Imagine tomorrow morning...

You walk into your private practice physiotherapy clinic, ready for the day. You sit down at your desk with your computer in front of you. A chime rings, notifying you that your first patient is here. The chart automatically pops up on your screen with the patient’s previous history with the clinic clearly (and legibly!) displayed. The referral and recent x-ray have been pre-loaded into the chart by an automatic connection with a provincial web portal. You take a history, perform an exam and enter the information. The computer recognizes the information you have entered and offers you the latest toolkit from PABC and proposes treatments along with their level of evidence. An outcome measure is automatically generated and the patient fills this out while you prepare for treatment. Education materials relevant to the injury are automatically generated and emailed to the patient.

After the treatment, you finish your documentation on the computer. You have some suggestions for diagnostic imaging and electronically send a quick note to the physician. A report is automatically pre-populated with patient particulars and you simply fine-tune the findings and recommendations and send it electronically to the appropriate insurer. Billing is automatically performed when you close the file. On the other side of the country, researchers are using your outcome data from the anonymous patient to look at population health and build best practice physiotherapy data. Sounds like a fantasy? Maybe for now, but this is the dream and the promise of electronic medical records (EMRs). The lure of the potential cost efficiencies and quality improvements offered by EMRs has been driving governmental strategy, health ministry strategy, and private investment across the globe, particularly in the last few years. Massive dollar resources have been poured into the dream – sometimes with success, often with failure.

As private practice physiotherapists, while we have largely been able to avoid the risks involved in converting our practices from paper to EMR, we may be missing the benefits. PABC has fielded a number of questions in regard to going paperless of late — questions that indicate our physiotherapy community is beginning to sense the time for transformation to EMR may be at hand. Some brave startups and larger clinics with substantial resources have already taken the plunge, but there are few who have converted an established clinic from paper to electronic records. The process is complex and must be managed on a number of different levels: administrative, technological, cultural, legislative, logistical and...
Hi folks,

I hope this edition of Directions finds everybody well. Please indulge me with some of your precious time for a brief update on events since my winter article.

Our most recent Board of Directors meeting was held in February 2014. Each year at this time we join the College of Physical Therapists Board of Directors for our annual joint meeting. This year the meeting displayed a new sense of cooperation and respect between our boards, indicating a stronger mutually beneficial relationship, while respecting the mandate of each organization. During this meeting we worked on a “values exercise” to identify some of the shared values that help define us as a profession; we collectively identified integrity, responsibility, respect, engagement, and honesty. These values have been brought to the Consortium table and all three parties, PABC, CPTBC, and UBC have agreed to use these values as part of a new “core value statement for the profession”. There is more to come on this item, so stay tuned!

Building on the value theme, the PABC Board established a task force to apply our work done on physiotherapy value statements towards progressive partners we identified. We believe that these value statements will help define why our strategic partners hold physiotherapy in such high regard and how we can continue to place ourselves as the leaders in rehabilitation and exercise therapy in British Columbia.

Continuing in our efforts to best serve our rural and remote members, we have decided to form a Rural Liaison position on the Board, and create a rural standing committee. This was in response to the Board’s decision to amalgamate the two northern regions. We feel that these actions will allow PABC to better serve the membership as a whole and more specifically our rural members. I look forward to this work being done as we believe it will help ensure our rural members feel connected to each other and to their urban brothers and sisters.

Lastly, you are all well aware now of the new WorkSafeBC service model negotiated on behalf of all members by our negotiating team: Marc Rizzardo (chair), Perry Strauss, Bill MacDonald, and Rebecca Tunnacliffe along with our WorkSafe liaison Jamie MacGregor. I would like to thank these members for their contribution. They have given much time and done a lot of work; they must not go unnoticed so please join the Board in thanking them at any opportunity. I would also like to thank you, our members, for your patience through the WorkSafeBC RFQ process and for your support of our efforts to help you through it. The new model marks a major shift in the delivery of physiotherapy to injured workers. There will be some ups and downs in the implementation but we believe it will prove to be a very positive change for our profession and our partnership with WorkSafeBC.

In closing, I would like to thank all of the PABC Directors for their recent work; we have seen much commitment from them in their personal journeys of leadership and in their selfless work for PABC and for you, our members. Thank you.

My email box is always open president@bcphysio.org so please drop me a line.

Jason Coolen co-owns Oakridge Physio, Vancouver Physio, and North Vancouver Physiotherapy clinics. He is the father of two young children, and is completing his osteopathy credentials. Jason has been on PABC’s Board of Directors for three years and has presided over PABC in his voluntary leadership capacity since April 2013.

Changes to PABC’s Board Directors

Jen Bay and Patrick Jadan have been newly elected to PABC’s Board of Directors. Jen is the Fraser Valley Director, and Patrick is the Vancouver Island Director; find out more about them at http://bcphysio.org/content/pabc-board-directors. Leaving the Board at the end of their terms are Remmert Hinlopen (Fraser Valley 2008-2014) who also served as the Finance Chair; Tanja Yardley (Vancouver Island 2009-2014); Val Niefer (North West 2010-2014).

Another significant change to the Board is the merging of the NW and the Central Interior/NE regions into one Northern Region. The Board and regional members believe that increasing focus on resources for rural members will increase the benefit of members living in remote regions throughout the province. A Director will be appointed by the Board to be the Rural Liaison who will be a member of the new Rural Standing Committee made of members representing our rural regions.

Additionally, the large Vancouver region will be divided into two smaller regions (yet to be defined). Watch for more information on these plans in the next newsletter.
Of the many events I’ve attended this quarter, there are two stand-outs because of the shop-talk that was so stimulating. One of the things I love about this job is hearing you talk shop; when you discuss physiotherapy, your passion lights you up, and your language emanates your expertise.

At the Centre for Hip Health’s Celebration of Research, the shop-talk was about researcher/community partnerships. I joined Alison Hoens and Alex Scott as panelists on effective partnerships (see RBT’s Leadership Tip for managing nerves). Together with two other pairs of community-researcher panelists, we cited why partnerships made our endeavours greater than the sum of their parts. Alison and Alex explained that the PABC/UBC tendinopathy project has become so wildly popular (16,000 views on Physiopedia, 800 downloads on PABC member site, a symposium, publications) because it partnered Alex’s research and Alison’s knowledge brokering with dozens of members on a few task forces. Their presentation about the process and outcome of their work created a palpable buzz in the room, and elicited kudos from the audience. That was the second great physio moment I witnessed this quarter.

At the gala event for the Northern Medical Society in Prince George last month, I got to hear Commander Chris Hadfield talk shop. While life doesn’t get more thrilling than steering a rocket into space or circumferencing the globe in a research spaceship, Commander Hadfield’s passion and utter commitment to his career parallels the passion and commitment you exude for your careers. He cited three components of leadership that have helped him succeed, components I see in PABC members too: competence, confidence, and taking care of people around you. His stirring presentation reached its peak with a shout-out to physiotherapy: thanks to the power of the northern physio community, Chris Hadfield was persuaded to mention the vital role his physiotherapy rehab played in his adjustment from space to earth. At that moment, the PABC members in the room erupted with cheers while the most famous astronaut and Canadian of our times paused and applauded. That was the second great physio moment I witnessed this quarter.

Just as I am inspired by hearing my members talk shop, so are your patients inspired by hearing you talk with competence, confidence and caring about your expertise that helps them keep moving for life.
financial. There is considerable risk and little physiotherapy-specific experience or research in our geographic and professional context.

In an increasingly technological world, new drivers of change may soon require us to play in the same electronic sandbox whether we want to or not. Nationally, the federally funded Canadian Health Infoway has a renewed strategy towards progressive adoption of a cradle-to-grave Electronic Health Record for all citizens. Provicially, BC has a reinvigorated eHealth strategy and is investing millions of dollars to allow health care providers access to portals with diagnostic imaging, lab results, consults, etc. The BC Ministry of Health substantially subsidized physicians in the last two years to convert their practices to EMR. The Physician Information Technology Office (PITO) reports that 93% of group practices of six or more physicians have now converted to electronic records. Additionally, recent legislative changes to chart retention requirements have cost implications. Locally, patients increasingly demand quickly available and searchable records and wonder why the health system is so slow to enter the technological world. Now may be the time, for the sake of our patients and our professional relevance, for us to start down the same road as the rest of the medical community.

The barriers to EMR implementation in private practice physiotherapy in BC will be the focus of my Masters in Health Administration final research project. This research will be done in conjunction with the UBC Faculty of Medicine and the Sauder School of Business in the next six months. I welcome your thoughts and questions as this project progresses, and we will be examining further issues related to EMR uptake by private practice PTs in the next two issues of Directions. Please feel free to email me at mcphysiocorp@gmail.com if you have any questions or comments on your experience with EMR. Alternatively, you can post to the Virtual Forum on the PABC website and we can include the community in the conversation.

The Benefits of Using Ultrasound to Aid Physiotherapy Assessments

by Gordon Bohlmann, BScPT, OMT, CGIMS, RMSK

Although physiotherapists in other countries have used musculoskeletal ultrasound extensively, it is only now reaching a critical mass of interest in BC.

Physiotherapists aspiring to use ultrasound to enhance their assessments need to understand where it fits within our model and scope, and how it is to be incorporated as an adjunct to the normal assessments we routinely perform. Think of it like a stethoscope, which gets used by many different specialties, depending on what they have been trained to do.

Knowing the boundaries will ensure that this tool becomes a valuable asset. Sufficient training, adequate knowledge, and experience are necessary before a therapist can become competent and confident in using this kind of non-diagnostic ultrasound in practice. Making the decision to incorporate its use into your clinical practice involves a steep learning curve and a thorough training, and is not for everyone. I believe the use of ultrasound to be a great addition to clinical practice, especially in orthopedic and sports injury populations, so I have undertaken specialized training, and have become accredited with the American Registry of Diagnostic Medical Sonographers.

Some benefits I have found in using ultrasound in my physiotherapy assessments are:

- It provides immediate information about dynamic movement i.e. the effect of movement can be seen on various tissues, fluids and fascial planes — perfect for physiotherapists who specialize in human movement.
- It aids us in our rehabilitation and exercise prescription decisions — when to load, when to rest, and what the local tissue response is. For example, fatty infiltration seen after a supraspinatus tendon injury could change the physiotherapist’s decision about how much to load the tendon. A tendon with heterogeneous appearance (the fibers don’t all look the same) would also be loaded differently to a tendon with homogenous fibers. This type of information cannot be gleaned from an “empty can”, or other special orthopedic test.
- It provides better information for a more accurate prognosis. If your default answer to the question “how long will it take” is “six to eight weeks” for a soft tissue injury, you are basing your answer on the connective tissue repair phases. But in doing so, you assume that the tissue is repairable. This is not always true, as there are times when a tendon, for example, is injured by a roughened cortical margin. Physiotherapy intervention will not change this, and this patient would do better by being referred.
- It assists physiotherapists in making discharge decisions. Which indicators are currently being used: pain levels, expense, functional ability, quality of life,
time? In addition to these, physiotherapists can use tissue imaging to make tissue-specific recommendations, based on changes in morphology over time.

- It can be placed right where the pain is, making it much easier to visualize the specific tissue that is affected.
- It is a wonderful tool for patient education and motivation. Patients can actually see the target tissue, understand the implications, and see the effects of physiotherapy intervention: Seeing is believing!

A small group at PABC has begun discussing how to support the use of ultrasound assessment in practice, and what education and clinical guidelines are needed. If you are interested, please join us on Friday, May 16th at 11am in Vancouver (RSVP rbt@bcphysio.org). It is an exciting new field in physiotherapy that will enhance our practice and benefit our patients.

Gordon Bohlmann is a physiotherapist, a Registered Diagnostic Medical Sonographer (RMSK), and a member of the BC Ultrasonographer’s Society. He practices in Vancouver where he is the Director of Marpole and Arbutus Physiotherapy Clinics. For more information on ultrasound education, contact him at gordonbohmann@me.com.

C-Spine Rules – What the Laminated Insert is all About

by Melina Kurtakis, MPT, BHK, CAFCI

What a journey it has been with the C-Spine Advisory Group (CRAG). I joined the group last year, and was so impressed with what they have accomplished in their three-year project. This dynamic group of PABC members has worked very hard to put together evidence-based information on the Canadian C-Spine Rule to disseminate to PABC members and physicians.

On the website PABC members will find an evidence-based summary of the current literature on the C-Spine Rule, the webinar from March 11th, a physician letter template, the C-Spine Rule video and a printable copy of the C-Spine Rule. All of the resources are meant to facilitate the incorporation of the rule into clinical practice. In addition to the resources on the website everyone will be receiving an 8.5”x11” laminated copy of the C-Spine Rule in this newsletter mailing, so keep your eyes peeled for your gift in the envelope!

It was great to see so many of you at our information booth at the Physio Forum where members of the CRAG team were on hand to answer your questions. We are very proud of the accomplishments of the group so far and are very excited to see everyone discover how helpful the new c-spine resources are!

The dissemination of this information would not be possible without the support of PABC, UBC, and countless individuals who, while leading busy lives, have donated their time and talent to the project. A big thank you to all of our contributors!

Our enthusiastic group leader, Marj Belot, has held the torch for this project and keeps us moving forward. Our group members range from students and new grads to seasoned practitioners specializing in cervical spine disorders. The team has worked together to create informative resources for PABC members that can be found in the member section of the PABC website. All of the tools provided are to help optimize care of acute traumatic neck pain patients by primary care providers in regards to appropriateness for referral for x-ray imaging.

The C-Spine Advisory Group L-R: Alison Hoens, (PABC’s RBT is not on the task force), Bill Lyons, Marj Belot (chair), Peter Francis, Antonio Zenone, Carol Kennedy, (PABC’s Fiona Chiu is not on the task force), and Melina Kurtakis. (missing: Guido Wisotzki, John Howick, and Linda Li).

Most recently, members of the CRAG team presented a live webinar that I hope many of you were able to catch. If you missed it, you can watch the recording on the PABC member site under Search the Library. Following the webinar, the whole group got together to meet for the very first time in person for a celebratory evening generously put on by our very own RBT. Many of our meetings are by conference call so most of the members had never met except by voice. It was a great evening to celebrate the accomplishments of the group thus far; and what better to celebrate with than a bottle of complimentary Moet champagne. Well deserved, I think!
**Public Practice Directions**

**Why I Choose Rural Rehabilitation**

*by Angela Pace, BSc (Hons) Physiotherapy, CWCE*

Currently there is a shortage of rural practice physiotherapists in BC. Why, you ask? It seems to be too well kept a secret that rural practice is very rewarding and provides satisfying challenges to our professional skills. The majority of my career has been in rural areas, both in private and public practice. As a member of PABC’s Public Practice Advisory Committee, I thought that I would share my rural practice experience in order to entice those who are thinking of a change.

I served in the British military for 15 years until I suffered a severe knee injury that led to my medical discharge from the army in 2002. After serving for such a long time I was at a loss as to second career options. I had undergone extensive physiotherapy both in hospital and at a rehabilitation centre. I was drawn to the idea of becoming a physiotherapist and helping people achieve their goals, just like the people that had helped me.

I earned my physiotherapy degree in the UK, and since 2006 I have worked in many practice settings from professional sport, to public and private practice.

I moved to Canada in 2008, and to BC from NWT last year to take the job of Rehabilitation Manager at Kitimat General Hospital in Northern BC. My job is very diverse; for example today I have dealt with post-operative and medical patients on acute care, rehab patients in the out-patient department, have been on a combined OT/PT home visit and visited the seniors at Mountain View Lodge. No two days are ever the same.

I love the variety of patients that I have on my daily caseload; I am able to use all of my physiotherapy skills. Rural practice allows me to become a generalist; I deal with a wide range of conditions daily, which in turn has increased my knowledge base.

I am often asked what it is like not to be in a big city hospital. My reply is always the same: “The northern way of caring is special, more personal.” I am sure this is because the community is so small and everyone knows each other. The most rewarding part of my job is seeing the critically ill patient in acute care return home, get back into the community.

We regularly take students on practicum from UBC’S rural cohort. Students have all really enjoyed the variety and diversity of their caseloads. They are often surprised how much a rural practicum can offer them in both professional and personal development.

If you are looking for a challenge, varied caseloads, and being able to use all of your physiotherapy skills, rural practice is worth considering. And you’ll love the outdoor lifestyle and sense of community; it is awesome — where else can you catch salmon on your lunch break?!

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**How I Became a Physio Face in Cyberspace**

*by Anke Smit, Physiotherapist*

Some of you might be familiar with my face on the government website www.workbc.ca/job-seekers promoting physiotherapy as a profession. PABC asked me how it all came to this.

In June 2012, I got a phone call from the producer of a company asking if I would be interested in participating in a project. The company was making video clips about the top 20 most needed professions for the next two decades. These clips are to entice students to go to university and study in those fields. The production team was touring around BC and would be travelling through Penticton in August, so if I was willing to set aside a day...

Since I am always interested in helping out the younger generations (and it sounded like good promotion for my clinics) I agreed to become a “movie star”. It was a bit nerve-racking, not only being in front of the camera, but also making sure my information was accurate, especially regarding patient care, course length, income etc.

All in all, it turned into a fun day at the office — a novel way to break the routine of treating patients, making phone calls and doing paper work. I hope I am a good representative for our profession (or, as I call my job, paid entertainment); it has given me so much joy in the ability to help people.

Anke Smit owns Pro-Physio Clinic located in three Okanagan centres: Penticton, Summerland, and Keremeos.
Rural Peer Mentor Experience
by Gillian Grant, MPT, BKin

Rural British Columbia is a pretty special place to call home, and working in a rural community that is far removed from urban centers also has its challenges. Access to professional development courses and large numbers of experienced colleagues is not a reality for most physiotherapists working rurally. As a second year physiotherapist working in Prince Rupert, it was a natural choice to sign up for the PABC Public Remote Peer Mentor webinar meetings, organized and moderated by our fearless CEO Rebecca Tunnedcliffe.

The format is a one-hour meeting via videoconference with physiotherapists connecting from diverse small communities across BC. One person volunteers to lead each session by presenting a challenge that everyone can relate to, and each physio on the call takes a turn describing a time they’ve faced a similar challenge, and how they navigated that situation.

For example, the group has discussed the challenge of treating a wide range of conditions, and the difficulty we may have with feeling confident and competent when treating conditions that we might be seeing for the first time. All members of the group were able to share very practical ideas, from specific websites and resources, to general ideas and philosophies on how to approach the unknown.

It’s an opportunity that I would urge other physios working in rural public practice to take advantage of, as it has connected me with some fantastic people and great practice ideas and resources!

Gillian graduated from Queen’s with her MPT in 2012 after earning a Bachelor of Kinesiology in 2009. She lives in Prince Rupert and works at Prince Rupert Regional Hospital. She was drawn to rural practice because of the opportunity to see and work with a wide variety of conditions, learn about First Nations cultures, and explore and play on the endless rivers and mountains.

Thoughts from an Olympian

Alpine skier Brad Spence wrote to PABC from Sochi with this thought about his physiotherapist Stefania Rizzo: “I can vouch for how important physiotherapy is because without her miracle work, I probably wouldn’t be able to ski.”

Top 3 Strategic Plan Actions This Quarter

PABC’S elected Board of Directors, your peers from the 7 regions of the province, lead the Association according to priorities they’ve identified in the Strategic Plan. This past quarter the Board has focused on:

1. Engage Members: hosting two sessions for students featuring PABC members – 1. Insights into Public and Private Practice; 2. How to land your first physio job
2. Support Networking: launched Virtual Forum on Members site; created Buddy-Up function at the Physio Forum;
3. Engage Rural Members: created Rural Peer Mentor group; rural task force released a report; rural Liaison and standing committee to be appointed.

For the full strategic plan, see the members’ site http://bcphysio.org/resource/pabc-strategic-plan

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www.WTinjury.com
The AlterG Treadmill at Concept Physiotherapy by Kimberly Byrne, BScPT and Dawn Collins, BScPT

We took the leap and got the AlterG Treadmill in January. We decided to bring this equipment into our clinic because we have an active population in our amazing four-season climate that is always bringing some new condition into the clinic.

Initially, to determine the interest level in having a machine like this available, we surveyed doctors, specialists and members of the running clubs in the area. We wanted to know interest both in using the treadmill and in paying for the use of it.

Our clinic needed just a few small renovations to find an optimal space for the machine. Overall it’s not a lot bigger than a normal treadmill but with the blower, there was some concern about the noise level. We have an open concept clinic and when the blower is on it turns more into “white background noise” and doesn’t interfere too much with day-to-day operations. We decided to partition off the areas with panels for a little bit of noise reduction, instead of hiding the machine in a room; we did want people coming into the clinic to see it.

Since getting the machine, we have been busy getting the word out. We invited leaders of the running groups, doctors and foot specialists in to use it. We had the newspaper do a story about our clients using it and on the technology behind it. We have also incorporated the treadmill into our in-clinic talks about OA, and have been offering free trial passes to people that attend some of our other talks about knee pain at other facilities.

We have structured our pay schedule into two options for clients: they can get physio treatment and use the treadmill, or they can use the treadmill on its own. We did this so we can offer the use of the treadmill to our own clients but also to people who may just want it for general fitness or who may be attending physio at another clinic in a surrounding area.

So far the best part of getting the machine in our clinic has been the patients’ responses. We have had a wide variety of patients on the machine, from competitive youth soccer players with ankle sprains (pictured) to elderly patients who want to use it for general fitness. They have all had the same smile spread across their faces when they get on the machine and get moving again... pain free. One of our first patients to use the machine said that it was the best she had felt in two years since surgery.

Another had not run in seven months since a second ACL surgery, and with a huge grin was able to do so. We were able to start another patient eight weeks post op ACL repair, jogging at 30-40% percent of his body weight for 20—30 minutes with his surgeon’s approval.

We are happy to have had nothing but great feedback from all of our clients that have been on the treadmill thus far. We are really excited to be able to offer this kind of technology and to get patients moving again that may not have been able to do so otherwise.

Kimberly Byrne & Dawn Collins are Owners & Physiotherapists at Concept Physiotherapy in Vernon. ⚽

My Journey into the World of Fascial Manipulation®

by Cheryl Megalos, BScPT, RCAMT, CGIMS, Fascial Manipulation® Practitioner

Research into fascia has vastly expanded in the last four years since I have been studying with the Stecco family in northern Italy, and applying Fascial Manipulation® in my practice. Stecco’s model is aimed at treating the fascia to address the loss of fascial gliding, which causes pain and inhibits proprioception, ROM and strength. It is a manual therapy that allows the therapist to treat the historical cause of the dysfunction and make a more permanent change than by treating the joint or the muscle alone. www.fascialmanipulation.com/en/

The model is a valuable tool to assess movement systems that allows the therapist to effect painful tissue often at a distance from the site of pain. It uses an anamnesis protocol to find the most likely root of the problem, make a hypothesis, assess ROM, strength and pain. Then a palpatory verification is applied to ascertain the plane(s) of movement needed to treat. This process has been simplified into looking at assessing the body as movements of 14 segments, in 3 planes, with 6 myofascial units. The Steccos realize that these segments are linked by fascia that is continuous from one segment to another sequentially, and also at the antagonist of the restricted movement, in the same segment.

The treatment itself is aimed at a point of tissue that demonstrates the lack of ability to glide at a fascial level. The theory is that there is a densification of the extracellular matrix, specifically hyaluronic acid, within the deep fascial layers that restricts and therefore inhibits the mechanoreceptors and muscle spindles within. This affects the ability for the joint movement to occur in a balanced way.

For more information on the Stecco Fascial Manipulation® model, join us for the PABC workshop on May 10th. ⚽
Ten or fifteen years ago lymphedema was not a well-known term in the physiotherapy world. I first wrote an article for *Directions* about lymphedema in 2006. Since then I have steered my practice towards cancer-related lymphedema. While my practice consists mainly of breast cancer-related lymphedema, over the last few years I have been seeing more patients with lymphedema secondary to melanoma surgery and treatment.

I currently have five patients with lymphedema secondary to melanoma treatment: three have swelling in their lower extremity and two in their upper extremity (I currently have no patients with face, head or neck lymphedema). All five patients had a malignant mole removed 6-9 years previously either from their leg or upper arm/shoulder area and were fine until more recently when the cancer returned and spread to the regional lymph nodes, requiring either inguinal node dissection or axillary node dissection. All five patients noticed a painful or uncomfortable lump in their groin or axilla that turned out to be reoccurrences.

Rates of melanoma have been rising over the past 30 years and while the average age of diagnosis is 61 years, it is the most common cancer killer in young adult women and is 20 times more common in people of Caucasian origin than those of African-American origin. Living in areas with high sun exposure and a history of severe sunburn at a young age continue to be the main risk factors for developing melanoma.

Complete decongestive therapy continues to be considered the gold standard treatment for lymphedema and consists of meticulous skin care, manual lymphatic drainage, compression and remedial exercises.

During axillary node and inguinal node dissection between 8-30 lymph nodes are removed depending on the individual person and the location of the tumour. The protocol for treating lymphedema secondary to melanoma is the same as for breast cancer-related lymphedema, but I find treating melanoma patients can be very interesting. When removing inguinal lymph nodes an incision 20-30 cm long over the groin is often required. This means the scars can be much more intrusive and often more challenging to deal with, particularly when fitting for compression garments and when finding pathways to redirect lymphatic fluid while using manual lymphatic drainage techniques.

Since writing my last article for *Directions*, British Columbia now has a patient support organization, the BC Lymphedema Association bclymph.org, founded in 2006, which educates, advocates and supports people living with lymphedema to take an active role in their care.

Janet Sprague, BHScPT

**Lymphedema Association of North America as a Lymphedema Therapist - Complete Decongestive Therapy.** Janet practices at Keary Physiotherapy Clinic in New Westminster.  

**Kudos – WCB RFQ**

Thank you for PABC’s continued support and guidance through this RFQ process. I have no idea what physios would do who are not members of PABC, or whether they’re even aware that changes are occurring. JK

Thanks for all your patience and diligence in helping to negotiate ‘our’ way through a challenging transition. RW

Thank you very much for all the work you have done, and are continuing to do for all of us physios! AA

I cannot thank all of you enough, the committee and RBT, for the continuing information and emails. There has been some angst, stress in reaction to this thing. PABC emails have lowered the stress level around here immensely. PL

I wish that WSBC would roll out the new contract without this RFQ requirement...just have the PABC sign the new contract on behalf of all physios as it was with the previous ones... that would have simplified things and not stirred up anxiety around the RFQ process. Thanks for advocating on our behalf. JL

Thanks for being so involved in this new WorkSafe contract, and helping fix the many errors in the RFQ process. PB

Thanks for going to bat for us. We appreciate the ongoing communication from PABC. And I’m sure once this little headache is taken care of, we’ll look back as if it were nothing. KC

I just wanted to pass along my sincere gratitude for the efforts of PABC and the WorkSafeBC team preparing the tips and documentation for completion of the proposal especially the Privacy Policy! Even with all the assistance it still took hours but I can’t imagine what I would have done without it. EM
WorkSafe Contract Insights

by Jamie MacGregor, BScPT, CHT

As you all know, we’re knee-deep in the roll-out of the new WSBC Physiotherapy Services model, with the program about to launch June 1st. PABC & WSBC jointly held five town hall meetings throughout the province, as well as the initial WSBC-hosted presentation RFQ webinar. PABC has generated a lengthy FAQ document that continues to be added to, and we have an active Virtual Forum blog where members can ask their questions and have answers shared with peers. All PABC info is on the Members’ Only webpage. Throughout this process, Rebecca has worked tirelessly to assist members with questions and issues with WSBC’s RFQ process; because of PABC’s advocating on behalf of members, WSBC made a variety of changes and supports. Through these efforts, WSBC responded by streamlining, extending deadlines, and providing more support to PABC than they have in any previous RFQ process.

Despite this, there have clearly been bumps in the road. RFQ process aside, there have been many questions regarding the need for this monumental change in treatment model, fee schedule and administrative processes. While I feel the urge to continue to address these questions, they have been well-addressed multiple times not only here prior to the new model roll-out, but also in the various media mentioned above.

Recently I was bemoaning to Rebecca that I find myself, after these few years of working on the development of this treatment model, fee structure, and negotiation process, not able to focus discussion on the benefits of this new model for us as a profession and as individual therapists, but instead answering questions regarding the RFQ process. She suggested that I do so, right here. So without further adieu, here are five great things about this new model, in no particular order:

1. **Guaranteed funding for not just one session, but up to a week of treatment, whether the claim gets accepted or not.** For my entire time as the PABC-WSBC liaison, I have fielded complaints from PT’s about barriers to accessing our care that injured workers face while awaiting funding. This new model eliminates that barrier to immediate access, and gives us as therapists the ability to initiate treatment of injured workers immediately, and without referral from a GP. This is a huge step forward in the treatment of injured workers;

2. **Direct access.** We no longer need a GP referral to treat injured workers. We now have negotiated for injured workers the direct access to physiotherapy that everyone else in BC enjoys;

3. **Meaningful inclusion in the Return to Work Process.** As a profession we have watched workers be moved from our care to the care of other providers and programs. We successfully argued that we are best able to speak to a worker’s ability to return to work in some capacity, and that the old contract didn’t seek our opinion in the return to work discussion. With this new model, we have meaningful involvement in this critical step of treating injured workers, and we secured funding for this involvement for the first time;

4. **Increased funding.** There has been much discussion regarding the new block funding model, and some debate among members as to whether we will be adequately funded for the increased and different level of service required. Without delving too deeply into that here, if you’ve read or listened to any of my previous ramblings you will know that this model will not only pay us fairly for the service we are asked to provide, but results in a significant increase in fees for the average treatment. What’s more, WSBC has budgeted for a significant increase to their costs with this new model — they know as well as our team knows, this new model increases money in your pockets’

5. **Positioning our profession to shine.** In addition to the benefits listed above, there are many positive changes in this new contract for us. Taken as a whole, I strongly believe that this contract creates an environment that will allow therapists to really excel at treating injured workers. From gaining early and less restricted access to treatment, to adequate compensation and efficient communication with all stakeholders, to reports that include meaningful information at the important timeframes throughout a claim. Taken as a whole, these aspects and others create a working model that will allow PT’s to really show their value and excellence in treating injured workers. The improved outcomes that will result can only help to open doors for further service delivery enhancements, fee improvements, and a strengthened relationship with a key funder for our profession.

As always, I look forward to your feedback. jm_macgregor@hotmail.com

Little Physios

**Sean and April Campbell** brought a daughter into the world on February 28th. Vanessa Olivia weighed 7 lbs 12 oz.

**Jen Fyfe** birthed daughter Hannah Irene at Campbell River Hospital on January 24th, weighing 7 lbs 6 oz.

**Tanya Bossio** was surprised when her first child, Ella, arrived over 5 weeks early on November 5th. She weighed 5 lbs 2 oz, but Mom and daughter are healthy and happy.

**Derrick Young** celebrated the birth of his 4th child on April 3rd, his son Micah Daniel weighed a trim 4 lbs.
As part of ICBC’s commitment to improving value and service for customers, we are introducing a pilot initiative designed to improve quality and consistency of customer recovery outcomes, with a focus of getting customers back to their lives as quickly as possible. The Disability Management Program pilot uses a multi-disciplinary, structured, team-based treatment approach to help injured customers get back to an optimal level of function more effectively and efficiently. The overall program goal is to identify and address the barriers that impede recovery/return to work and to mitigate the development of chronic conditions.

The customer-focused program promotes a proactive and positive injury recovery experience by establishing a common-goal-oriented approach involving the customer, ICBC, health service providers and the employer. This will be achieved by educating the injured customer about what is expected during the recovery process and treating return to work as a form of therapy as well as a desired outcome. Customer participation in the program will be based on the availability of appropriate resources within the community.

The disability management team generally consists of physiotherapists, occupational therapists and/or disability management doctors working together in a clinical setting. Their assessment will help to determine at what stage the customer is in the recovery process and what treatment approach is needed in order for the customer to return to functional activities and employment. The assessment is intended to provide a value-added benefit to recovery and will not replace the services of health practitioners who are currently or have previously been involved in providing care. Community-based physiotherapists are valuable members of the customer’s extended recovery team and there will be situations where they will be asked to provide a consultation or professional opinion concerning the development of a treatment plan. In these cases, ICBC will reimburse physiotherapists for their input as a verbal CL20 fee code.

The ICBC Disability Management Program pilot is focused on early intervention and is designed to prevent injuries from becoming long-term disabilities. ICBC will be gathering data during the pilot to determine if the program has been successful in producing better recovery outcomes at a reasonable cost. We ask for your patience and input as we work together as partners to improve the recovery experience and maximize functional outcomes for our mutual customers. PABC note: CBI and Lifemark are the providers for this program which has been running for several months and has no specified end date.

Stay Connected at the Tap of a Button

by Fiona Chiu, MLIS, Member & Information Services

We realize that as a physio, you’re always on the go. Amongst treating clients, furthering your practice knowledge, and staying active, the opportunity to sit in front of a computer can be sporadic.

With your time challenges in mind, we have been working on a PABC mobile app for your expediency. At the tap of a button on your mobile home screen, you will be able to stay connected with member news and virtual forum updates, to create job and course postings, and to update your Find a Physio profile. In addition to keeping members connected throughout the day, the mobile app will make it easy for physicians to refer their patients to you, and make it easy for patients to navigate and find a physio or clinic in their area. All this and more in the palm of your hand, wherever your demanding schedule leads you!

For the mobile app to be effective, we need your participation! Please take five minutes to update your public profile and/or clinic profile on bcphysio.org. Simply log in, click on “My Account” and start editing. Don’t hesitate to contact me at fiona@bcphysio.org for assistance. Stay tuned for updates on the mobile app, arriving this summer.

Kudos

Recent practice toolkits

I would like to add my congrats to the c-spine group for the outstanding work. This group, under Marj’s leadership, is truly inspiring. It has been a pleasure and privilege working with all of you.

The c-spine group and PABC have done a fantastic job disseminating the C-spine rule in the clinical community. The success of your work is exemplary for clinician/researcher collaboration. LL

I wanted to say how great it is that PABC is developing practice toolkits, and we have incorporated them into our practice. I appreciate that you are disseminating the information freely. We presented the Lat Epi toolkit to the GP’s in the community at one of their morning rounds; it was very well received and we found our presentation an excellent way to share it locally and establish some relationships. We will do the Achilles toolkit in April. SS
Blurred Lines: Clarify your Working Status

by Jonathon Carkner, BSc (UBC MPT1 Student), and Cassandra Basi, BScPT

As members of PABC’s Business Affairs Committee, we recently discussed some of the risks and benefits for associates and clinic owners regarding Independent Contractor (IC) and employee status. We offered to interview PABC members about their transition from IC to employee. We also interviewed clinic owners to gain their perspectives on the topic. What are the pros and cons? Here is what they had to say.

From the Employee’s Perspective
All of the members that we spoke to were happy with their change from IC to employee. Some employees became salaried employees with a set annual income, while others became commissioned employees. Benefits such as a steady paycheck and job security were high on the list of reasons.

Added benefits include:
- Less administrative work (EI, CPP, payroll, accounts receivable/payable)
- Less risk with CRA (Canada Revenue Agency) auditing
- Lower or no accountant fees - many now doing their taxes themselves
- Not required to make quarterly tax installments
- Some clinics provide paid benefits, vacation/stat pay, overtime pay, performance bonus
- Some clinics provide continuing education funding
- From salaried employees, greater potential for inter/intra-office collaboration with other disciplines as “pay is not affected by visit numbers.”

The main cons are:
- Fewer deductible expenses
- No write-offs - may lower net income whether a salaried or commissioned employee
- Some loss of flexibility in work schedule

From the Employer’s Perspective
In considering a transition from IC to employee, your first step may be to ascertain if your clinic owner is in favor of the switch. It was apparent from our interviews with clinic owners that most clinics have their own configurations and many have a strong preference for one arrangement over the other. Three different opinions emerged, which did not necessarily reflect the current state of the clinic. They are:

i) Preference for employee status:
These clinic owners prefer to mitigate the risk with a potential CRA audit by having either salaried or commissioned employees. Additional expenses (accountant fees, benefits if provided, vacation pay, etc.) in addition to employee caseload are taken into account when negotiating the contract. Some clinic owners expressed their preference for commissioned over salaried employees, which in their opinion maintains the employee’s responsibility for case load, and augments motivation and autonomy.

ii) Preference for IC status:
Some clinics historically have hired only ICs. The perks expressed for this arrangement include lower accounting fees and more motivated, autonomous PTs. This arrangement allowed their ICs to write off expenses, which was a selling point to attract the ICs to the clinic. It is important to understand that with ICs, significant risk with a potential CRA audit falls on the shoulders of the clinic owner. Risk for the owner is reduced when a contract requires the IC to pay rent, purchase some equipment, have a business license, and take other measures to prove an element of risk to the CRA. See below for more on IC requirements to the CRA.

iii) No preference:
These clinics have a mix of ICs and employees, and encourage the associate to consult with an accountant to determine the best status for the individual. The contract for either an IC or employee can be set up to provide the clinic with roughly the same income and comes down to the PT’s preference. In this arrangement, the preference for commissioned over salaried employees was expressed for the aforementioned reasons.

CRA Considerations
When determining the nature of the working relationship, CRA has a list of guidelines to help involved parties clarify their status. When assessing employment status, CRA will generally look at the following:

• the level of control the payer has over the worker
In a self-employed situation, ICs generally work with little supervision, are free to define their own hours, and can provide services to different payers at the same time.

• whether or not the worker provides tools/equipment to do the job – this is significant in determining employment status. If an IC has purchased his/her own tools/equipment, it is likely that they have the right over use of the equipment and thus greater control over how work is performed.

• whether the worker can subcontract the work or hire assistants – employees are generally restricted from hiring coverage/replacement workers. In an IC situation, the associate has the ability to sub-contract or hire assistants, and thus increase the risk of a financial loss as profits can be affected.

• the degree of financial risk taken by the worker – ICs incur losses through expenses such as tools, equipment, office space, advertising and unfulfilled contract obligations. Conversely, employees do not generally have any financial risk associated with
their work (expenses are typically reimbursed).

- **the workers have opportunity for profit** – the ability to manage profits with respect to expenses and remuneration for performance, and the opportunity to realize a profit or incur a loss, indicates how much an IC controls the business/self-employment status.

By looking at and answering these questions, you can determine whether the relationship is a contract of service (employer-employee) or a contract for service (self-employment relationship).

For clinic owners who have ICs who work exclusively in your clinic, here are some recommendations to ensure that the ICs are truly independent, and to mitigate the risk with the CRA:

- charge them rent (up to 40% of the IC's monthly gross revenue);
- rent them an allocated space and have them set their hours;
- ensure they buy some equipment of value;
- ensure they are incorporated;
- ensure they have a business license in municipalities requiring them;
- sign a contract with them that cites that they pay $X for X space, will come and go as they please within a timeframe, and will have access to the services of the clinic (billing, reception, etc);
- bill them GST for the services.

In conclusion, we found that most associates were pleased with the transition from IC to employee. For those considering making the change, consult with your clinic owner. CRA’s RC4110 Employee or Self-employed is a great reference tool (http://www.cra-arc.gc.ca/E/pub/tg/rc4110/).

Clinicmaster Management Software

by J. Rainville and J. Hampton (BC office)

We have written this article to highlight the many features of Clinicmaster, one of the popular health management software packages available to physiotherapy clinics. The feedback received from our Clinicmaster user panel in the physiotherapy community and studies done with busy practices have provided invaluable information. Above and beyond appointment scheduling, capturing patient demographics and performing billing tasks, what are profitable clinics doing differently? They have put in place processes for excellent customer service, thus allowing their time to be spent on money-generating tasks.

**Offering excellent treatment and measuring it**

In order to assist in the treatment plan and to achieve optimal outcomes, you can send custom exercise programs directly to your clients via Clinicmaster. The client via a “cloud” portal can access these exercise programs, by email or by a simple PDF printout. You can even video your clients and make this part of the electronic chart, which will assist in keeping track of progression and goals.

Clinicmaster allows analysis of items such as treatment duration, treatment revenues, and statistics on patients who have not returned to the clinic for the full treatment or before being discharged.

**Offering excellent customer service and optimizing time**

With the use of Clinicmaster’s automation features, reduce posting errors and reduce administrative time spent doing unproductive tasks. Our panel uses a variety of automated features such as: automatic email or SMS to remind clients of upcoming appointments; alerts to evaluate the number of returning and non-returning clients to your clinic; automated reports to determine which service or professional attracts patients to come back and which do not.

**How busy is your clinic?**

Practices are using Clinicmaster to measure their monthly workload ratios to analyze ROI and referrer statistics. Clinicmaster can help you analyze the effectiveness of your campaign, and provide statistics on who is referring to your clinic as well as the revenues generated from those referred clients.

By analyzing your statistics you can focus on specific campaigns, decide on future marketing investments and create referral programs to maximize your advertising dollar.

**Go paperless, use the cloud capabilities**

With cloud access for patients to complete their intake form, Clinicmaster offers a professional portal and solutions to reduce paper and accommodate the use of mobile devices. Electronic charting, importing and saving imaging reports, emails, videos, pictures, or almost any other type of document are part of your clients’ files in Clinicmaster. Digitization of files and back-up capabilities offered meet all Canadian Privacy Act specific requirements. Clinicmaster offers easy handling for creating those files and to print old ones when those unexpected audits or client/lawyer requests arrive. Think of all the storage costs you will save by moving towards paperless charting! Think about Clinicmaster.

In Memoriam

We are sorry to announce that **Anne Scott** passed away the end of January. She was a role model for young colleagues and an active volunteer on many committees. Her guidance and generosity are a loss to the profession.

PABC thanks Clinicmaster for their annual Title Sponsorship of the Physiotherapy Forum.
Loving Your PABC Library: Everyone is a Winner

by Deb Monkman, MLS, BSc, PABC Librarian

Congrats to Ryan Sleik of Creekside Physiotherapy in Kimberley for winning a provincial library contest. Ryan, who is on the PABC Library Advisory Board (LAB), won a $50 iTunes card from Electronic Health Library of BC (eHLbc) for sharing his experience with our PABC library databases and journals from eHLbc:

“When I come across an obscure problem or need to find the latest research on a topic, eHLbc is always a useful resource. Generally, I can find most full text articles on my own without too much effort thanks to having all the resources available to me on one page. When I’m in need, a quick request to Deb, our librarian, and even the most obscure article appears in my inbox.”

PABC was recognized provincially thanks to Ryan’s winning entry.

Have you had the same experience with your PABC library databases and journals? I had two other members recently tell me of their experiences:

“Thanks so much for your help with these articles. It made writing my report a little less gruesome! I really appreciate all the hard work you put into it.”

“I find your series of webinar recordings and tutorials on how to do a lit search and find information in the PABC library very useful and I would like to review them again.”

Deb’s note: they can be found on the member site in the Clinical Library. I’ll be running a new series of webinars in the autumn to reflect the many changes that have occurred in the world of information.

We’re fortunate to be able to provide these essential resources — Medline, CINAHL, PsycINFO, Cochrane plus and thousands of full-text journals — for our members through the Electronic Health Library of BC, a provincial consortium of health organizations that includes PABC. Through this consortorial effort, PABC pays a per-member fee to provide you access for free. I sit on the eHLbc management committee and steering committee, and will be presenting a paper at the upcoming Canadian Library Association conference on behalf of PABC and eHLbc.

PABC’s Library Advisory Board

The LAB is a PABC committee of members interested in our library resources. My LAB Partners are Brandon Butt, Tasha Carmichael, Farron Fedechko, Marta Kemecsey, Erin Macri, Darrell Skinner, and Ryan Sleik; they review the latest library materials (e.g., tutorial on “How to Find Practice Resources on the Member Site”) and help to make our resources relevant for all members so that you too can Love Your PABC Library.

Your Favourite Ways to Keep Up with Physio Literature: Rehab+ and OrthoEvidence

While there are many ways to keep current with the literature in your area of practice, our members overwhelmingly appreciate resources that not only update them but which also review the quality of the research. Rehab+ is a free resource from McMaster University, and OrthoEvidence is free as a benefit of membership. LAB members had this to say:

“My two favourite resources are Rehab+ and OrthoEvidence. I have been using OrthoEvidence more frequently lately because I love the layout. I get the most for my time as each article is broken down to very clinically relevant sections. The additional info about funding/sponsors and conflicts is great. It is essentially critically appraised for you... not to say you shouldn’t make your own decisions about what you read but it’s certainly a great way to quickly get the relevant information from the articles.” – Marta Kemecsey, PABC Library Advisory Board, Jan 2014

“I have just started using OrthoEvidence and like it! Not all the articles are relevant to physio but the ones that are relevant are usually high quality. There have also been some cost effectiveness studies relevant to physiotherapy that have been really valuable!” – Brandon Butt, PABC Library Advisory Board, Jan 2014

To sign on and for more details about Alert services available to PABC members, see PABC’s Guide to Alerts in the Clinical Library on the member site.

And a final note: We in the PABC office are always delighted by expressions of appreciation from our members. This month we were delightfully surprised by the generosity of one member who wrote to us to say: “I would like to make a donation that will go towards Deb our librarian’s work and to say thank you for all her help.” PABC used this donation to purchase the ODG database and to fund my travel to the Canadian Library Association conference.

Looking for practice resources on the member site?

Go to Clinical Library and watch the two-minute tutorial on how to find guidelines and toolkits, patient education, outcome measures, anatomy, journals and databases, and much more.

Are You a Mobile Physio?

Be sure to visit MPT2 student Thomas Zhou’s Tech Talk reviews of mobile apps he uses and recommends on the PABC member site. View PABC’s Mobile App Treasure Trove on our site and add your recommendations by emailing librarian@bcphysio.org
Prolific, Potent and Proud Period

by Alison Hoens, Physical Therapy Knowledge Broker

This is difficult. How can I possibly summarize in a few words all the great work and outcomes associated with multiple Knowledge Broker projects? At the risk of doing a grave injustice to both the quantity and quality of the work undertaken by over 130 amazingly talented people who are involved with these projects, here are the highlights from an extremely prolific and potent period: (full list available at bcphysio.org/sites/default/files/file_attachments/page KBpartners%20March%202014.pdf)

Cervical Spine Trauma and the Need for X-ray Imaging
- Three years of work are concluding with the unveiling of a suite of resources to help PTs use the Canadian Cervical Spine Rule to identify which patients need an x-ray to rule out significant injury post trauma.
- The webinar on March 11th shared the tool, FAQs, video demonstrating how to use the rule, case histories illustrating its use and interpretation, templates of letters to physicians, and a review of the results of the survey of PABC members last year.
- This material is being shared with our physician colleagues and being incorporated into PT pre-licensure and post-licensure education.
- A poster will be presented at CPA Congress 2014. A manuscript is being prepared for publication.

Achilles Tendinopathy Toolkit
- There have been ~16,000 views of the toolkit from over 45 countries!
- We have submitted a grant application to develop the toolkit into an app.
- We recently received ethics approval for a survey evaluating the impact of the toolkit. Stay tuned to your email for the invitation to participate — we need hundreds of PABC members to respond to the questionnaire, regardless of whether or not you treat this patient population, in order to get valid and meaningful results.

Lateral Epicondyle Tendinopathy Toolkit
- Recently released and already almost 4000 views
- Publications regarding the toolkit for our physician colleagues on the UBC Continuing Practice Development blog “This Changed My Practice” (~8,000 hits/month) and in the BC Medical Journal have elicited many positive comments.

Total Joint Arthroplasty and Outcome Measures (TJAOM)
- Over four years of work are culminating in the launch of a toolkit providing resources to help PTs select, apply, score and interpret outcome measures for patients with total joint arthroplasty (THA and TKA) along the continuum of care.
- The third (and final) webinar in the series on outcome measurement provided participants with a detailed review of all the resources in the toolkit:
  - The recommended outcome measures for THA and TKA (both patient-reported and performance measures) derived from the combined results of the chart audit, focus group, survey, Delphi process and corresponding literature
  - One-to two-page summaries of the key information on each of the recommended outcome measures
  - On-line learning modules for each outcome measure
  - Template of a discharge letter that PTs can use to share the results of these outcome measures with referring physicians
- The results of the survey were recently published in Physiotherapy Canada:

Safe and Effective Exercise Prescription in Acute Exacerbation of COPD
- Spawned from the very popular SAFEMOB clinical decision-making tool to aid safe mobilization of acutely ill patients, a similar tool Safe and Effective Prescription of Exercise in Acute Exacerbation of COPD is currently been evaluated in interdisciplinary focus groups undertaken together with UBC MPT students.
- The AECOPD decision-making tool was developed from findings of a systematic review (http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3363140/) and a Delphi process with multiple health care disciplines and patients/families.

Guidelines for Wheelchair Provision in Progressive Neuromuscular Disease
A four-year project involving the appraisal, updating and translation of the UK guidelines for the BC context is in its final stages of editing. It will soon be posted on relevant paediatric websites.

Functional Engagement in Assisted Therapy through Exercise Robotics (FEATHERS)
An interdisciplinary group is developing exercise technologies that use social gaming supported by robotics to help children with cerebral palsy and older adults after stroke to practice their bilateral upper extremity home exercises. Prototypes, informed by focus groups with therapists, patients and families, are currently being tested.

Animated, Self-serve, Web-based Research Tool (ANSWER)
A team including experts in rheumatology and digital media has developed a prototype of a decision aid to assist patients with rheumatoid arthritis (RA) with their decision whether to proceed with medication treatment using “biologics” (genetically engineered proteins) as recommended by their doctors. The next step is to conduct usability tests with patients.

continued on next page
Making Evidence-Based Practice Practical

by Kristyn Harrington, MPT

There was probably nothing more emphasized throughout my two years in physio school than the importance of incorporating the latest evidence into one’s physiotherapy practice. As new graduates, our hands-on experience and clinical knowledge are limited, and so the latest research plays a critical role in our decision-making. However, even the most experienced clinicians often pride themselves on being evidence-based therapists. So how does one find the time and resources to stay current with the research while maintaining a busy caseload? When I began working at Neuromotion Physiotherapy I was very pleased to discover that Pauline Martin, the clinic owner, had found a way to achieve this in her two clinics.

Pauline wanted to ensure that her therapists at both the Vancouver and Victoria clinics were up to date with the latest research, and needed a way to ensure that all of her staff were on the same page. To do this, she has begun scheduling a weekly article review. Each week, a different member of staff at one of the two clinic locations selects an article that they find interesting or applicable to their patient caseload. This article is distributed to the rest of the staff, along with a list of questions related to the article, by mid-week. Each staff member is assigned one or two questions to answer. At the end of the week the team meets at each clinic to review the article and discuss the questions via Skype. All of Neuromotion’s article reviews are then posted onto the clinic’s blog www.neurolitreviews.blogspot.ca.

Bringing everyone together to discuss the evidence behind what we practice is a great way to connect the two clinics. As a team, we are able to critically evaluate the research, as well as the techniques we are using in our practice. I find it invaluable to see how my colleagues integrate the evidence with their clinical expertise, and how their experiences may influence the way they interpret the results or validity of a piece of literature. For example, a few weeks ago I chose a study that investigated how different combinations of treatment approaches affect functional outcomes in stroke patients. The approaches used by practitioners in the study included the Bobath concept, Proprioceptive Neuromuscular Facilitation (PNF), the motor learning approach, the functional approach, and the orthopaedic approach; I am familiar with all of these in theory, but lack experience with their practical application. However, collectively, my colleagues have several years of experience using techniques based on these approaches, and a much more comprehensive understanding of their practicality and relevance in the clinic. Many, if not all, of my colleagues have also taken supplemental courses in these techniques to further their practices. The article discussion was a great opportunity for me to ask questions related to these approaches, and receive feedback regarding which approaches are most successfully used in our clinic with the clientele we typically treat. As the study was carried out in the hospital, it was also interesting to discuss how the approaches might become more or less relevant and/or effective for clients as they leave the acute phase and enter the chronic phase of their disease or injury, which is when they would start to seek therapy at our clinic. The discussion will

continued on next page
Assessment: The Key to Improved Clinical Outcomes for Low Back Pain?

by Colin Davies, PT, Dip. MDT and Richard Rosedale, PT, Dip. MDT

There are no guidelines for chest pain because we are able to make accurate subgroups of people with chest pain, e.g. angina, esophageal reflux. Similar subgroupings in the case of back pain have eluded us. The Quebec Task Force report of 1987 [1] laid most of the blame on medicine’s lack of validated examination procedures and nothing much has changed since then. In a thoughtful and provocative paper, Kevin Spratt described an entirely new way of viewing the problem of low back pain [2]. Spratt proposed that the first requirement is to have a validated assessment process which reveals relevant information about the clinical picture. Such a tool enables the clinician to group patients according to their clinical signs and symptom behaviour. Once a subgroup is established different treatments can be tested to demonstrate their effectiveness. In summary, first validate the assessment, establish diagnostic accuracy, develop possible treatments and finally test their effectiveness using randomized controlled trials.

Let’s apply Spratt’s model to the McKenzie Method® of Mechanical Diagnosis & Therapy (MDT®), a widely used system of assessment, classification and treatment of musculoskeletal pain. MDT assessment is based on exploring the symptomatic and mechanical effects of movements, postures and loading strategies on the musculoskeletal system. Patients are classified according to their response to the assessment. With certified clinicians a good level of reliability on diagnostic agreement is demonstrated, with Kappa values from 0.79 to 1.00 [3]. Treatment can then be matched to the specific classification. With low back pain, 50-70% of patients report that their symptoms relocate from a distal position to the midline of their spines. This phenomenon is termed centralization. Research clearly shows that centralization is a reliable predictor of a good outcome and determines the specific direction of movement that the patient needs to perform in order to achieve a successful outcome [4]. Centralizers thus form a specific subgroup of low back pain. This process of assessment, classification and treatment leading to improved outcomes can have a major impact on health care for this population. This was dramatically illustrated by a Danish study in 2005 which reported on two clinics in North Jutland, Denmark where all patients with sciatica were screened using the McKenzie MDT assessment. Over the 10-year study period rates of lumbar spine surgery decreased 50% in that district, whereas they rose in the same period in the rest of the country [5].

All clinicians would benefit from using Spratt’s Assessment - Diagnosis - Treatment - Outcome protocol to test the effectiveness of their management system.

References
Professionalism
by S. Jayne Garland, Head

PABC, UBC, and CPTBC are working together to create a statement of core values for the profession, values that we hope will resonate with all physiotherapists from new graduates to expert clinicians. This statement will form the basis of a “pledge” to be recited by PT students as they enter the MPT program and start their journeys as members of the physical therapy profession. While the pledge will start with MPT students, it is intended to foster and instill professional pride and responsibility in all physiotherapists, encouraging support for progression of our profession, for example by mentoring colleagues and students, and by committing time, knowledge and experience for advancement of best practices in physiotherapy to improve health outcomes for our patients. These types of value statements and pledges are used by other professions either on entry to their educational program or on its completion (for example the Hippocratic Oath that is recited by new graduates in Medicine). Joan Cleather’s book, Head, Heart and Hands: The Story of Physiotherapy in Canada epitomises what we hope to achieve with our pledge — that physiotherapy is more than skilled hands and educated minds, but what we value as physiotherapists.

Clinical Education

Exploding the Myths: You do not need to be an experienced practitioner and work full time to take a student!
by Sue Murphy, Associate Head

There is a rumor going around in the clinical community that you can only supervise students when you work full time, and that you should be, if not an expert, at least a practitioner with many years of experience. Not so, we say! You do not need to work full time to supervise a student. There are many wonderful examples of placements where the student has more than one supervisor, and/or may learn in two different clinical environments during the same placement. Students are expected to be able to adapt to two (or more) supervisors if the situation demands — which it often does. Most students appreciate the opportunity to experience different treatment approaches or different sets of clinical reasoning, as well as to learn from different skill strengths. Students may be assigned to two supervisors on a daily basis (for example, one in the morning, and another in the afternoon — and no, they don’t have to be in the same clinical area), or a weekly basis (for example, one supervisor two days per week and another three days per week), or many other creative combinations. The most important thing is for the supervisors to collaborate and make sure that their learning objectives for the student are complementary rather than diametrically opposed, which can lead to confusion.

You do not need have many years of experience prior to hosting a student placement. In recent years, the experience level of preceptors has changed dramatically, with many new grads taking their first student in their first year of practice. Whether new to the profession or new to an area of practice, preceptors without years of experience often make the best clinical supervisors as they are more able to identify “entry level” skills and to relate to the student experience.

As always, if you have any questions about these myths or about any aspect of hosting student placements we would be delighted to hear from you!

West Meets East
by Marcia Denhoed, MPT2 Student Columnist

During five weeks this winter, I put my somewhat new clinical skills to the test in a very new location: India. Joined by MPT2 classmates Danielle Boyd, Kailen Houle and Maegan Mak and clinical educators Hilary Crowley and Andrea Mendoza, we immersed ourselves in the culture of rural southern India for a pediatric and adult spinal cord placement. As students, we quickly realized that what we had learned in the classroom had to be adapted to our new surroundings.

A far cry from the sterile, climate controlled clinics of the west, pediatric sessions could best be described as sweaty chaos. The treatment space usually saw the diaphoretic therapist crawling around on the floor barefoot — crawling carefully that is, to avoid puddles left by children who have never heard of diapers. While working with the child, numerous well-meaning family members simultaneously rattle and squeak loud toys to attract the child’s quickly fraying attention. All the other patients and their extended families, who will wait patiently for the better part of a day to be seen, are crammed into the treatment space, contributing to the chaos.

Forget about confidentially; with insatiable Indian curiosity and indifference to personal space, strangers witness the sessions of others with reverent fascination. When making a home visit, this same curiosity often results in half the neighbourhood being huddled in the doorway of the patient’s
small house, often blocking the only source of sunlight that allows you to see your patient. Occasionally sharing the treatment space with cattle or sheep adds to the authenticity, and even more surprising is that it’s totally acceptable to press pause on a treatment session to enjoy some cookies and tea.

India proved to be a rewarding and challenging experience, teaching invaluable lessons in thinking outside the box. We saw people with very few resources or formal education create fantastic solutions to mobility problems, such as a wheelchair made from a plastic patio chair affixed to bicycle wheels. Here in Canada we have access to seemingly limitless resources, but by learning, problem-solving for the benefit of patients, and helping transcend geography and language.

We were given a fantastic send-off by the whole crew at the Samuha Samarthya Community Resource Centre in Koppal, India. PABC student leaders joined RBT for some nosh as they discussed plans for PABC events for their MPT1 & MPT2 peers in 2014. L-R Emilie Whittemore, Trevor Potts, RBT, Rebecca Lee, Melina Mirzaei (missing: Tiger Ye).

Kudos for Directions
Yes, I do read Directions cover to cover! JS
I just read Directions. There are lots of great tid bits in this issue! TP

Free PABC Webinars
If you missed them live, “Search the Library” to view the free recordings and course materials for these Knowledge Team webinars held in 2013/14. Stay tuned for our new series coming in the fall.

Measuring Outcomes Series:
1. How to Find, Select, Apply, Score, and Interpret Outcome Measures, Alison Hoens and Dr. Vanessa Noonan
2. Move Beyond Impairment with Outcome Measures: Shoulder Pathology, Alison Hoens and Cameron Bennett
3. Move Beyond Impairment with Outcome Measures: Total Knee Arthroplasty and Total Hip Arthroplasty, Alison Hoens and Dr Marie Westby

Sticking Your Neck Out: Do All Patients with Neck Trauma Need an X-Ray. The Canadian C-Spine Rule Project webinar, Alison Hoens and the C-Spine Task Group

Private Hosted Courses
Details at www.bcphysio.org - Courses
May
- Mindful Professionals: Enhancing Resilience & Effectiveness for Helping Professionals - UBC Continuing Studies, Vancouver
- Communication for Collaborative Care - UBC Continuing Studies, Vancouver
- Pilates For Health Professionals, North Vancouver
June
- Soft Tissue Release Workshop with Jim Bilotta, Langley
- K-Taping® Sport, Burnaby
- Soft Tissue Release Workshop with Jim Bilotta, Victoria
July
- Soft Tissue Release Workshop with Jim Bilotta, Kelowna
September
- Dr. Stuart McGill - Building the Ultimate Back: From Prevention and Rehabilitation to Performance, Calgary, AB
October
- K-Taping® Pro, Burnaby

Join PABC’s Stephanie Dutto in reading Directions on the phone with PABC’s new mobile-friendly site www.bcphysio.org
Auditor’s Report for 2013

To PABC Members

This condensed financial report has been extracted from the audited financial statement for the year ending December 31, 2013 as reported by our auditors Morrow and Company Certified General Accountants. A complete copy of the audited financial statement is available to PABC members through the PABC Office.

Physiotherapy Association of British Columbia (a branch of CPA)

YEAR END FINANCIAL STATEMENTS AS AT DECEMBER 31, 2013

STATEMENT OF FINANCIAL POSITION AS AT DECEMBER 31, 2013

<table>
<thead>
<tr>
<th>ASSETS</th>
<th>2013</th>
<th>2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cash</td>
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<td>Capital Assets</td>
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<td>1,468</td>
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<tr>
<td>TOTAL ASSETS</td>
<td>$ 1,331,166</td>
<td>$ 1,244,823</td>
</tr>
</tbody>
</table>

LIABILITIES

| Accounts payable and accrued liabilities (Note 6) | $ 67,723 | $ 94,961 |
| Inter-funds payable                             | 270,924  | 264,525  |
| Deferred revenue                                | 312,724  | 300,717  |
| TOTAL LIABILITIES                               | 651,371  | 660,203  |

FUND BALANCES

| Unrestricted                                     | 407,843  | 318,627  |
| Invested in tangible capital assets             | 1,029    | 1,468    |
| Internally restricted                            | 270,924  | 264,525  |
| TOTAL FUNDS                                      | 679,795  | 584,620  |

TOTAL FINANCIAL POSITION | $ 1,331,166 | $ 1,244,823 |

BUDGET 2014

<table>
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<tr>
<th>Account Category</th>
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<td>4617 Website</td>
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<td>DEFICIT / SURPLUS</td>
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STATEMENT OF OPERATIONS FOR THE YEAR ENDED DECEMBER 31, 2013

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<tr>
<th>REVENUE</th>
<th>2013</th>
<th>2012</th>
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<tbody>
<tr>
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<table>
<thead>
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<th>EXPENSES</th>
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<td>576,701</td>
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EXCESS OF REVENUE OVER EXPENSES | $ 95,174 | $ 44,397 |

Full financial statements for 2013 are posted on the PABC Members Only Site at www.bcphysio.org
What Members are Doing

Chiara Singh (Surrey Memorial Hospital) has received the honour of being awarded CPA’s 2013 Silver Quill Award in Qualitative and Quantitative Research. At national Congress Chiara will receive this prestigious award for her article published in Physiotherapy Canada: The Effect of Prospective Monitoring and Early Physiotherapy Intervention on Arm Morbidity Following Surgery for Breast Cancer: A Pilot Study, Volume 65, 2nd Edition, Spring 2013.

Scott Okrainetz (Royal Jubilee Hospital) has created a National Physio Month initiative throughout his health authority. He calls it “Island Health in Motion” and has enlisted the enthusiastic support of the decision-makers at the highest level of the executive to support having this physical activity initiative that also promotes our profession. Employees throughout Island Health would send in their total kilometers of walking, running, cycling or swimming and see how many Earth’s circumference of 40,075km in trips Island Health staff can make around the month. There are prizes as well as bragging rights. Scott has also just opened a new clinic, Fernwood Physio in Victoria.

Christina Mattiello, Teresa Agar, and Kevin Stoll at Trailside Physiotherapy were chosen as the therapy providers to the Vancouver Stealth Lacrosse Team of the National Lacrosse League. The Stealth moved to Langley this year from their previous home in Everett, Washington. Kevin is serving as the Head Trainer/Physiotherapist.

Erin Macri won Faculty of Medicine heat and took Runner Up and People’s Choice for the UBC competition, “the 3 minute thesis competition” from last month. See her performance at http://goo.gl/feQLRv.

John Hunter and Lisa Munkley opened a new clinic in Victoria, Rise Heath Centre. Ange Capson, Jodi Ganton, and Felicity Klimstra join them as associates. Their vision is to positively contribute to the quality of life for clients, staff and their new community.

Paige Larson, North Shore Sports Medicine Clinic, won the Social Impact Award from the Air Miles Small Business Achievement 2014 recognition awards for outstanding leadership and entrepreneurial spirit across Canada.

Dean Clark, DR Rehab Inc, recently announced a community workshop for those with chronic pain and fibromyalgia. Says Dean, “It’s in a moment of pride and awe for the warm hearts of my peers that I tell you that within 24hrs of sending out information on the workshop, I had three offers to help subsidize multiple patients who may not be able to afford the full fee.” This act of collective kindness inspired Dean to create a discounted fee for businesses that may also want to help the less fortunate attend the workshop.

Eddy Betino, The Joint Physiotherapy Clinic, was honoured to be included in the Top 20 under 40 Business and Community Achievement Award for Vancouver Island.

Calling Members Together

Northern Members

Kerrie Roberts, a clinical instructor with UBC PT Northern & Rural Cohort and practicing physio, recently coordinated some members to view PABC’s Knowledge Team free webinar on Outcome Measures and Shoulder Dysfunction, presented by Alison Hoens and Cameron Bennett. Kerrie said: “It was a really worthwhile and informative session, so I hope others from our region were able to take it in as well. We got so engaged in discussion following the webinar that we didn’t even have time to fill in the survey as a group! I am hoping to engage northern physios with more group activities, so if anyone is interested, please contact me at phsioke@telus.net”

Lower Mainland Members

Patricia Jiang wants to get out and play with her peers. She is organizing a picnic potluck and hike to the first peak on Mt. Seymour on Sunday, May 25th from 10-3. If you are interested in hiking, food, fun, and meeting colleagues while being physically active, email jiang.patricia@gmail.com. The hike is an intermediate difficulty taking ~3 hours, plus a lunch break at the top! The goal is to enjoy together the active lifestyle that we promote as BC physios. Friends and family welcome. Share your favourite picnic food. Bring your camera! Patricia would love to hear from you for suggestions on more upcoming events.

Retired Members

Past PABC president Patricia Grohne is hosting a gathering of all retired physios in BC at Hycroft Manor on Thursday, June 12th from 2-6 pm. Contact Patricia for details: pgrohne@gmail.com.
Come for the job. Stay for the team.

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Articles on members’ clinical practice are welcome. The editor retains the right to determine content. Unless specifically indicated, statements do not reflect the views or policies of PABC. Services or goods advertised are not endorsed by PABC.
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For Advertising rates, please contact Stephanie at: steph@bcphysio.org.

PABC Professional Development 2014

Evening Lecture/Vodcast Series

Fall 2014 – “Our BC experts share their secrets – part III”
Case studies with our local experts. Join us to “ask the expert”. Bring your questions and hear how they would manage specific clinical scenarios.
First up will be Tyler Dumont, MSc, Diploma Sport Physiotherapist discussing knee pain in cyclists. Date TBC.
Paetzold Lecture Theatre, Vancouver General Hospital, 899 West 12th Avenue, Vancouver BC, Registration and refreshments 7:00 pm, Lecture 7:30 – 9:00 pm
Vodcasts: distributed to registrants one week following the live lecture

Weekend Courses

PABC Course: Fascial Manipulation® and its biomechanical model: a guide to the human fascial system (one-day workshop)
May 10, 2014 with Cheryl Megalos, BScPT, RCAMT, CGIMS, Fascial Manipulation® Practitioner
UBC Friedman Building, Vancouver

Vestibular Rehab: A practical approach
September 27 – 28, 2014 with Bernard Tonks
UBC Friedman Building, Vancouver

In the planning stages, so keep your eyes peeled:
Fall 2014 – Cecile Rost/Susannah Britnell – Rost Therapy: Relieving Sacro-iliac and Pubic Pain During and After Pregnancy
Spring 2015 – Cathy Eustace/Deb Treloar – Bridging the Gap: Understanding gait from both the neurological and orthopaedic perspectives.
Fall 2015 – Bob Powls – Muscle Energy Techniques for the lumbar spine and pelvis

To register for courses or lecture/vodcast series, follow these four easy steps:
1. Go to www.bcphysio.org and click Courses
2. In Type box, choose “PABC Education” and click “Apply”
3. Under the Event column, click the course title you want
4. Click “Register for in-person lecture HERE”, “Purchase Vodcast HERE”, or “REGISTER NOW”

For more information, call PABC at 604-736-5130, ext. 2 or email Andrea Reid at education@bcphysio.org

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