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Physical Therapy Education in Illinois – *a Partner in Achieving Vision 2020*

You may recognize the APTA's Vision 2020 essence: "By 2020, physical therapy will be provided by physical therapists who are doctors of physical therapy, recognized by consumers and other health care professionals as the practitioners of choice to whom consumers have direct access for the diagnosis of, interventions for, and prevention of impairments, functional limitations, and disabilities related to movement, function, and health."

The Full Vision Statement is as follows: "Physical therapy, by 2020, will be provided by physical therapists who are doctors of physical therapy and who may be board-certified specialists. Consumers will have direct access to physical therapists in all environments for patient/client management, prevention, and wellness services. Physical therapists will be practitioners of choice in patients'/clients' health networks and will hold all privileges of

autonomous practice. Physical therapists may be assisted by physical therapist assistants who are educated and licensed to provide physical therapist-directed and -supervised components of interventions.

Guided by integrity, life-long learning, and a commitment to comprehensive and accessible health programs for all people, physical therapists and physical therapist assistants will render evidence-based service throughout the continuum of care and improve quality of life for society. They will provide culturally sensitive care distinguished by trust, respect, and an appreciation for individual differences.

While fully availing themselves of new technologies, as well as basic and clinical research, physical therapists will continue to provide direct patient/client care. They will maintain active responsibility for the growth of the physical therapy profession and the health of the people it serves."

Illinois is home to 7 schools of Physical Therapy and 9 Physical Therapist Assistant Schools. These academic institutions, both public and private provide quality education for the future therapists and assistants who will provide much needed health care services to patients in Illinois, as well as in other parts of the country. In addition, this education provides a firm foundation for the achievement of Vision 2020.

The US Department of Education and the Council for Higher Education Accreditation recognize the Commission on Accreditation in Physical Therapy Education (CAPTE) as the accrediting agency for education programs in physical therapy. The 26-member commission, comprised of physical therapy educators and practitioners, basic scientists, administrators from institutions of higher education, public representatives and educators in other health disciplines, evaluate

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President's Message **Peter J. McMenamin, PT, MS, OCS**

"Failure of Imagination"

Dear Colleagues,

As I write, Hurricane Katrina is still dominating the news, including coverage of its physical and human devastation and the resulting political fallout and accountability.

A Newsweek analyst has it right: The New Orleans devastation results from a "failure of imagination", a term first used by the "9/11 Commission" to explain our nation's failure to prevent the World Trade Center destruction and other terrorist acts of 9/11/01.

FAILURE OF IMAGINATION

So much critical information was available prior to 9/11, including names of some perpetrators being on national alert lists. The World Trade Center had been the target of a previous effort to destroy it only a few years prior. Osama bin Laden's intentions to wreak havoc on our nation were no secret. But we (citizens and agencies of government) were collectively in denial, preferring to live in our daily consciousness of the ordinary, oblivious to the extraordinary threats confronting us. We failed to imagine and take seriously the very real menace that was being quietly mounted against us. Failure of imagination.

New Orleans: same story. For years the local, state, and federal authorities knew

that the levees protecting a million people in a poor, sinking city already below sea level, could not withstand a category four or five hurricane. In disaster drills over recent years, serious preparedness gaps had been identified. But amnesia and blindness—a collective entropy—are the path of least resistance. Subconsciously hoping for the best, so as not to disturb the comfort zone of daily ordinariness, authorities and common citizens at all levels pushed out of mind the very real threat that eventually such a hurricane was absolutely bound to hit them. The levees could have been rebuilt or fortified. That would have saved New Orleans, its people, and an entire region's economy. But they were not rebuilt. Failure of imagination!

TRIUMPHS OF IMAGINATION

Lest we succumb to pessimism, let us also cite triumphs of imagination. The United States itself represents such a triumph. The creative imagination and genius of our founding fathers at the Constitutional Convention, conceived of a totally new form of government, which included built-in checks and balances against the worst parts of our human nature, and which has stood the test of time for well over two hundred years. It had to be imagined by real people before



it could happen: Triumph of imagination!

The founding of the physical therapy profession is a triumph of imagination. When the "reconstruction aides" returned home after their mission of rehabilitating World War I soldiers was accomplished, they could have dispersed and disappeared into the social fabric to raise families and resume normal life. No. They imagined something larger, a new reality, a new profession. And this at a time when the very concept of a professional woman was at odds with the collective consciousness. They formed a profession, an independent association, a code of ethics, a journal...and the rest is history. Their imaginations triumphed!

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PT PRIORITY

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Rules for Submission of Materials for Publication in *PT PRIORITY*

1. Topics should be of interest and/or assistance to physical therapists and physical therapist assistants.
2. Articles should be submitted to the Chapter Office via facsimile, e-mail, or on diskette using Microsoft Word or in ASCII format. Photos are also welcomed.
3. Quotations and references should be properly identified. A bibliography should be identified as appropriate.
4. Name of author with address and brief biography should be included.
5. The editor reserves the right to accept, reject, or edit all materials for grammar, spelling and eligibility. If after editing, the content or thrust of the article appears to have been substantially altered, the author will be consulted before publication.

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Achieving Vision 2020

Continued from Page 1

physical therapy education programs to determine if they meet the evaluative criteria for approval. Accreditation recognizes professional education programs for a level of performance, integrity and quality that entitles them to the confidence of the education community and the public they serve. All of the schools in Illinois are CAPTE accredited.

According to A Guide to Health Careers in Illinois, published by the Illinois Department of Employment Security, Physical therapist and physical therapist assistant are among the top 50 fastest growing occupations in the state. Employment is also expected to grow faster than

average nationally through 2010.

As the Illinois Physical Therapy Association continues to work to achieve Vision 2020, we are grateful for the role that the 16 academic institutions in Illinois play in achieving the goals of the profession. In this issue, we highlight topics in research from Connections, 2005, the IPTA Fall continuing education conference, student essays on what makes a good clinical student, information on the student shared interest group, as well as information on Medicare, workers compensation, and the future of the profession, all integral to achieving Vision 2020.



Student Shared Interest Group Under Development

During the past year, students from the Rosalind Franklin University have been working to contact students at the PT and PTA schools throughout the state to revitalize the IPTA Student Shared Interest Group (SIG). The objective of the IL SIG is to create a network for physical therapy students in Illinois, and its purpose is to improve communication among students in Illinois. Specifically, the SIG seeks to:

- Support network between students in the academic and clinical setting
- Help establish funding for research, equipment, activities
- Create collaborative research opportunities to help with evidence based practice – this would also allow access to equipment that students may not otherwise have access to
- Create a working network of communication and support for Illinois Physical Therapy students for:

- Collaborative research
- Initiating an Illinois Student Conclave
- Forming an active group of Physical Therapy students involved in community service for the purpose of increasing community awareness of Physical Therapy
- Create a network to enhance communication with respect to fundraisers, activities, speakers
- Increase awareness of Physical Therapy in the community through collaborative efforts of Illinois Physical Therapy schools
- Create a network to help put together an Illinois student conclave

If you are interested in the student SIG, please contact the IPTA Chapter office at 630-571-1400 or by email at ipta@ipta.org.



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Another example is close to my wife's Finnish heart. Finland is about as remote a country as Alaska is a state. A company in my wife's home town of Tampere used to make rubber boots, plastic products such as buckets, and wood products for construction. In the 1980's the company felt it needed to "re-imagine itself" to remain viable in the evolving sophistication of modern Finland. It got into computers briefly, then cell phones. Within 10 years Nokia was eating Motorola's lunch in the international cell phone marketplace, and became a mighty international corporate heavyweight. Nokia: now an international household word and brand: a

true triumph of imagination for a once hum-drum company, from a tiny country of 5 million people, in a remote part of the world, with inhospitable weather for 9 months of the year! Imagination triumphs!

DOES PHYSICAL THERAPY HAVE A FUTURE?

Nations rise and fall. Great companies rise and fall. Even great cities rise and fall. Witness: New Orleans. Witness: Pan American, TWA, Ma Bell, International Harvester, Arthur Andersen: All giant companies and leaders in their industries, once considered unassailable: all fell into the dustbin of history.

Could that happen to physical therapy? Absolutely. If we do not re-imagine and take charge of our future, we are bound to be overtaken by the hurricane of change in the world of healthcare just as New Orleans was overtaken. We are at our most critical crossroads, where we either succeed as an autonomous profession, or we recede to our erstwhile status as technicians controlled by other professions which often do not understand what we offer and stand between us and our patients.

VISION 2020: LEAP OF IMAGINATION

Fortunately Vision 2020 represents a great achievement: the leap of imagination that can propel physical therapy to the standing it deserves within healthcare, to better enable us to serve society's healthcare needs. Now it is our challenge to take the leap, in reality. The realization of Vision 2020 is not just a bunch of words. It entails a new way of thinking, a new set of behaviors and expectations,

and above all, the assumption of larger responsibilities with regards to the healthcare of individual patients and of society. The realization of Vision 2020, when we get there, will represent a true Triumph of Imagination for physical therapy!

Realization of Vision 2020 will mean that the American public will have a profession that is truly autonomous and that has a unique angle of vision on human health and disease, based on science, but clearly offering something not offered by other health professions. The realization of Vision 2020 will provide for America a profession whose members can be trusted to provide independent evaluation, judgment, and intervention in matters of human physical function. All Americans will benefit by being able to choose to visit a physical therapist to address their physical function and performance needs, at any point in the life cycle, and in any state of health or disease. It is our duty to assume this mantle of responsibility, and to make this happen.



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Education in focus

What Makes a Good Clinical Student?

Shannon Graham, SPTA

There are so many answers to this question. Certain responses may stand out in your mind over others, probably because we all learn in different ways. But I think most of us would probably agree that the element of learning is the largest area of focus for any student during this phase of our career as a health professional. It doesn't matter how one learns, whether you are a visual learning, auditory, hands on etc., or like many of us, a combination of these. As a student, it goes without saying; it is our "job" and a privilege to learn as much as we can each day. What we take away from our clinical experience is what will contribute in a big way to the type of professional we will be one day. We all know there is an infinite amount of information out there just waiting to be acquired. In order to help try to keep the stress levels down, and the positive attitudes up, there are some key factors a clinical student should try to focus on in order to avoid feeling overwhelmed and experiencing brain overload.

When we start our clinical rotations, it is very similar to going to a new job which for most of us, can involve some increased anxiety levels. First, as a clinical student it is important to get your bearings. When you begin at each new clinical site, and the

introductions are made, show confidence and be pleasant to everyone, because there's a chance you could be working with them one day! It is important to become oriented with the facility where you will be for the next several weeks. Your clinical instructor will probably be more than happy to show you around and help you become more comfortable with any equipment you will be using. It is also important to begin becoming familiar with patient charts that your clinical instructor is working with as well as the documentation style at that facility, because this will probably vary from place to place. Touch base with your clinical instructor on your personal goals that you would like to achieve during your time there. This will help your instructor get a feel for what you want to get out of the experience and is a good ice breaker for the two of you in order to get things going.

The next phase should involve the student applying the skills they have learning and working with the patients. This is why we are here, to build on what we have learning in order to best care for our patient. A good clinical student will know any pertinent information for each patient with which they are working. If you need to find out something, ASK! Your clinical instructor or other staff members are there to help you operate within your scope and

capability level. Never compromise care because you feel foolish to ask a question. People will respect you more if you do what is required of you in order to perform your job correctly. Another important thing to remember is to get in there and try it! Simply watching is not going to help you learn as well as applying it yourself. See it, feel it, understand it. By hands on application, you can better understand not only the technique itself, but how it is helping the patient and why. It is also important to remember the ever so critical element of flexibility. In this field, the ability to make the most of our time with the patient is of the utmost importance. If something isn't working according to planned, don't get frustrated. Remember as we said before, we all learn differently. Anyone who has been a student surely knows that. Rather than talking the patient to death and getting mediocre to no results, change what you are doing and accommodate it to the patient in order to get what you need from them to best progress their treatment. This doesn't have to be a negative thing, instead look at it as a time to have fun and get creative.

Don't forget to welcome any feedback and or constructive criticism from your clinical instructor, peers, etc. This should not be something you are afraid of or that let get you down. This is what will help

you improve on your skills and become a more proficient therapist.

Lastly, be a curious person. Look things up, read articles, try ideas out during down time in the clinic. Basically try to observe and take in as much knowledge as you add more goodies into your knowledge basket! Think of your visit as one long drawn out interview process, because not only are you getting the chance to observe and learn things at each facility, but the people that work there are also observing you and the way you interact with the patients as well as the staff. Remember that even though you are a student, you are representing the field of physical therapy. Be professional at all times – you know the rules and regs by now. Simply be yourself and be confidence in the skills you have learned thus far and be thankful that you are able to be out in the field with professionals. It's a nice break from the classroom for awhile!

Shelby Wertz, SPTA

The knowledge obtained from the classroom and the experiences learned from clinicals are what help shape the mind of a good clinical student. Advantages to being a clinical student include the experience and the opportunity to be exposed to different areas of physical therapy, as well as being able to see how other

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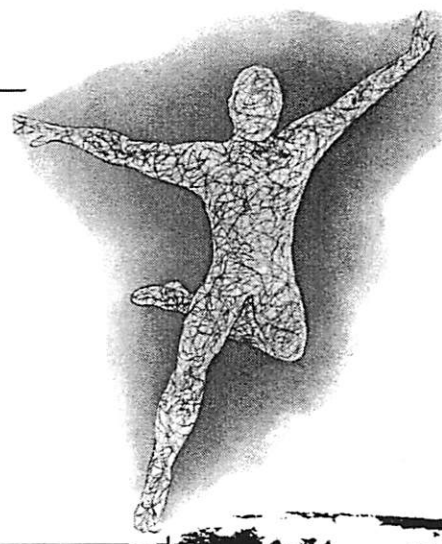
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What Makes a Good Clinical Student?

Continued from Page 6

practitioners organize and prioritize their treatment plans. It is important that the student understand that the impression made at their clinical site may influence an employer's decision regarding future employment.

Many attributes define a good clinical student. The student needs to present themselves in a professional manner by arriving on time, dressing appropriately, and having a positive attitude. It is important that the clinical student have the desire and the ability to work well with others as well as have some basic knowledge about their clinical site. A good clinical student needs to possess compassion, caring, and understanding, while being respectful to patients, their families and other staff members.

The student needs to approach each learning experience with an open mind, understanding that no two practitioners do everything exactly alike. A good clinical student needs to be confident in his or her work, but at the same time recognize their own limitations. The clinical student should take the initiative with their treatment plans and step up to new challenges and opportunities to problem solve. The student also needs to be accountable for his or her actions and display competence in their treatment and documentation.

It is important for the student to be able to accept

constructive criticism from his or her clinical instructors and incorporate these suggestions in order to improve their clinical performance. The student should not feel intimidated to ask questions when they don't understand something. The clinical environment is meant to be a learning process. It is important that the student seek out the challenging and unfamiliar situations, for these may prove to be invaluable to the student in the future.

Finally, the student needs to be flexible with his or her schedule and understand that situations may arise where they need to jump in and offer help to others. Learning how to be a team player within a clinical setting may open up new opportunities for the student, as well as possibly forge valuable alliances within the physical therapy community.

As a physical therapist assistant student, I have been fortunate to have had many positive clinical experiences. I feel the clinical instructors have always provided an enhanced learning environment. I have been challenged to problem solve, plan, organize, and prioritize within the clinical setting. Learning and becoming competent in one's profession requires give and take from the student. Knowledge gained is proportionate to the effort and drive for excellence put forth by the clinical student.



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Medicare "Incident To" Rules Implemented

As of Monday, July 25, Medicare will only pay for physical therapy services provided in physician offices "incident to" the physician's services if the physical therapy services are provided by "qualified personnel" as defined in a June 24 transmittal (http://www.cms.hhs.gov/manuals/pm_trans/R36BP.pdf) to Medicare contractors. The immediate implementation of the standards follows the dismissal last week of a lawsuit filed by the National Athletic Trainers Association (NATA) challenging the personnel standards, as explained in a new MedLearn article (<http://www.cms.hhs.gov/medlearn/matters/mm/cles/2005/MM3648.pdf>) released by the Centers for Medicare and Medicaid Services.

In addition to the implementation of the personnel requirements for physical therapy services provided incident to a physician/NPP, Section 230.5 of the Medicare Benefit Policy Manual also clarifies the requirement that services provided by PTAs cannot be billed incident to the physician/NPP's services. PTAs must be supervised by a physical therapist in all treatment settings, including in a physician/NPP office. The services of PTAs are covered under the benefit for physical therapy services and not under the benefit for services provided incident to a physician/NPP. In order to bill for the PTAs' services in a

setting where the PT and PTA are employed by a physician/NPP, the PT would need his or her own Medicare provider number. Payment for physical therapy services billed using the PT provider number would then be reassigned to the physician/NPP.

230.5 - Physical Therapy, Occupational Therapy and Speech-Language Pathology Services Provided Incident to the Services of Physicians and (Rev. 36, Issued: 06-24-05, Effective: 06-06-05, Implementation: 06-06-05) References: §1861(s)(2)(A) of the Act, 42 CFR 410.10(b), 42 CFR 410.26, Pub. 100-02, ch. 15, § 60.

The Benefit. Therapy services have their own benefit under §1861 of the Social Security Act and shall be covered when provided according to the standards and conditions of the benefit described in Medicare manuals. The statute 1862(a)(20) requires that payment be made for a therapy service billed by a physician/NPP only if the service meets the standards and conditions--other than licensing--that would apply to a therapist. (For example, see coverage requirements in Pub. 100-08, chapter 13, §13.5.1(C), Pub. 100-04, chapter 5, and also the requirements of this manual, §220 and §230.)

Incident to a Therapist. There is no coverage for services provided incident to the services of a therapist. Although PTAs and OTAs

work under the supervision of a therapist and their services may be billed by the therapist, their services are covered under the benefit for therapy services and not by the benefit for services incident to a physician/NPP. The services furnished by PTAs and OTAs are not incident to the therapist's service.

Qualifications of Auxiliary Personnel. Therapy services appropriately billed incident to a physician's/NPP's service shall be subject to the same requirements as therapy services that would be furnished by a physical therapist, occupational therapist or speech-language pathologist in any other outpatient setting with one exception. When therapy services are performed incident to a physician's/NPP's service, the qualified personnel who perform the service do not need to have a license to practice therapy, unless it is required by state law. The qualified personnel must meet all the other requirements except licensure. Qualifications for therapists are found in 42CFR484.4 and in section 230.1, 230.2, and 230.3 of this manual. In effect, these rules require that the person who furnishes the service to the patient must, at least, be a graduate of a program of training for one of the therapy services as described above. Regardless of any state licensing that allows other health professionals to provide therapy services,

Medicare is authorized to pay only for services provided by those trained specifically in physical therapy, occupational therapy or speech-language pathology. That means that the services of athletic trainers, massage therapists, recreation therapists, kinesiotherapists, low vision specialists or any other profession may not be billed as therapy services.

The services of PTAs and OTAs also may not be billed incident to a physician's/NPP's service. However, if a PT and PTA (or an OT and OTA) are both employed in a physician's office, the services of the PTA, when directly supervised by the PT or the services of the OTA, when directly supervised by the OT may be billed by the physician group as PT or OT services using the PIN/NPI of the enrolled PT (or OT). (See Section 230.4 for private practice rules on billing services performed in a physician's office.) If the PT or OT is not enrolled, Medicare shall not pay for the services of a PTA or OTA billed incident to the physician's service, because they do not meet the qualification standards in 42CFR484.4.

Therapy services provided and billed incident to the services of a physician/NPP also must meet all incident-to requirements in this manual in chapter 15, §60. Where the policies have different requirements, the more

Continued on Page 10

Medicare "Incident To" Rules Implemented

Continued from Page 9

stringent requirement shall be met.

For example, when therapy services are billed as incident to a physician/NPP services, the requirement for direct supervision by the physician/NPP and other incident to requirements must be met, even though the service is provided by a licensed therapist who may perform the services unsupervised in other settings.

The mandatory assignment provision does not apply to therapy services furnished by a physician/NPP or "incident to" a physician's/NPP's service. However, when these services are not furnished on

an assignment-related basis; the limiting charge applies.

For emphasis, following are some of the standards that apply to therapy services billed incident-to the services of a physician/NPP in the physician's/NPP's office or the beneficiary's residence.

A. Therapy services provided to the beneficiary must be covered and payable outpatient rehabilitation services as described, for example, in this section as well as Pub. 100-08, chapter 13, §13.5.1.

B. Therapy services must be provided by, or under the direct supervision of a physician (a doctor of medicine or osteopathy) or NPP who is legally

authorized to practice therapy services by the state in which he or she performs such function or action. Direct supervision requirements are the same as in 42CFR410.32(b)(3). The supervisor must be present in the office suite and immediately available to furnish assistance and direction throughout the performance of the procedure. It does not mean that the physician/NPP must be present in the same room in the office where the service is performed.

C. The services must be of a level of complexity that require that they be performed by a therapist or under the direct supervision

of the therapist, physician/NPP who is licensed to perform them. Services that do not require the performance or supervision of the therapist, physician/NPP, are not considered reasonable or necessary therapy services even if they are performed or supervised by a physician/NPP or other qualified professional.

D. Services must be furnished under a plan of treatment as in §220.1.2 of this chapter. The services provided must relate directly to the physician/NPP service to which it is incident.

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New Workers' Compensation Law

Tim Hennessey, IPTA Lobbyist

The Governor has signed into law a new worker's compensation act. This is an extensive rewrite of the old act contains various effective dates for its provisions. The new law will impact physical therapists both as providers and employers. For a more detailed summary of the new law, along with the effective dates of various sections, go to www.iwcc.il.gov, click on "news", then click on "summary of act". Highlights (with specific provisions of interest to PT bolded) of the bill include:

BENEFIT DELIVERY

- Ensures prompt payment for medical providers who treat injured workers by allowing 1% interest per month after 60 days of unpaid medical bills.
- Prohibits a medical provider from billing an injured worker for the balance of charges not paid by an insurance company while the workers' compensation claim is pending. Under this legislation, Illinois will become the last state in the nation to adopt a balanced billing prohibition.
- Creates a 3rd Workers Compensation Commission panel to expedite resolution of disputed claims and expands and expedites emergency hearings to resolve cases within 180 days.
- Simplifies procedures for introduction of workers medical records into evidence.
- Requires vocational rehabilitation counselors

who provide services to workers to be certified.

- Ensures the rate Adjustment Fund is made solvent and phased out over the next 10 years.
- Enhances penalties, for the unreasonable delay of workers' compensation benefits from \$10 per day to \$30 per day and from \$2,500 per claim to \$10,000 per claim.
- Provides for collection of claims paid data by the State Division of Insurance to allow both business and labor to track worker compensation injuries and cost.

BENEFIT STRUCTURE

- Increases the minimum benefit for a worker killed on the job to the great of \$500,000 or 25 years (was \$400,000 for 20 years)
- Increases the burial benefits to \$8,000 from \$4,200
- Ties the minimum temporary total disability and permanent partial disability rates to the Illinois Minimum Wage for a 40-hour week. These rates have not changed for 20 years.
- Sets the minimum rates for Amputations at 40% of the Statewide Average Weekly Wage (SAWW).
- Increases the number of weeks by 7 1/2% for loss of use of scheduled body parts and disfigurement.
- Sets the maximum wage differential rate at 100% of SAWW for workers who qualify and extends the reopening of the claim to 60 months.

COST CONTAINMENT

- Creates cost containment in workers' compensation by joining 44 other states in creating a medical fee schedule. The fee schedule allows for providers treating injured workers to charge up to 90% of the 80th percentile utilizing Illinois medical databases.
- Provides for Utilization Review of proposed or provided medical treatment to ensure the treatment is reasonable and necessary.
- Reconstitutes the Workers' Compensation Advisory Board composed of

business and labor interests.

FRAUD

- Creates a workers compensation fraud statute and investigation unit within the Division of Insurance, IFDPR.
- Enhances penalties and fines. Creates work stop order for employers who do not pay workers' compensation. Civil liabilities for person who knowingly and fraudulently attempt to obtain workers' compensation benefits.



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Spotlight

ROBERT D. JOHNSON, PT, MC, OCS

Bob Johnson has been the Chair of the Orthopedic Specialty Council for the American Board of Physical Therapy Specialties since 2001 and is responsible for the examination and board certification of Orthopedic Physical Therapists nationally. A suburban Chicago resident, Bob is currently Co-Owner/Clinical Director of Achieve Orthopedic Rehabilitation Institute with locations in the Gold Coast/Loop, Burr Ridge, and Orland Hills. While Bob's clinical practice is focused on manual therapy and patient treatment, he is also well known for his local, national and international education of physical therapists. For almost two decades he has been committed to providing continuing education opportunities for physical therapists on topics related to orthopedic manual therapy.

Bob began his physical therapy education at Northwestern University Medical School, where he received both his BS and MS in Physical Therapy with a Specialization focus in Orthopedic Manual Therapy. He received his board certification as an Orthopedic Clinical Specialist in 1992 and was chosen 1 of 12 Orthopedic Subject Matter Experts in the United States by the Orthopedic Specialty Council of the American Board of Physical

Therapy Specialties. From 1993 to 2002, Bob worked as an Orthopedic Clinical Specialist at the Chicago Institute of Neurosurgery & Neuroresearch, and then in 2002, opened his current practice that specializes in patients with spine-related movement dysfunctions, acute/chronic pain and arthritis rehabilitation. He is considered an expert in orthopedic manual therapy and its application to the evaluation and treatment of acute and chronic pain associated with extremity and spine pathology.

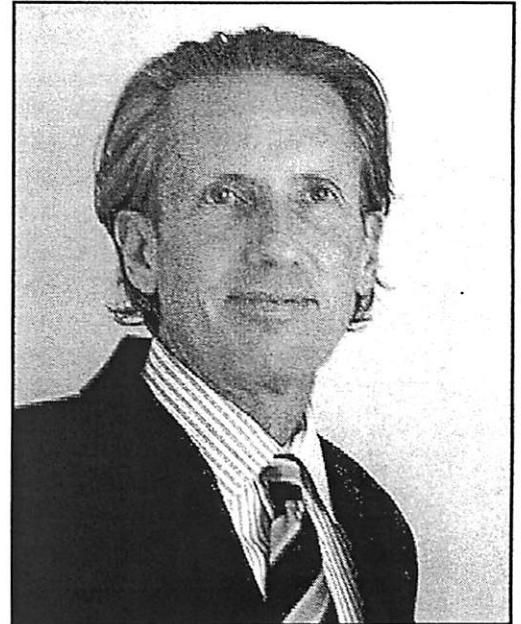
Bob is a firm believer in continuous professional education as a supplement to any physical therapy practice. His work is motivated by this desire to not only teach his patients more about their health and chronic conditions, but also to provide clinical education as an important component in professional development and job satisfaction. He is devoted to stimulating these professional qualities in his staff, as well as for his colleagues, by developing a varied and creative curriculum useful to clinicians practicing in a neuro-musculoskeletal clinical environment.

Immediately after obtaining his Master's degree, Bob began mentoring numerous students and clinicians at the Northwestern University Medical School, Programs in Physical Therapy, contributing at the entry and graduate levels. He served on many graduate thesis committees and helped design parts of the course curriculum.

In 1993, he developed a long-term course of study in Orthopedic Manual Physical Therapy (OMPT) for Physical Therapists in Chicago. Still offered today, this course was the first and only Long-Term Continuing Education Seminar in the Midwest and has since trained over 150 local clinicians in

the clinical analysis of the neuromusculoskeletal system as related to the spine and extremities. Bob teaches a clinical problem solving approach with emphasis throughout the curriculum on a clinical reasoning thought process as applied to examination technique and treatment selection options. A highlight of his teaching occurred between 2003-2004, when he traveled to Riyadh, Saudi Arabia to teach the OMPT seminar to colleagues who attended throughout the Middle East.

Bob is also one of only 5 United States instructors for David Butler and the Neuro-Orthopedic Institute (NOI), providing continuing education opportunities for physical therapist interested in Pain Science and movement related dysfunction of the nervous system. NOI's core philosophy is to provide progressive, current



material; to challenge existing management protocols, to promote professional reinvestment, and to ensure that course participants benefit from the most recent research. Bob brings this philosophy to his teachings and clinical practice daily.

Because of his expertise in the clinic and the classroom, Bob has been invited to participate in 'Operation Walk', a Chicago based medical mission to Cheng-Du, China, during the summer of 2005. As one of only 2 physical therapists on a medical team of more than 40 medical professionals, Bob will be responsible for the rehabilitation of over 65 patients undergoing total-hip or total-knee replacements. In addition, he will have the opportunity to teach rehabilitation techniques to Chinese medical colleagues.





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Topics in Research - Poster Presentation Abstracts

The Illinois Physical Therapy Association Fall Conference was held September 16-17, 2005 at the Crowne Plaza, Springfield, Illinois. We are pleased to present in this month's PT Priority, abstracts of poster presentations that were exhibited at the conference. Look for photos and a summary of the conference coming in the next issue of PT Priority.

THE ROLE OF MANUAL LYMPHATIC DRAINAGE IN THE POST-OPERATIVE CARE OF COSMETIC RECONSTRUCTIVE PLASTIC SURGERY PATIENTS

Maria Sobol, P.T., CLT-LANA; Laurie A. Casas, M.D., FACS
Swanston Northwestern Healthcare Rehabilitation Services, Glenbrook Hospital Division of Plastic Surgery

PURPOSE/HYPOTHESES:

Aesthetic and reconstructive plastic surgery patients prefer a short postoperative recovery phase leading to the return of normal activity and sensation in the operative area. The purpose of the observational study performed by Laurie A. Casas, M.D., FACS and Patricia DePoli, M.D.*, was to evaluate Manual Lymphatic Drainage, (MLD), as a possible adjunct in the postoperative care of a series of patients having aesthetic and reconstructive plastic surgery.

SUBJECTS: The following patient groups received a series of postoperative treatments: Breast Reduction; Liposuction of the Abdomen; Abdominoplasty; Facelift; Forehead Lift; Otoplasty;

Liposuction of buttocks, hips, and thighs; Breast Augmentation; Mastopexy.

MATERIALS/METHODS: Two Vodder trained therapists performed a series of postoperative treatments on the subjects listed above. Manual Lymphatic Drainage and Deep Tissue Massage were performed as needed, one to two times per week for the first three to six weeks following the procedure. Treatment was initiated with Manual Lymphatic Drainage and Deep Tissue Massage was incorporated as subcutaneous fibrosis developed. The patients' subjective feeling that the operated area felt "almost" normal determined the end of the therapy.

RESULTS: In the ten groups listed above who underwent MLD and Deep Tissue massage, postoperative swelling and fibrosis resolved within 6 weeks to 3 months. Patients who DO NOT undergo postoperative decongestive therapy have a predictable and consistent postoperative course. Patients experience postoperative edema which peaks 2-4 days following surgery and is followed by soft tissue fibrosis of the operated area by day 14-42. The extent of the edema and fibrosis depend on the following variables: 1) the operated location, (dependent areas swell more), 2) the patient's activity level, 3) fluid retention, 4) previous surgery on the same area. Complete resolution of postoperative edema and fibrosis in this group is seen between 9 months to 18 months following surgery.

CONCLUSION: All surgical patients prefer a

shortened postoperative recovery phase. Decrease in swelling, pain, and subsequent soft tissue fibrosis has been achieved by instituting Decongestive Therapy and Deep Tissue Massage to the operative site in surgery patients' postoperative regime. In conclusion, MLD with Deep Tissue Massage significantly shortens the postoperative recovery phase in these patient groups.

CLINICAL RELEVANCE: The protocol for cosmetic surgery postoperative recovery was developed to include MLD and Deep Tissue Release to shorten the recovery phase.

*Paper presentation at the Annual Conference of the American Society of Lymphology, Chicago, IL, August 1999: Title: MANUAL LYMPHATIC DRAINAGE THERAPY: AN INTEGRAL COMPONENT OF POSTOPERATIVE CARE IN PLASTIC SURGERY PATIENTS; Authors: Laurie A. Casas M.D., FACS and Patricia DePoli, M.D.

BREAST CANCER SURVIVORS PERFORM UPPER EXTREMITY RESISTIVE EXERCISE WITHOUT DEVELOPING LYMPHEDEMA: A SINGLE SUBJECT DESIGN STUDY
Antoinette P. Sander, Christina Gamzer, Kristyn Kneeland, Heather Lossau, Jennifer Seitz, Christine Wiatr, Department of Physical Therapy and Human Movement Sciences Feinberg School of Medicine, Northwestern University

BACKGROUND AND PURPOSE: Anecdotal guidelines discourage women

post-breast cancer from lifting objects greater than 15 pounds or engaging in resistive exercise programs. The purpose of this A-B-A single subject design study was to test the necessity of this guideline. We hypothesized that a graded free weight exercise program would not result in a greater than 10% increase in arm volume and would improve Quality of Life (QOL).

SUBJECTS: Four women post-unilateral breast cancer treatment without lymphedema were selected.

METHODS: There were 4-week baseline, 8-week intervention and 3-week follow-up phases. The intervention consisted of 6 upper extremity exercises completed twice a week using free weights. Exercises were individually progressed using a 1-Repetition Maximum (1RM) formula. Measurements of volumetric girth and QOK, using the RAND-36 and the FACT B+4, were taken during each phase. A questionnaire regarding changes in arm sensations was completed at each exercise and each measurement session. Results: Subjects increased weights lifted and achieved a calculated 1RM that ranged from 8.6-17.3 pounds. Percent difference in change in arm volume ranged from -3.2% to +3.3%, which did not approach the 10% change of clinically relevant lymphedema. Based on a two standard deviation band analysis, one subject had a statistically significant decrease in arm volume. Two subjects demonstrated improvement in QOL. Spearman Rho analysis

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Poster Presentations *contd.*

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found no significant relationship between the subjective questionnaire and the percent change in arm volume.

DISCUSSION AND CONCLUSIONS: This study suggests that exercise programs based on a calculated 1RM may safely challenge breast cancer survivors and may improve QOL. Self-report of arm changes may be useful in monitoring resistive exercise programs. [This work is supported by a grant from the Coleman Foundation]

BARRIERS TO ACCESSING SERVICES FOR INDIVIDUALS WITH CP

Robbie O'Shea, PT, PhD
Elizabeth Cada, ORT/L

Governors State University
University Park, IL

Chronic disability in their own right, add stress to a family. Children with developmental delays experience significantly more doctor visits, hospitalizations and longer hospital stays than children without developmental delay (Boyle, Decoufle, Yeargin-Allsopp, 1994). Poverty presents a myriad of issues for families seeking medical care for their children with cerebral palsy. Several factors related to poverty influence the families' ability to receive adequate therapy services.

Families living in poverty must continually focus on several additional facets in

addition to the additional needs of the child with cerebral palsy. Several factors influence the caregiver's ability to obtain adequate therapy services for their child. Caregivers may have limited resources remaining to dedicate to therapy services after providing for the safety and survival needs of their family (Porr & Rainville, 1999).

Children with disabilities can receive therapy services in a myriad of settings. For the young child ages 0-3 therapy services can be home based or center based. As the child reaches school age (ages 3-21) therapy services can be received at school, at a hospital or in an outpatient clinic. Affluent families often can afford to provide the child with private therapy to augment school related therapy. Conversely, children from underserved

areas must rely on school based therapy as their sole intervention. Additionally, funding of services, transportation and family demands on caregivers present as major barriers in access to clinic based therapy.

The purpose of this study is to investigate the causes of apparent disparities in service availability to children with cerebral palsy living in poverty as compared to their affluent peers in the south metropolitan Chicago region. This study is ongoing and findings to date will be presented that examine factors that prevent individuals with cerebral palsy from acquiring sufficient health care and therapy services

PHYSICAL THERAPY GENERIC ABILITIES: THE PATIENT'S PERSPECTIVE

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Poster Presentations *contd.*

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Wynn Hall, PT, MPT
Bradley University, Peoria, IL

Physical therapists work hands on with patients daily to enhance patient health. In doing so, most professional physical therapists recognize that the patient's perception toward their health professional is important in the overall spectrum of quality health care.

In 1995 May et al established a model for ability-based assessment for physical therapy students which lists 10 important generic abilities in a ranked order for the physical therapist to express.¹ The generic abilities that May established in rank order are, commitment to learning, interpersonal skills,, communication skills, effective use of time and resources, use of constructive feedback, problem solving, professionalism, responsibility, critical thinking and stress management. May's study was further validated in 2003 when Jette and Portney concluded that their study "provides evidence for the construct validity of the generic abilities".²

Unfortunately no studies indicating what patients want in their health professional specifically targeted the Physical Therapy profession. Therefore, utilizing May's Generic Abilities, this study examined what qualities patients perceive as most important for a physical therapist to express. The goal was to answer the research question, which of May's Generic Abilities is (are) most valued by patients?

Subjects were drawn through

a sample of convenience from three outpatient clinics in Central Illinois. Fifty subjects (26 males, 24 females; ages ranging from 18-90) were asked to order the generic abilities from 1 to 10 (1-most important attribute for his/her physical therapist to express, 10- least important attribute for his/her physical therapist to express) With the significance level set at 0/05, the chi square statistical procedure was used to analyze the data. Chi-square analysis showed significance in the areas of communication skills, critical thinking and stress management.

¹May, M.W., Morgan, M.J., Lemke, J.C., Karst, G.M., & Stone, H.L.: Model for Ability-Based Assessment in Physical Therapy Education. *Journal of Physical Therapy Education*, 9:3-6, 1995. ²Jette, D.U., & Portney, L.G: construct Validation of a Model for Professional Behavior in Physical Therapist Students. *Physical Therapy*, 83:432-444, 2003

EXPLORATION OF A CLINICAL MEASURE OF VERTICAL PERCEPTION

Andrew J. Strubhar, PT, PhD
Vincent McQuirter, BS, SPT
Kathleen Meranda, BS, SPT
Bradley University, Peoria, IL

BACKGROUND AND PURPOSE: The purpose of this study was to explore the use of a standard goniometer to measure the perception of vertical. Some patients with brain lesions have a misperception of vertical and thus are prone to balance impairments. The current

Continued on Page 18

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Poster Presentations *contd.*

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measure of vertical perception includes the use of a luminous rod in a darkened room (subjective visual vertical or SVV). The subject moves the rod to his or her perceived vertical position. A consistent undershooting of vertical occurs in normal subjects when their head is in a horizontal position (the Aubert effect or A-effect). In this study we measured the perception of vertical using a goniometer with the subjects eyes closed (subjective non-visual vertical or SNVV) and compared the perception of vertical in upright and side lying positions to determine if the A-effect was measurable with the goniometric technique.

SUBJECTS AND

METHODS: Data was collected from 50 subjects ages 18-24 with no known orthopedic, neurological or balance impairments. The stationary arm of a standard goniometer was anchored to a tripod in a vertical position. With their eyes closed, the subjects moved the movable arm of the goniometer in three trials to the perceived vertical position using their dominant arm. This was done in standing and side lying. Additional impairment measures were also performed.

RESULTS: Preliminary results indicate that most subjects placed the arm below vertical in the side lying position compared to the standing position.

DISCUSSION AND CONCLUSION: The misperception of vertical in side lying as measured by the goniometer (SNVV) may reflect the same A-effect measured by the luminous rod test (SVV). This indicates that a simple measure with a goniometer may be a valid screen of vertical misperception in patients. Further studies should include a comparison of the SVV and an SNVV test that includes subjects with known vertical perception difficulties.

EMPLOYER PERCEPTIONS AND OBSERVED PROFESSIONAL BEHAVIORS OF DPT GRADUATES

Judith L. Stoecker, PT, PhD
Wang Lee, PT, PhD
Department of Physical Therapy
Rosalind Franklin University

North Chicago, IL

PURPOSE/HYPOTHESIS: Academic programs in the health professions have the responsibility to evaluate their educational programs to insure students are provided with an appropriate educational foundation for practice. The employer is a key evaluator of graduate preparation and optimal observer of professional behaviors. The purpose of this research is to document employer's observations of select professional behaviors and their perception of preparation for practice of a group of Doctor of Physical Therapy (DPT) graduates at 6 months post-graduation. Subjects: Employers of the 2001 and 2002 DPT graduates from a Midwestern university were surveyed. Four-four employers

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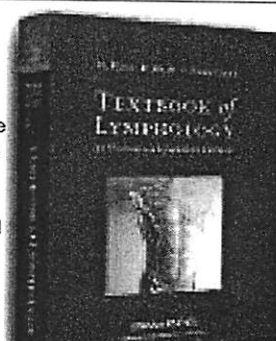
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Poster Presentations *contd.*

Continued from Page 18

of a total of 48 responded for a response rate of 91.7%. Fifty-two percent of the facilities were hospitals and forty-three percent were outpatient clinics. The typical respondent was the department or clinical director.

MATERIALS/METHODS: A survey was constructed and field tested. The survey included questions on observed professional behaviors and on assessment of educational preparation, curriculum and qualifications. All questions covered the period from hire to 6 months post graduation.

RESULTS: Specific professional behaviors such as acting as a patient advocate and interacting with other health professionals had the highest frequency of being observed,

with a mean of over 10 times in 6 months. Exhibiting the use of evidence based practice as observed with a mean of 2.8 occurrences. Research activities and journal writing was, on average, observed less than one time in the first 6 months. Employers perceived graduates to have met practice expectations. For example, 94% of employers perceived graduates to practice physical therapy in a professional manner, to effectively practice within the healthcare system, and to interact with each patient with empathy and understanding.

CONCLUSIONS: For DPT graduates practicing within the first 6 months post-graduation, patient care behaviors were

Continued on Page 20

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Poster Presentations *contd.*

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observed more frequently than research-based activities. The overall perception of preparation fro practice was high. Clinical Relevance: The data provide documentation of observed professional behaviors and practices of DPTs within 6 months of date of graduation. This is relevant to assist employers to have realistic expectations of new graduate behaviors and better meet employer needs. Also, this information may be a resource to programs developing curriculum and doing program evaluation.

AMBULATORY ABILITY IN PEDIATRIC PATIENTS AFTER A SPINAL CORD INJURY

*Melissa Mendoza, PT, MSPT
Jennifer Schottler, PT, MPT
Shriners Hospital for Children
Chicago, IL*

STUDY DESIGN:

Retrospective single-center design.

OBJECTIVES: To examine the level of ambulation achieved by pediatric patients with spinal cord injuries (SCI) who utilized lower extremity bracing for ambulation or standing through a retrospective chart review.

METHOD: 639 pediatric patients with SCI were treated at Shriners Hospitals for Children-Chicago in the last 20 years. Chart reviews were completed for patients who were followed for 4 or more years, achieved ASIA impairment level a, B, C or D and had no secondary medical diagnosis that would limit ambulation. Patient

demographics, type of brace, highest level of ambulation and the length of use were recorded.

RESULTS: 169 subjects met the study criteria. The average age of injury was 9, 53% were male and the average length of follow-up was 8 years. 113 (67%) patients utilized bracing for ambulation, 11 (7%) utilized bracing for standing regularly, and 45 (27% did not use ambulatory or standing devices. Of the 113 patients who ambulated, 17 achieved community level ambulation during the course of their treatment. The mean ASIA motor score for patient score for patients who utilized standing devices was 25, therapeutic ambulators was 50, household ambulators was 57 and community level ambulators was 72. All 26 (15%) ASIA D patients achieved ambulation, with 10 (39%), community and 9 (35%) household. Of the 7 remaining community level ambulatory patients, there were no patients with cervical or high thoracic injuries, 6% (3/54) with low thoracic, 11% (1/9) with upper lumbar and 50% (3/6) with lower lumbar lesions.

CONCLUSIONS:

Community level ambulation was achieved by 27 or 169 patients. A patient's level of injury, ASIA impairment score and motor score are three variables that should be examined prior to developing achievable ambulatory goals for pediatric patient with SCI.

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Poster Presentations *contd.*

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ORTHOPEDIC COMPLICATIONS OF CHILDHOOD OBESITY

*Mary Wills, PT, DHS, OCS
Shelby Memorial Hospital*

PURPOSE: The purpose of this presentation is to describe the orthopedic problems known to be associated with being overweight or obese during childhood to assist the clinician in the evaluation and management of these patients.

SUMMARY OF KEY

POINTS: Children who are overweight or obese are becoming an increasing concern in our society; the number of children and teens described as overweight or obese tripled from 1980 to 2000. Many problems have been associated with obesity

and are well described in the literature, including cardiovascular problems, diabetes mellitus, liver complications, cholelithiasis, sleep apnea, and specific types of cancer. Orthopedic complications are also related to being overweight or obese during childhood. Specifically, the incidence of spinal complications, slipped capital femoral epiphysis, Blount disease and acute fractures has been related to being overweight or obese.

CONCLUSIONS:

Clinicians should be aware of the orthopedic problems related to obesity to better educate individuals as well as to better treat children with this condition.

SURVEY TO ASSESS THE NEEDS FOR UNIVERSITY RESOURCES TO IMPROVE

THE QUALITY OF LIFE FOR RESIDENTS IN A RURAL RETIREMENT COMMUNITY

*Wanda Baran, Mona Bose, Gary Bellert, Amanda Manzoello,
Graduate Students in the
Physical Therapy Program at
Northern Illinois University,
DeKalb, IL. Nancy A. Nuzzo,
PT, PhD, faculty advisor.*

Universities located in rural communities have resources available that may benefit the residents of local retirement communities. However, in many cases, these resources are underutilized because the resources have not been matched to the needs of the residents. A literature review has revealed that there have not been any surveys completed to assess the needs of rural retirement communities the University resources can fulfill. The purpose of this study will be to establish the needs of the residents in a rural retirement facility and to propose university programs to meet those needs. In this study, the needs of approximately 100 residents will be assessed using a survey which will consist of a questionnaire including the topics of health education, recreation and social activities.

The analysis of the data collected will identify the unmet needs of the residents in the previously mentioned areas. It is anticipated that future research will develop plans to match resident needs with university resources to improve quality of life.



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Qualifications include: an earned PhD/EdD; Board Certification in a Clinical Specialty desired; demonstrated excellence in teaching; and Illinois licensure or eligibility for licensure. Persons in the dissertation stage of the PhD will be considered, as will persons with the post-professional DPT. Rank and salary are commensurate with credentials and experience. Review will begin immediately and the search will remain open until the positions are filled.

Send letter of application and CV to: James Dayhuff, PT, MA, MS, Chair, Search Committee, Department of Physical Therapy, Rosalind Franklin University of Medicine and Science, 3333 Green Bay Road, North Chicago, IL 60064 (James.Dayhuff@rosalindfranklin.edu; 847-578-3307). EOE/AA: minorities and women are encouraged to apply.



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Dateline

Date	Course Title	Location	Contact	CE Credit	Specialty Area
OCTOBER 2005					
Oct 1-2	Part E: MDT of Human Extremities Sponsor: McKenzie Institute USA	St. Louis, MO	Stacey Lyon 315-471-7612	13.5	Orthopedics
Oct 1-2	Getting Results Faster: Using NDT to Increase Challenge of the LE's and to Improve Gait (Part II) Sponsor: Recovering Function	Atlanta, GA	Recovering Function (408) 268-3691 www.recoveringfunction.com	15	Neurology
Oct 1-2	Aquatic Therapy in Physical Medicine and Athletic Rehabilitation Sponsor: Stricker and Associates	Oak Lawn, IL	James Stricker 630-778-6407	15.5	Education
Oct 1-2	Spinal Segmental Stabilization for Low Back Pain - An Evidence-Based Approach Sponsor: Midwest Spine Therapists/ NOI-USA	Chicago, IL	www.midwestspine.com 816 331-1877	14.5	Orthopedics
Oct 4-8	Functional Capacity Evaluation Certification Program Sponsor: Roy Matheson and Associate Inc	London, England	Roy Matheson 800 443-7690	32	Education
Oct 6-9	CTI - Cervical Thoracic Integration Sponsor: Integrative Manual Therapy Solutions	Palm Beach, FL	Vicky Meigel 631 723-0023	29.5	Orthopedics
Oct 6-9	Ergonomic Evaluation Certification Program Sponsor: Roy Matheson and Associate Inc	London, England	Roy Matheson 800 443-7690	30	Other
Oct 7-8	Practice & Management of Occupational Ergonomics Sponsor: Back School of Atlanta	Chicago, IL	www.backschoolofatlanta.com 404-355-7756	16	Education
Oct 8-9	Work Hardening and Work Conditioning Sponsor: Roy Matheson and Associate Inc	London, England	Roy Matheson 800 443-7690	9.5	Other
Oct 13-15	Chain Reaction Transformation Sponsor: Wynn Marketing	Chicago, IL	Cindy Coburn 517 264-1166	22.5	Education
Oct 14-16	Spanish for Physical and Occupational Therapists Sponsor: Del Norte Seminars	Chicago, IL	Monika Mann 510 898-1778 www.delnorteseminars.com	13	Orthopedics
Oct 14-17	Part D: Advanced Technique Workshop Sponsor: McKenzie Institute USA	San Diego, CA	Stacey Lyon 315-471-7612	27	Orthopedics
Oct 15 -16	Practice & Management of Occupational Ergonomics Sponsor: Back School of Atlanta	Seattle, WA	www.backschoolofatlanta.com 404-355-7756	16	Education
Oct 15-16	Pilates Mat Level I Sponsor: Pilates Institute of America	Chicago, IL	piaworkshops.com 561-784-9613	15.5	Education
Oct 18	Professional Continuing Education Series Sponsor: Glantz Richman Rehabilitation Associates	Norridge, IL	Nancy Richman 847-945-1917	26.5	Geriatrics
Oct 19-23	Functional Capacity Evaluation Certification Program Sponsor: Roy Matheson and Associate Inc	Toronto, Ontario	Roy Matheson 800-443-7690	32	Education
Oct 20-23	LPI - Lumbo Pelvic Integration Sponsor: Integrative Manual Therapy Solutions	Denver, CO	Vicky Meigel 631-723-0023	29	Orthopedics
Oct 21-22	Motor Control and Gait in Stroke, TBI and the Elderly Sponsor: Education Resources, Inc.	Alexandria, VA	www.educationresourcesinc.com 800-487-6530	12.5	Geriatrics
Oct 21	Anterior Cruciate Ligament Injuries in the Female Athlete: An Update on Prevention, Reconstruction and Rehabilitation Sponsor: WCS	Oak Brook, IL	www.wcsrehab.com 773 575-8545	6	Sport

Dateline

Date	Course Title	Location	Contact	CE Credit	Specialty Area
OCTOBER - NOVEMBER 2005					
Oct 21-22	Dementia therapy: Achieving Positive Outcomes for the Dementia Patient Sponsor: Dementia Care Specialists, Inc.	Richmond, VA	Kris Palazzi 636 527-8448	13	Geriatrics
Oct 21-22	Life Care Planning Sponsor: Roy Matheson and Associate Inc	Toronto, Ontario	Roy Matheson 800 443-7690	14.5	Education
Oct 21-23	Part C: MDT Problem Solving Workshop Sponsor: McKenzie Institute USA	Springfield, IL	Stacey Lyon 315-471-7612	20.5	Orthopedics
Oct 22-23	Part E: MDT of Human Extremities Sponsor: McKenzie Institute USA	Nashville, TN	Stacey Lyon 315-471-7612	13.5	Orthopedics
Oct 27-30	Part A: MDT of the Lumbar Spine Sponsor: McKenzie Institute USA	Hartford, CT	Stacey Lyon 315-471-7612	27	Orthopedics
Oct 27-30	CTI - Cervical Thoracic Integration Sponsor: Integrative Manual Therapy Solutions	Holbrook, NY	Vicky Meigel 631 723-0023	29.5	Orthopedics
Oct 29-30	A Clinical Approach to Myofascial Release Sponsor: Great Lakes Seminars	OH	Ann Crandall 419-865-4690	15.5	Orthopedics
Oct 30-31	Pediatric Developmental Pilates Sponsor: Hampton CARES	Novi, Michigan	Antoinette Kent 631-725-8263	13	Pediatrics
Nov 3-6	Part D: Advanced Technique Workshop Sponsor: McKenzie Institute USA	Chicago, IL	Stacey Lyon 315-471-7612	27	Orthopedics
Nov 4-6 Nov 11-13	When The Feet Hit The Ground... Everything Changes Sponsor: American Physical Rehabilitation Network	Green Bay, WI Jacksonville FL	www.aprnl.com Raydene Segrist	22	Orthopedics
Nov 4-6	Functional Relationships of the Lower Half Sponsor: Richard Jackson Seminars	Chicago, IL	www.rj-seminars.com Anna Jackson	20	Orthopedics
Nov 5	Sports Medicine Update - CME Sponsor: Loyola University Medical Center	Maywood, IL	Neeru Jayanthi M.D. 708-216-1071	7	Sport
Nov 5	Administration of the Alberta Infant Motor Scale (AIMS) Sponsor: Rainbow Center Inc.	Aurora, IL	Marilyn Weisner 630-898-2200	7	Pediatrics
Nov 5-6	Pilates Mat Level I Sponsor: Pilates Institute of America	Chicago, IL	piaworkshops.com 561-784-9613	15.5	Education
Nov 5-6	Who Takes Care of the Physical Therapist? ...You Do? Sponsor: Associates in Physical Therapy	Woodstock, IL	Molly Oakford 815 334-8850	14	Orthopedics
Nov 10-13	Part A: MDT of the Lumbar Spine Sponsor: McKenzie Institute USA	Chicago, IL	Stacey Lyon 315-471-7612	27	Orthopedics
Nov 10-13	CTI - Cervical Thoracic Integration Sponsor: Integrative Manual Therapy Solutions	Lake Forest, IL	Vicky Meigel 631-723-0023	29.5	Orthopedics
Nov 11-12	Motor Control and Gait in Stroke, TBI and the Elderly Sponsor: Education Resources, Inc.	White Plains, NY	www.educationresourcesinc.com 800-487-6530	12.5	Geriatrics
Nov 11-13	Spanish for Physical and Occupational Therapists Sponsor: Del Norte Seminars	Chicago, IL	Monika Mann 510 898-1778 www.delnorteseminars.com	13	Orthopedics
Nov 12-13	Bells & Whistles Sponsor: Adams Brothers Communication Inc	Rockford, IL	Gregory Adams 877-428-2527	13	Acute Care

Dateline

Date	Course Title	Location	Contact	CE Credit	Specialty Area
NOVEMBER - DECEMBER 2005					
Nov 12-13	Pilates Mat Certification for Healthcare Professionals Sponsor: The Professional Health and Fitness Institute	Chicago, IL	Elizabeth McGlynn/ Megan Stewart 301-263-9115	18	Other
Nov 12-13	An Introduction to NDT Treatment Sponsor: IPTA Central District	Decatur, IL	Heidi Tippner 217-384-6306	14	Neurology
Nov 15	Professional Continuing Education Series Sponsor: Glantz Richman Rehabilitation Associates	Norridge, IL	Nancy Richman 847-945-1917	26.5	Geriatrics
Nov 18-20	Part B: MDT of the Cervical/Thoracic Spine Sponsor: McKenzie Institute USA	Indianapolis, IN	Stacey Lyon 315-471-7612	22.5	Orthopedics
Nov 18-20	Part C: MDT Problem Solving Workshop Sponsor: McKenzie Institute USA	Somerville, NJ	Stacey Lyon 315-471-7612	20.5	Orthopedics
Nov 19-20	Movement System Impairment Syndrome: Level I Sponsor: Washington University School of Medicine	Glenview, IL	Washington University School of Medicine 847 570-2083	14	Orthopedics
Nov 30- Dec 3	Ergonomic Evaluation Certification Program Sponsor: Roy Matheson and Associate Inc	San Antonio, TX	Roy Matheson 800-443-7690	30	Education
Nov 30- Dec 4	Functional Capacity Evaluation Certification Program Sponsor: Roy Matheson and Associate Inc	San Antonio, TX	Roy Matheson 800-443-7690	32	Other
Dec 1	Professional Ergonomics Sponsor: Roy Matheson and Associate Inc	San Antonio, TX	Roy Matheson 800-443-7690	7.5	Education
Dec 1-4	LPI - Lumbo Pelvic Integration Sponsor: Integrative Manual Therapy Solutions	Atlanta, GA	Vicky Meigel 63- 723-0023	29	Orthopedics
Dec 2	Innovations in Contracture Management Sponsor: J & D Restorative Products & Restorative Solutions	Naperville, IL	John Kenney 949-716-8767	8	Orthopedics
Dec 2	Practicum Ergonomics Sponsor: Roy Matheson and Associate Inc	San Antonio, TX	Roy Matheson 800-443-7690	7.5	Education
Dec 2-4	Part B: MDT of the Cervical/Thoracic Spine Sponsor: McKenzie Institute USA	Cleveland, OH	Stacey Lyon 315-471-7612	22.5	Orthopedics
Dec 2-4	Part C: MDT Problem Solving Workshop Sponsor: McKenzie Institute USA	St. Louis, MO	Stacey Lyon 315-471-7612	20.5	Orthopedics
Dec 2-4	Functional Relationships of the Lower Half Sponsor: Richard Jackson Seminars	San Francisco, CA	www.rj-seminars.com Anna Jackson 888 889-6363	20	Orthopedics
Dec 3-4	Work Hardening and Work Conditioning Sponsor: Roy Matheson and Associate Inc	San Antonio, TX	Roy Matheson 800-443-7690	9.5	Education
Dec 8-11	Part D: Advanced Technique Workshop Sponsor: McKenzie Institute USA	Austin, TX	Stacey Lyon 315-471-7612	27	Orthopedics
Dec 8-11	CTI - Cervical Thoracic Integration Sponsor: Integrative Manual Therapy Solutions	La Jolla, CA	Vicky Meigel 631 723-0023	29.5	Orthopedics
Dec 9	Low Carb Frenzy Sponsor: Institute for Natural Resources	Clayton, MO	Richard Colman, PhD 925-609-2820	6	Other
Dec 9	Prevention and Early Intervention of Pressure Ulcers Sponsor: Smith & Nephew Wound Management	Chicago, IL	Judith Madura 520-568-2648	1	Other

Dateline

Date	Course Title	Location	Contact	CE Credit	Specialty Area
DECEMBER 2005					
Dec 9	TIME Principles of Wound Bed Preparation Sponsor: Smith & Nephew Wound Management	Chicago, IL	Judith Madura 520-568-2648	1	Other
Dec 10	Low Carb Frenzy Sponsor: Institute for Natural Resources	Overland Park, KS	Richard Colman 925-609-2820	6	Other

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- Rationale for the program
- Specific target audience
- Instructional level*
- Stated learning outcomes
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- Program description or outline
- Content that is described based on best available evidence in practice
- Specified limit to the maximum number of participants for a demonstration course
- Faculty qualifications
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- Attendee endorsements of the program

Instructional Level*:

- Basic (1) - This level assumes that participants have little information within the areas to be covered so that the focus of the activity is a general orientation and increased awareness.
- Intermediate (2) - This level assumes that the participants have a general familiarity with the topic, so it focuses on increased understanding and application.
- Advanced (3) - This level assumes thorough familiarity with the topic and focuses on advanced techniques, recent advances, and future directions.
- Various (0) - This category indicates that a single level cannot be determined. It is intended for programs in which the instructional level may vary.

Using a critical eye when it comes to evaluating CE courses can help you make the most of these opportunities. For information on upcoming quality continuing education programs sponsored by the IPTA, visit the IPTA website at www.ipta.org.

(Adapted with permission from the American Physical Therapy Association)

JOB OPPORTUNITY

PHYSICAL THERAPISTS WHO DESIRE TO LEAD
If you're a therapist who's ready to run the show,
then we're ready to show you how!

Clinic Director

Our Illinois Region is searching for qualified physical therapists to lead a clinic in the Chicago and suburbs markets. This is a Clinic Director position with vast growth potential. Qualified candidates must be eligible for immediate IL licensure with at least 5 years of experience. Candidates should possess the skills and ability to open new clinics, grow existing clinics, and lead them into being the #1 provider of outpatient rehabilitation services in Illinois. This position will oversee professional and supportive staff. The clinics offer services in orthopedics, sports medicine, work conditioning and a strong high school outreach program. Must have the ability to work independently on a variety of outpatient cases and be able to communicate well with an established patient and physician base.

Interested candidates should send a current resume to:

Staci Burkard, Senior Group Director
Attn: Clinic Director Position
7814 W. North Avenue, Elmwood Park, IL 60707
Phone: 708-456-2322 • Fax: 708-456-2395
Email: staci.burkard@physio.strykercorp.com

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Save The Date

NOVEMBER 2

Eastern District Meeting • Location: TBA
East Central District Meeting

Location: Elmhurst Memorial Center for Health • Time: 3:30-5:00pm

NOVEMBER 8

Northern District Meeting

Location: RIC Northshore, Northbrook, IL • Time: 7:00pm

NOVEMBER 8

Central District CE Course and Meeting

Location: Decatur Memorial Hospital, Decatur, IL
NDT Course, presented by Rob Cook, PT

Illinois Physical Therapy Association

1010 Jorie Boulevard, Suite 134
Oak Brook, IL 60523

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