is tracked, it is unlikely there is much lost time for the practicing therapist. It is important to anticipate possible down time and have a plan in place for other clinical responsibilities as needed. To this end, there is a wide range of classes offered at CVAMC that capture common educational needs for patients with chronic joint degeneration or who are at risk of joint injury. The ED PT oversees the development and delivery of curriculum for these groups as well as other programs such as MOVE! (a Veteran weight loss program). By offering these additional group education services, staffing is easily supported while simultaneously covering other areas of priority within the CVAMC such as obesity and chronic disease self-management services.

In a retrospective data collection, CVAMC has capture information from over 1800 patients seen in the ED in 2015 and referred to specialty services. Initial review of the data provides considerable insight into the needs of Cincinnati Veterans, diagnoses, patient flow, service delivery, utilization of imaging, and common patient outcomes. One of the most striking is the connection between patients suffering from injuries warranting physical therapy...
In the coming years, CVAMC will require greater staffing of PT to ED services to better service a higher volume of patients and at more opportune times. Longer days of PT availability are warranted to address patients coming in early evening hours and at peak times on weekend days. This creates an excellent opportunity to develop a sustainable model in which mentor-mentee practice can be developed. Of course, further development in system design will be important to continue to maximize resources and to meet the needs of Veterans at the times they need. Ongoing data collection and reporting of CVAMC findings to not only the national Physical Therapy field, but medical and Emergency practice fields, will continue to build CVAMC ED PT service as a model for VA and civilian practice alike.

Post professional Student Scholarship (1)
- Student must be a Federal Physical Therapist Section (FPTS) member enrolled in a post professional graduate educational degree program or residency program for physical therapists
- Student should be seriously considering federal employment upon graduation
- Student must submit the following to federalptsection@federalpt.org as a PDF packet
  - Brief statement (no more than 1 page) outlining why you wish to work as a federal PT
  - Professional resume
  - 1 letter of recommendation from a professor/residency director

Early Career Member Scholarship (1)
- Applicant must be a FPTS member
- Applicant must have graduated from a PT or PTA program no more than 5 years from Sept 1, 2017
- Applicant must submit the following to federalptsection@federalpt.org
  - Brief statement (no more than 1 page) outlining how attending CSM would enhance the applicant’s professional or clinical practice

Submission Deadline: 01 September 2017

Selection:
All applications will be submitted to the FPTS board of directors. Those with the most relevant qualifications will be selected and be notified via e-mail no later than 25 October 2017. Those selected will be given a check at the FPTS business meeting at CSM 2018.

FPTS Student Liaison Message
Shane Harris, SPT, University of Miami, Department of PT

Joining the Federal Section as a student has been one of the most rewarding decisions I have made since starting physical therapy school. The Federal Section has proven to be full of contributing members from the military services, Public Health Services, and Veterans Affairs Hospital System that are willing to share their knowledge and open doors for opportunities within their respective branches of service. Members of the executive board and other section members who participate at Federal Section functions at national conferences, such as National Student Conclave (NSC) and the Combined Sections Meeting (CSM), have served as an invaluable resource for both myself and other student members. As the student liaison, I have been honored to assist my fellow students that are also interested in serving in the military or other uniformed services or interested in providing care for veterans. At events such as NSC and CSM, I have been fortunate to meet fellow student section members from across the country and have informed them as to how they can become more involved in the section and how they can participate in other opportunities offered by the section. Students are typically most interested in residencies offered by the VA system, scholarships to help cover the cost of attendance to CSM, special programming and lectures offered by the Federal Sections at CSM, assistance setting up clinical sites, and the new Amputation Care Special Interest Group. Student members of the Federal Section have the greatest opportunities for building their professional network and are beneficiaries of the sections ability to improve communication between students and the many branches of service.

Student Physical Therapist Scholarships (2)
- Student must be a FPTS member
- Student must be a second or third year DPT student
- Student should be seriously considering federal employment upon graduation
- Student must submit the following to federalptsection@federalpt.org as a PDF packet
  - Brief statement (no more than 1 page) outlining why you wish to work as a federal PT
  - Professional resume
  - 1 letter of recommendation from a PT or professor

The FPTS is offering scholarships to cover the cost of early bird registration for Combined Sections Meeting 21 FEB – 24 FEB 2018 in New Orleans for (3) qualified students interested in pursuing physical therapy careers within the federal government and (1) for an early career section member.

F e d e r a l  P h y s i c a l  T h e r a p y
Getting a Federal Job

How can I get a job in the federal sector or in the military? This is one of the most frequently asked questions we receive. There is no simple answer to this question. We've compiled information from the various service areas that will be helpful.

Employment in the Navy

Those interested in becoming an Active Duty Navy PT should contact their local medical recruiter. The recruiter will be able to provide the number of opportunities available for joining the Navy that year and guide you in the administrative processes for recruitment. Information about Navy PT can be found HERE.

To qualify for Active Duty employment consideration as a Physical Therapist in the Navy Medical Service Corps, you must meet these basic requirements:

- Be a U.S. citizen currently practicing in the U.S.
- Master of Science or doctoral degree in physical therapy (entry-level or advanced) from an institution accredited by the American Physical Therapy Association (APTA)
- GPA of 3.0 or higher on a 4.0 scale
- Be willing to serve a minimum of three years of Active Duty
- Be between the ages of 18 and 41
- Be in good physical condition and pass a full medical examination

You may also be expected to meet certain preferred requirements:

- Previous experience as a physical therapist (constructive credit for work experience now offered to physical therapists)
- Letter of recommendation from a physical therapist currently serving in the military
- Professional and personal recommendations (letter of reference from professor[s] for new graduates, or letter of reference from supervisors in physical therapy for workforce applicants)
- Current licensure required for workforce applicants (newly graduated therapists have one year to become licensed)
- Personal interview with an Active Duty Physical Therapist

Employment in the VA

1. USA JOBS: Keep an eye out here for any job postings. Click HERE. You can also search for VA jobs HERE.
2. Reaching out to your local VA HR department and Chief of PT/Rehab medicine: Because we have direct hiring authority, we can hire people without posting on usajobs.gov. This process is preferred a lot of times as posting the position causes many more delays and takes much more time to fill the position. A lot of hiring officials will prefer to pull from a stack of resumes they already have and skip the job posting process, so sending your resume in ahead of time will already put you at the top of the list.

Employment in the USPHS

Attention potential U.S. Public Health Service Commissioned Corps applicants!

When: Continuous starting June 1, 2017

Who: The general public, Uniformed Service members and Civil Service employees that meet the following criteria:

- Hold a qualifying/eligible degree in Physical Therapy
- Currently hold an unrestricted, valid licensure/registration
- U.S. native or naturalized citizen
- Less than 44 years of age (this may be adjusted based on eligible federal PHS civil service and uniform service active duty time)
- Less than 8 years of prior active duty service in any uniformed service other than the Commissioned Corps
- Meet suitability, professional, medical and security requirements

Interested in becoming a USPHS Commissioned Corps Officer? Visit the www.usphs.gov website for details.

The priority is to fill clinical vacancies specifically with an emphasis on the Indian Health Service (IHS).

Potential applicants should direct their recruitment process and eligibility-related questions to the Commissioned Corps via 1-800-279-1605 or corpsrecruitment@hhs.gov.

The updated clinical vacancy list for therapists in the USPHS can be found HERE.

Getting a Federal Job...continued...
In order to support the health and readiness of Army Medicine beneficiaries, Army Physical Therapy relies on the talents of a diverse group of licensed Physical Therapists. One of the most frequently asked questions asked of the Federal Section Army Service Representatives is how to become employed within Army Medicine. Fortunately, there are a variety of employment opportunities available, to include an entry level Doctoral Program, Active Duty and Reservist positions, and civilian careers. Here is more information on joining our team:

Active Duty/Doctoral Program in Physical Therapy
- Applicants must have a bachelor's degree in biological sciences, anatomy and physiology, chemistry, physics, social sciences or statistics
- Minimum overall GPA requirements of 3.25 on a 4.0 scale
- Minimum cumulative score of 1000 on the GRE (or 297 on the new GRE scale)
- Minimum GRE verbal score of 450
- At least 100 volunteer observation hours in a physical therapy clinic
- Between 21 and 40 years of age
- U.S. citizenship

Active Duty/Direct Commission
- Bachelor's degree or higher from an accredited physical therapy program
- Between 21 and 42 years of age
- Current state license for physical therapy
- U.S. citizenship

Army Reserve
- Bachelor's degree or higher from an accredited physical therapy program
- Between 21 and 42 years of age (may request a waiver, locate a recruiter for more information)
- Current state license for physical therapy
- Permanent U.S. residency

Civilian Employment
- Bachelor's degree or higher from an accredited physical therapy program
- Current state license for physical therapy
- At least 1 year of qualified experience
- U.S. citizenship

For more details and contact information, please visit the following websites:

www.baylor.edu/graduate/pt/

www.baylor.edu/graduate/pt/index.php?id=87580


www.goarmy.com/locate-a-recruiter.html

www.usajobs.gov/
2017 Elections Nomination Form

2017 Elections – The following will start their terms of office in February 2018. All terms are for 3 years.

Vice-President
Treasurer
Air Force Service Representative
Army Service Representative
Navy/Marines Service Representative
USPHS Service Representative
VA Service Representative

Nomination for the office of: ________________________________

Nominee Information

Name ________________________________________________
Email ________________________________________________
Phone ________________________________________________

The Federal Section office will contact the nominee directly to request supporting information for the nomination packet. Please provide any additional input that may help the nominating committee in slating the candidates for 2017 below:

_____________________________________________________________________________________________________________
_____________________________________________________________________________________________________________
_____________________________________________________________________________________________________________

Name of person submitting the nomination form: ________________________________________________
(You may nominate yourself)

Please return this form NLT October 16, 2017 to federalptsection@federalpt.org.

Thank you for submitting a nomination. If you have any questions, please contact the FPTS office at federalptsection@federalpt.org or by calling 1-800-765-7848 X7105.