Orthopedic Cerebral Palsy Program at BC Children’s Hospital

by Stacey Miller, BScPT

It is common practice for a multidisciplinary team to be involved in the orthopedic management of children with cerebral palsy (CP) and similar neuromotor conditions. However, the Orthopedic Clinic at BC Children’s Hospital (BCCH) has had very limited therapy services available to support this population. Orthopedic surgeon Dr. Kishore Mulpuri recognized the need for improved care at BCCH and, with the support of the Physiotherapy Department, advocated for increased services. In May 2010, funding for a full-time physiotherapist (PT), part-time occupational therapist (OT), and part-time nurse was secured to support children with CP. While still in development, there are lofty goals for this new team.

Hip Surveillance Program

The lack of a coordinated hip management strategy in BC has lead to preventable hip dislocations in children with CP. The incidence of hip subluxation in children with CP has been reported as 35%, with the most severely involved children having a 90% risk. Early identification and timely orthopedic management can reduce the need and complexity of the surgical intervention required to treat this problem. Hip surveillance programs in Sweden and Australia have significantly reduced the incidence of hip dislocations and eliminated the need for salvage surgeries. A framework for a provincial Hip Surveillance Program is currently under development by the Orthopedic CP team with the support of hospital administration, Sunny Hill Health Centre, and ChildHealth BC.

Assessment, Communication, & Coordination of Care

Successive measures over time provide valuable information when making treatment decisions. With the addition of a clinic PT, standardized measures are now consistently being recorded. However, as a comprehensive assessment cannot be completed in a short clinic visit, improved communication with a child’s community therapists is required. The community team offers valuable insight into the child's development and the family's goals and concerns. We are currently working to create pathways for improved communication and collaboration between the community and clinic PTs.

Orthopedic interventions must be supported by therapy services. The addition of a PT in the Orthopedic clinic has resulted in the identification of children receiving interventions without therapy. This occurs because children have no funding available, existing funding is inadequate, or there are no therapists available in their community. The clinic PT is responsible for ensuring adequate post-intervention therapy is available and providing support to community therapy teams.
President’s Report

PABC Discussions with CPTBC and PABC Members on the QAP

Scott Brolin, BSc(PT) Honours, President

It has certainly been a busy couple of months. You will all recall the email that I sent out to the membership regarding our concerns regarding the key features component of the College Quality Assurance Program (QAP) — specifically the Registrant Competency Assessment. Many of you have emailed me to express your appreciation of PABC acting on your behalf to engage the College on some outstanding questions and concerns regarding certain aspects of the program. I have made the personal commitment to respond to all emails sent to me from our members — if you have emailed me and have not yet received a response, please email me again as your message may have gotten lost in cyberspace!

I wish to offer some key points of clarification that have come up from discussion with individual members:

- PABC completely supports the College’s mandate to develop a Quality Assurance Program — they are required through legislation to develop this program;
- PABC’s letter to the College in December was intended to seek answers to specific outstanding questions of our Board and members;
- CPTBC responded quickly and thoroughly to our queries, and we are reviewing their information and preparing a response;
- Both PABC and CPTBC will post these letters on our websites early in February;
- We value our relationship with the College, despite current differences in opinion about this particular component of the QAP.

Through regular communication with the College leadership, we remain hopeful for open dialogue between our two organizations. Please also remember that as a physiotherapist member of PABC you are also a registrant of the College. As such, you are also encouraged to express any of your individual questions and concerns directly to the College (604 730 9193, brenda_hudson@cptbc.org). Of course, we welcome your thoughts and concerns (604 736 5130, president@bcphysio.org) and are happy to convey them to the College.

Have a wonderful and prosperous winter season! ♦

Physiotherapy Practice Forum 2011
Saturday April 2nd
8 am – 5 pm

The huge success of our first annual Forum in 2010 predicts a swell in the crowd in 2011 — we hope for 500 members to join the fray.

Why attend PPF 2011?
The magnetic program in 2011 is back, and better. We start with Breakfast Theatre, a dramatization of a patient being treated in hospital, clinic and home and the “bloopers and best practices” hosted by our Joint Initiatives Committee of the association and college. The afternoon will feature a new event, Rapid Research, which features UBC physio professors giving a 5 minute overview of their research and how it impacts your practice. We finish the day with a clinical/academic poster presentation and UBC PT alumni reunion over wine and cheese.

Come enjoy a day of free education, food, trade show offerings, prizes, and updates from both PABC and the College, as we co-host this day that focuses on your practice.

See the insert for the full program and registration, or go to www.bcphysio.org to register online.

Call for Posters for Physio Practice Forum 2011

PABC is pleased to invite your participation in the 2nd Annual Clinical and Scientific Poster Session at the 2011 Physiotherapy Practice Forum on April 2nd. Abstracts based on unique clinical cases and all aspects of physiotherapy research are being accepted. We encourage submissions from the clinical world, as well as from the academic community (faculty and students). There will be prizes for the best student, faculty and clinical posters. All abstracts must be submitted online by February 25, 2011. Web submission will open on February 5, 2011 at www.bcphysio.org Members Only site.

This is an excellent opportunity to participate in a peer-reviewed adjudication process — a great addition to any CV and generally to professional bragging rights. For more information, contact poster project lead Lois Lochhead, PABC Board Director for the Central Interior/NE Region at lois.lochhead@shaw.ca.

Posters will be on view throughout the Forum. UBC-PT Dept will host a wine and cheese alumni reception and poster voting at 4:30 where members can sip wine while viewing the posters and speaking with presenters.
CEO’s Report

Being a Role Model — Consciously

Rebecca Tunnacliffe, MA
Chief Executive Officer

The CBC recently released its report on a study on the health of Canadians, undertaken in November 2010. The findings are astonishing, and resulted in a CBC Network initiative called Live Right Now from January through June 2011. The initiative is “a national project designed to inspire Canadians to join together and change the health of this country. The idea is built around the small steps everyone can take in their lives to improve their health.” Let’s take up the challenge of making “small steps” by talking about our own active lifestyles for which physiotherapists have a reputation.

This media movement is a golden opportunity for PABC members to get involved in a dynamic way. The easiest point of entry as a role model for your patients and colleagues is to magnify what you already do — raise the topic of your active lifestyle. Mention those many things you do to maintain your physical health: your exercise habits, your nutritional axioms, your self-motivational techniques, and also your challenges in keeping fit.

The CBC report findings are astonishing, and methinks you will be inspired to action when you see that the conditions from which the majority of Canadians suffer (overweight, tiredness, and stress) are ones over which you can have an influence. I encourage you to look into the CBC report and resultant initiatives. Jesse Royer, our Member Services Manager, has made it easy by putting together key points and actions on the Members Only site www.bcphysio.org under What’s New/Live Right Now.

I challenge us all to motivate those in our sphere of influence by seeking opportunities to talk about physiotherapy passions — increasing activity, maintaining mobility, preventing illness, reducing weight. Initiate those discussion topics in your hospitals, clinics and community. You already have the advantage of “walking the walk”; so start talking about it too.

New PABC Initiative: BRANDING

Champions of the cause, champions of the brand.

That’s what our credo is for 2011 as we undertake for the very first time a PABC brand. Given the public’s growing emphasis on health, coupled with the increasing field of other health providers, it was time for us to take ownership of a clear, engaging brand that articulates who we are, increases our visibility in the health care community, and positions us as the rehabilitation leader.

We engaged Bare Advertising & Communications (Bare) to work with us to define who we are; we found both PABC and its members share similar values and attributes of integrity, open-mindedness and trust, to name a few.

Bare then created a positioning tagline that would be the foundation of our visual identity and communications. Recognizing that British Columbians enjoy an amazing array of activities, and that we often define ourselves in part by the activities we pursue, Bare developed the line: Physiotherapy: Keeping British Columbians Moving For Life. The line positions physiotherapy as not only dealing with mobility issues from cradle to grave, but also as an integral part of the BC lifestyle; a position to which no other profession can lay claim.

This in turn led to our new TV spot now in development, which features a comically exaggerated line of patients in a clinic: a mud-covered mountain biker; wheelchair athlete; deep sea diver, etc., and an announcer who informs us “…that no matter what you love to do in BC, your physiotherapist will help you keep doing it.”

Our brand also includes a new logo that reflects the balance between PABC’s role of “champion of the cause” for mobility issues in BC, with its corporate responsibilities.

It points to exciting developments for PABC and its members in 2011, and we hope you join the unveiling at our Physio Practice Forum April 2nd.

New PABC Offering for Members: Exercise Videos for Patient Education — Courtesy of Active Life Physiotherapy

Are you tired of drawing stick men for the exercises you prescribe to patients? PABC members Heather King and Sophia Sauter of Active Life Physiotherapy Inc. have developed a solution to the stick man by creating a professional database of 300 exercise videos.

After reading the Fall 2010 Directions article on patient education, Heather contacted PABC and explained that a year and a half ago, tired of drawing stick men, Active Life Physiotherapy embarked on a project to script and professionally film 300 exercises and make them available to patients through their booking system. Each patient can access videos prescribed by their physiotherapist by logging on to the system. Heather reports a positive reception from patients and improved exercise adherence.

Heather and Sophia have kindly provided PABC members with free access to a selection of their patient education videos on the PABC website. They are also offering you the full suite at a small cost. Email her at heather@activelifephysio.ca or phone 604.987.5433 for more information.
Orthopedic Cerebral Palsy Program... continued from page one

therapists. Protocols for hip interventions have been created to support therapists and will be available soon.

Botulinum Toxin-A

The use of botulinum toxin-A is effective in treating lower extremity spasticity in children with CP and, along with physiotherapy and orthoses, may improve gait and goal attainment.\(^1\) To maximize benefits from this treatment, it is essential that there be formalized goal setting, coordination of therapy services, and recording of outcome measures. The Orthopedic CP program PT and OT are working to create a process to ensure these steps are followed for all children receiving Botox at BCCH.

Transition to Adult Services

Families always have questions regarding the care of their children as they approach the age of eighteen. To support families and ensure continuous care, we are working with colleagues at GF Strong to develop a system to transition adolescents to adult services.

Unfortunately, we lack the capacity to care for all of the health needs of these children and must focus primarily on a child's orthopedic needs. Referrals to other specialists will be completed when indicated. If you have questions about the orthopedic management of a child on your caseload, would like to refer a child, or have questions about the program, please contact Stacey Miller, Orthopedic CP Program physiotherapist, at smiller4@cw.bc.ca.

References


Valuing your Services: the issue of fees

by Perry Strauss, BHScPT, MHA, Business Affairs Committee Chair

New PABC Fee Guidelines for 2011

PABC’s Business Affairs Committee (BAC) has just updated its recommended fee guidelines for core services offered by PABC members. They are posted on the Members Only Site at www.bcphysio.org. The information used to set the guidelines was gathered from clinic owners through two major surveys, the CPA 2009 Cost of Business Survey (COB) and the BAC provincial fee survey. The COB survey collected clinic financial information to determine the cost of running a business in each province, and then calculated a rate per visit that would produce a predetermined profit margin. The BAC survey completed in the fall of 2010 collected actual fees being charged for a wide variety of services.

The fee guidelines are used by third party payers and the PABC negotiation team to design contracts that capture the major fee models and average rates. PABC members use the fee guidelines to re-evaluate their own fee model and rates, and to gauge their costs and local market before making rate changes.

BAC has changed the guideline structure to better reflect the way in which services are being offered and to better reflect the cost of direct time with the client. Treatment fees are in a range of time periods, and provide the ability to quantify the cost per minute (the rate vs. the fee). This also allows third party payers to understand what they are paying for, particularly when the trend is for longer direct care visits and for complex treatment needs. Physiotherapists will be able to set rates for both predominantly direct care as well as for indirect care (e.g. supervised or independent therapeutic exercise in the clinic).

Fees

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<th></th>
<th>30’</th>
<th>45’</th>
<th>60’</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial visit:</td>
<td>$90</td>
<td>$135</td>
<td>$180</td>
</tr>
<tr>
<td>Treatment visit:</td>
<td>$60</td>
<td>$90</td>
<td>$135</td>
</tr>
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The new guidelines also address a trend of concern noted in the survey results: longer visits were charged at a lower rate basis (dollar per minute) than shorter visits. For example, the survey showed that the average initial visit of 40 minutes ($70 or $1.75/min) was charged at a lower rate than the 20 minute subsequent visit ($55 or $2.75/min). When adding in the administrative costs of the initial visit and associated reporting, the rate basis is even lower than for subsequent visits. Similarly, the survey showed that an extended visit of an hour was charged at a lower dollar per minute basis than a regular visit of 20 minutes. BAC cautions against this trend to undervalue the rate basis for longer visits because it suggests that the physiotherapist’s time is less valuable the longer they are treating.

A second area of analysis related to the difference between rural and urban rates for initial, subsequent and ICBC clinic surcharge. Based on our assumption of higher rates for rent in the cities (rent is the major expense in most clinics, next to wages),
we anticipated a significant difference in urban and rural rates. However, the difference was not as substantial as we anticipated.
- Initial visit fee: almost the same when considering the median fee
- Subsequent visit fee: 10% higher in urban areas
- ICBC clinic surcharge: 25% higher in urban areas

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<thead>
<tr>
<th></th>
<th>Urban</th>
<th>Rural</th>
</tr>
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<tbody>
<tr>
<td>Initial Median</td>
<td>$60</td>
<td>$59</td>
</tr>
<tr>
<td>Initial Average</td>
<td>$65</td>
<td>$62</td>
</tr>
<tr>
<td>Subsequent Median</td>
<td>$55</td>
<td>$50</td>
</tr>
<tr>
<td>Subsequent Average</td>
<td>$57</td>
<td>$54</td>
</tr>
<tr>
<td>ICBC fee Median</td>
<td>$25</td>
<td>$20</td>
</tr>
<tr>
<td>ICBC fee Average</td>
<td>$26</td>
<td>$25</td>
</tr>
</tbody>
</table>

What does the 10% difference equate to in dollars per month? Consider one physiotherapist seeing an average of 10 subsequent visits per day. At $5 more per visit, this is $50 more revenue per day, approximately $12,000 more per year. Depending upon the size of the clinic and compensation model for physiotherapists, one could see how a small change in subsequent fees can bring in substantial revenue.

Other notable numbers from the BAC survey:

<table>
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<tr>
<th>Service</th>
<th>Average</th>
<th>Time with Physiotherapist in Minutes</th>
<th>Rate $/minute</th>
</tr>
</thead>
<tbody>
<tr>
<td>Premium assistance clinic surcharge</td>
<td>$21 (+$25 MSP)</td>
<td>34</td>
<td>1.35</td>
</tr>
<tr>
<td>Extended fee visit</td>
<td>$87</td>
<td>54</td>
<td>1.61</td>
</tr>
<tr>
<td>Neuro fee</td>
<td>$76</td>
<td>50</td>
<td>1.52</td>
</tr>
<tr>
<td>IMS fee</td>
<td>$70</td>
<td>35</td>
<td>2.00</td>
</tr>
<tr>
<td>Acupuncture fee</td>
<td>$59</td>
<td>36</td>
<td>1.64</td>
</tr>
<tr>
<td>Other specialty fee (e.g. pelvic floor, hand therapy)</td>
<td>$90</td>
<td>52</td>
<td>1.73</td>
</tr>
</tbody>
</table>

The BAC survey also collected data on other services. Over 80% of clinics do not have rates specifically set for other services, suggesting that most clinics predominantly focus on core physiotherapy services. The most common other service was exercise supervision offered by a kinesiologist, exercise therapist, or personal trainer. Fees for this service ranged from $50 to $90 per hour, or a rate of $0.83 to $1.50 per minute.

Report writing fees were also collected. There was a lack of consistency in what constitutes a report, and the length of a report can vary greatly so that having set fees can limit flexibility. When respondents provided data to determine the time spent on the report, fees ranged between $100 to $180 per hour.

BAC recommends that clinics review their current fees in light of these revised fee guidelines. Specific consideration should be given to review the rates (dollar per minute) for the various fees. This may expose opportunities to improve revenue while maintaining a consistent fee. Be sure to make your time-based billing rate clear on invoices and receipts.

WorkSafeBC Negotiations

PABC’s current contract with WorkSafeBC for acute physiotherapy services expired on December 31, 2010. The PABC negotiation team (Marc Rizzardo, Rebecca Tunncliffe, and Perry Strauss) has been in talks with WorkSafeBC since the fall of 2009 attempting to craft a new model of care. The team has experienced delays and most recently a change in the WorkSafeBC negotiating team.

In December 2010, the PABC team presented our position on a number of improvements to the acute physiotherapy model to the new WorkSafeBC team. The recommended improvements reflect our dual goal of better injury management and support of an early and safe return to work. The major recommendations include primary access, market rates, and fees for communicating functional information with employers directly to support a return to work. Early access to injured workers will support improved functional recoveries (as with the management of athletic injuries). Collection of functional information that can be readily shared with employers will support appropriate return to work planning. We believe these recommendations are a ‘win-win’ for all parties. The recommendations are a result of best practice research completed by the PABC Back Strain Task Force back in 2007.

We expect to have an update on the progress of negotiations with WorkSafeBC shortly. In the meantime we will continue to provide services under the 2010 agreement.

In Memoriam

Maria Aleixa Haslam

It is with sadness that we announce Maria Aleixa Haslam’s passing on January 12th, 2011, following an 18-month battle with cancer. She was educated in the UK and a PABC member for over 40 years, operating Chinatown Physiotherapy Clinic in Vancouver for three decades. A champion for physiotherapy in Vancouver’s Downtown Eastside, she learned to speak fluent Cantonese to better educate, care for, and connect with her clients. She loved her profession and her role as a healer, working into her late 60’s. She will be missed by the physio community, and is survived by her husband, two children, and two grandchildren.
Evaluation of Rehabilitation Reference Center (RRC): A Point-of-Care Resource

by Deb Monkman, MLS, BSc, PABC Clinical Librarian

In the fall of 2010, courtesy of EBSCO, I secured a free trial of Rehabilitation Reference Center™ (RRC) for members to use in their daily practice, evaluate and report back on. I received an overwhelming 70 responses from you, from quick and dirty reviews to in-depth evaluations pointing out pitfalls and errors in the product (which have been passed on to the publisher). Overall the feedback was extremely positive, so I thought you’d like to know more about what excited your colleagues.

What is RRC?

RRC is an evidence-based clinical reference tool for use by rehabilitation clinicians at the point-of-care. As an EBSCO product, it can be integrated with our existing EBSCO databases, Medline and CINAHL, or with additional databases such as Rehabilitation & Sports Medicine Centre or SPORTDiscus, all of which support journal article searching.

What does RRC Contain?

RRC is designed to deliver current valid and relevant information at the point-of-care so that rehabilitation specialists can build customized treatment regimens for patients using the best available evidence. Our members’ top three picks were clinical reviews, exercise images and patient education. Drug information interested some members, while research instruments and books were of little interest, and news was of no interest. The great value of this product is that it’s an all-in-one, integrated source and, as one member said, “The rehabilitation bias is quite elegant.” The following components can be found in RRC, listed in the order in which members said they would use them:

1. Clinical Reviews – Summaries on rehabilitation topics incorporating the best available evidence through rigorous systematic surveillance, written by EBSCO’s team of rehab specialists
2. Exercise Images – More than 9,800 exercise images from Visual Health Information (VHI), along with a custom print feature that allows users to add personalized care notes as well as order and sort exercises based on a patient’s individual treatment plan
3. Patient Education – More than 1,500 patient education topics, many of which are quite general and medically-focused rather than rehab-focused. For example, some sheets say that physiotherapy may be recommended. The vestibular rehab sheet says that a doctor may prescribe exercises that can be done in the doctor’s office, but does not mention physiotherapists. A handy feature is the ability to email sheets to a patient.
4. Drug Information – Comprehensive drug information from AHFS, a US source for drug information, with over 11,700 drugs and their manufacturers
5. Research Instruments – Descriptions of research instruments, clinical assessment tools, psychological tests, attitude measures and more, with details on how to obtain the instrument. Instruments can be difficult to track down so this is a handy feature.
6. Books – Full-text of renowned textbooks and manuals, with manuals on modalities of greatest interest to our members
7. News – US-focused news was of no interest to members

Would Members Use this Product?

When asked whether they would use this product, the overwhelming answer was YES! The median and mean rating given was an eight out of ten. Even those who found drawbacks appreciated that “this is a unique approach to providing clinical recommendations along with the supporting evidence, patient education, suggested outcome measures and exercise illustrations.”

How Often Would Members use this Product?

When asked how often they would use RRC, on average members said they would use it weekly. One member recognized that “I can piece together similar information but it takes me way longer to find the information, which means I often don’t find the time. In a very busy day, minutes make the difference. This information is amazing to have at my fingertips. What a gift it would be to be able to access this information on a continual basis!”

What are the Drawbacks of RRC for Members?

Some members expressed concerns that information was incomplete, inaccurate, out-dated or not detailed enough for their specialty. Some comments about the pitfalls include:

- “There is not a great selection of paediatric exercise images, but what was there was good.”
- “For my specialties (lymphedema and incontinence), this particular site was there was good.”
- “I felt the summaries lacked depth with regard to physiology and pathology, although the list of contra-indications to certain treatments… was useful in a quick search.”
- “The exercises provided are quite basic, especially for hip and knee arthroplasty rehab”
- “I searched for total hip replacement exercise protocol… and did not find...”
a list of suggested exercises for each stage. There should be tons of info on such an easy topic.”
• “We are very focused on hand therapy so it’s not that useful for us.”
• “I looked up cerebral palsy hemiplegia and congenital muscular torticollis and it didn’t give me the detail that would be useful in my practice.”
• “I found the explanations good, the lists quite exhaustive, but the rehab advice vague and short on the conditions I searched.”

As an expert searcher, I look for clinically relevant information on behalf of members. I compared RRC to my usual ways of searching during the trial period. In most cases, I was able to find more current guidelines and evidence-based articles through our existing PABC resources than I could find in RRC. Finding exercise images and patient education on the Web took more digging on my part and was not always satisfactory. For now, I declare myself luke-warm on the product, seeing the great value of a point-of-care resource with excellent exercise images, but concerned that sometimes the best treatment guidelines and reviews may be found elsewhere.

Where Else Can You Find this Information?

Fortunately, much of this information is available to members through our existing resources. However, it is not as easy to access as it is in RRC. Many members will relate to this comment: “I find my search techniques for the other [PABC] databases not very effective at pulling articles that are clinically relevant for me.”

Members cited the following resources as their alternatives: PABC databases, PABC librarian, Google, Google Scholar, key websites in my specialty, commercially available patient education brochures, exercise software (e.g., Physiotec, ExercisePro), UpToDate, Medscape, books, journals, and colleagues.

Can You Find the Same RRC Information in the PABC eLibrary?

Here are some suggestions for finding similar information in the PABC eLibrary.

A handy place to start is under “Help”, where you can link to many physiotherapy websites and resources:

1. Clinical Reviews – while there’s nothing quite like this product written by EBSCO’s rehab clinicians, you can search Medline and CINAHL for practice guidelines, systematic reviews and meta-analyses. These and other databases are available in the PABC eLibrary and I provide regular training via webinars. Our knowledge broker also makes available guidelines, such as the recently developed guideline on safe mobilization.

2. Exercise Images and Patient Education – I have compiled a guide to exercise prescription and patient education resources, available in the PABC eLibrary.

3. Drug information – In addition to your print copy of the CPS, check out various sources of drug information in the PABC eLibrary.

4. Research Instruments – I can help you find research instruments. Most are not available for free but there is often information about them on the web or in research articles.

5. Books – Unfortunately we do not have access to books via the PABC eLibrary at this time. Instead, try searching the journal literature or the web.

6. News – There are many free Canadian and international health news sources on the web.

Will PABC Purchase RRC?

At this time, the cost of RRC puts it beyond our means and unfortunately EBSCO does not offer it to individuals. While we will certainly explore creative ways to purchase it, PABC already provides members with access to the eLibrary and clinical librarian’s services. The eLibrary gives all our members the same suite of evidence-informed resources and databases that health professionals practicing in BC’s hospitals and health authorities have through the Electronic Health Library of BC. My job is to help you find the kinds of resources you need for your evidence-informed practice, so feel free to contact me.

Open “Tools”, Click on “Librarian”

by Karen DeBorba

I recently discovered a PABC treasure. Where to start…? I have had the glorious life experience of choosing physiotherapy as a profession some 35 years ago. Fifteen years ago I moved to the rural community of Parksville. All the traditional therapies were well covered, but I knew that the key to success is to find a need and fill it. I have two current passions: paediatrics, with a focus on autism spectrum disorder (ASD); and pelvic floor rehabilitation. This story focuses on the latter.

Over the years I have found that my clients are more inconvenienced and isolated by fecal, rather than urinary, continence issues. In September of 2009, I had the good sense to attend The International Continence Society Annual General Meeting and Symposium in San Francisco. It was jaw-droppingly interesting. If you get a chance, I strongly urge you to look at John DeLancy’s keynote address*. He and his team are bringing the functional anatomy and physiology of the female pelvis into the 21st Century.

The ongoing melodrama of that conference — in effect an open cat fight among surgeons arguing the catastrophic history of mesh graft taping procedures to hoist up the urethra and bladder — was not enough to divert my full attention from some of the “fringe” sessions. At one of the poster sessions, I had a “eureka” moment: The young doctoral candidate was describing a cadaver dissection he’d done identifying a thin layer of smooth muscle running longitudinally along the anal canal. The probable function of this smooth muscle is to provide stability to the anal “chute” to allow rectal emptying.

That’s what had been missing in my educational program on managing fecal incontinence! There is too much detail to describe here, particularly, because I’ve been told it doesn’t make good mealtime reading. However, I came home with a full head of steam. I needed to find out more about this phenomenon.

continued on page 8

Directions

Winter 2011 • Members Make the Association
The Primary Therapist Transdisciplinary Model – Summary of Survey Results

by Kathy Davidson, MSR

Several months ago, the task force developing the Primary Therapist Transdisciplinary Model (PTTM) sought feedback from stakeholders via online survey on this proposed model for paediatric service delivery in British Columbia. As described in the original document (www.bcphysio.org Members Only Site/What’s New), our recommendation was to design a pilot study with the following goals:

- To identify supports required for and barriers to implementation
- To determine family and child outcomes (qualitative and quantitative)
- To measure direct and indirect time used by therapists practicing in this model

We discovered a range of reactions from participants in the survey when asked the following question:

The comments provided in the survey were analyzed using qualitative methods by an objective consultant, and four themes were identified:
1. The need for supports
2. Excellence in practice
3. Loss of professional identity
4. Alignment with current practice

More details about the subthemes and additional comments can be found in the summary document located on PABC’s Members Only Site. These themes and comments have helped the PTTM task force understand that while there is support for the model from some, there are also some ongoing misunderstandings about many elements of the PTTM. We need to continue to educate therapists on the model, to be available to address questions, and to continue to provide evidence on how the model can both enhance quality of service for our children and families, and improve job satisfaction for therapists. Our next steps include:

- Using these results to help in the design of the pilot. The stakeholder comments we received will help us design this study.
- Considering carefully how to communicate the PTTM to the Ministry, administrators and others
- Developing some education strategies to further explain the details of the PTTM to all stakeholders in order to eliminate misunderstandings evident in some of the survey responses
- Creating a plan for a pilot with MCFD support, and seeking out volunteer agencies to participate

We will continue to keep you informed as we move forward.

With support from: PABC, BCSOT, BCASLPA

PTs: Kathy Davidson (chair), Dianne Cameron, Margaret Warcup, Ka-Kei Yeung
SLPs: Kate Wishart, Melanie Houston
OTs: Jennifer Sexton, Susan Stacey
Knowledge Team Webinars: Winter/Spring 2011 Series

All new on-line interactive learning for PABC members, and free!! Join the Knowledge Team — Deb Monkman, Clinical Librarian and Alison Hoens, Knowledge Broker — for webinars on evidence-informed practice. Learn how to find, appraise and apply research to practice.

What is a webinar?
A webinar is a one-hour course held live online at the time specified. Participants are given a website to log into and can follow the presentation, ask questions through chat, and use interactive tools to communicate with the presenter or other participants. You will need high speed internet access and sound (computer speakers). A large screen for optimal resolution is highly recommended.

Time for all webinars below:
7:30 pm – 8:30 pm

February 2011

Anatomy of a Literature Search: PART 1 – Exploring subject headings for better results
Date: Thursday, February 10, 2011
Prerequisite: Intro for absolute beginners course or previous database search experience
In this one-hour webinar, learn how to find articles that are clinically relevant with EBSCO CINAHL & Medline — including hands-on practice time. Part 1 introduces you to the basic principles of searching with keywords and subject headings, Boolean logic, and managing your search results. Part 2 will be held one week later.

Anatomy of a Literature Search: PART 2 – Making searches even more relevant with limits
Date: Thursday, February 17, 2011
Prerequisite: Anatomy of a Literature Search Part 1 or previous database search experience
In this one-hour webinar, continue learning the anatomy of a literature search using EBSCO CINAHL and Medline

– including hands-on practice time. Part 2 continues with limits, setting up Alerts, and handy tips for more relevant physiotherapy searches.

March 2011

Journal Club: HIP PROTECTORS: Hard Shell or Soft Shell?
Date: Wednesday, March 16, 2011
Prerequisite: None
Join Alison Hoens, our clinical Knowledge Broker, with special guest Dr Teresa Liu Ambrose for this Journal Club presented online. Have you ever read an article and wondered whether it is ‘good enough’? Whether the methodology of the study, the stats analysis undertaken and the conclusions drawn are of sufficient quality to consider changing your clinical practice to incorporate its findings? Alison and Teresa will lead Webinar participants through the process of how to assess the quality of a randomized controlled trial and discuss the clinical application of the evidence.

April 2011

Finding Full-Text Articles
Date: Thursday, April 14, 2011
Prerequisite: Intro for absolute beginners course or previous searching experience
In this one-hour webinar, find out how to get full-text journal articles in the PABC e-Library, free on the Web, and from your Clinical Librarian.

May 2011

Journal Club: ACHILLES TENDINOPATHY: Eccentric exercise with or without LASER?
Date: Thursday, May 12, 2011
Prerequisite: None
Join Alison Hoens, our clinical Knowledge Broker, with special guest Dr Joseph Anthony for this Journal Club presented online. Have you ever read an article and wondered whether it is ‘good enough’? Whether the methodology of the study, the stats analysis undertaken and the conclusions drawn are of sufficient quality to consider changing your clinical practice to incorporate its findings? Alison and Joseph will lead Webinar participants through the process of how to assess the quality of a randomized controlled trial and discuss the clinical application of the evidence.

Register on the PABC website www.bcphysio.org under “Courses/Events” for these webinars:

• Feb 10 – Anatomy of a Literature Search Part 1 – Exploring subject headings for better results
• Feb 17 – Anatomy of a Literature Search Part 2 – Making searches even more relevant with limits
• Mar 16 – Journal Club: Hip protectors – hard shell or soft shell?
• Apr 14 – Finding Full-Text Articles
• May 12 – Journal Club: Achilles tendinopathy – eccentric exercise with or without laser? ♦

Kudos

Thanks for the KB tips, much appreciated! I’ll give it another shot before I ask the PABC librarian. What an amazing resource to have that I already forgot about so soon after graduation. DF

I feel compelled to write PABC to say thank you, after experiencing my first PABC Webinar. While I’m reasonably tech savvy, having never done a Webinar and I was a little put off by the idea. The motivator was that I really wanted to hear about the SAFEMOB guideline since I’m returning to acute care after a long absence, so I gave it a try, in the recorded version. First, it was easy (why was I worried?); second, the presentation made the document come alive; and third, I could split a one hour Webinar into three different sessions to fit my schedule (watched part of the Webinar at work during my lunch time, part while young children worked on homework, and part after they went to bed!). Best of all I could replay the section that had the material that was most relevant to me. It was free, it was easy, it was very useful. Thank you again for putting your educational content into a format that meets the needs of your members. SP
A Novel Role: The Physiotherapist Clinician-Scientist

PABC member Dr. Pat Camp was recently appointed as an Assistant Professor, Department of Physical Therapy, UBC, and a clinician-scientist, Providence Health Care James Hogg Research Centre. She is also the Head of the St. Paul’s Hospital Respiratory Rehabilitation Program. Her position is the first clinician-scientist appointment jointly supported by the University of British Columbia Department of Physical Therapy and the Providence Health Care Research Institute.

Dr. Camp received her physiotherapy degree from the UBC School of Rehabilitation Sciences in 1994. She went on to obtain her MSc in 1998 and her PhD in 2008. Her dream was not only to combine her passions in research and clinical practice, but to do so in an integrated and cohesive way. Prior to her appointment, physiotherapists who were on faculty either had to give up their clinical time or maintained their practice by working weekends or evenings. The vision was realized by the support and hard work of Dr. Brenda Loveridge and Dr. Jayne Garland of the UBC Department of Physical Therapy, Dr. Peter Paré and Dr. Bruce McManus of the James Hogg Research Centre, and Dr. Yvonne Lefebvre, the Vice President, Research & Academic Affairs, Providence Health Research Institute, which resulted in the creation of the position and Dr. Camp’s subsequent appointment on July 1, 2010.

As clinician-scientist and head of the Respiratory Rehabilitation Program at St. Paul’s Hospital, Dr. Camp directs the clinical care and research activities associated with the program, with Fiona Topp, PT. She envisions the creation of a ‘network of excellence’ of all the respiratory rehabilitation programs in BC, with ongoing engagement, training and support at the forefront. Her research interests focus on the diagnosis and management of individuals with chronic obstructive pulmonary disease (COPD).

Her current studies include:
- The analysis of administrative health services utilization data to investigate the epidemiology and health outcomes of COPD
- Gaps in the care of COPD
- Risk factors associated with hospitalization for COPD
- Optimal exercise prescription and the measurement of physical activity for COPD patients and other chronic lung disease patients in hospital and as part of a pulmonary rehabilitation program
- The development of clinical decision-making tools to aid in exercise and activity prescription

We thank Dr. Camp for inviting PABC to have a member delegate on her Consensus of Experts group working on a KT Synthesis project “Safe and Effective Parameters for Exercise in Patients with Acute Exacerbations of COPD.” Thanks to Beth Horniblower for offering to fill this role.

Dr. Camp is currently recruiting trainees who are interested in pursuing graduate studies in the UBC Rehabilitation Science Research Program. Interested applicants should email her at pat.camp@hli.ubc.ca.

ICBC Update

by Marj Belot, BScPT, MSc Biomedical Physiology and Kinesiology, FCAMPT, CAFCI, PABC-ICBC Liaison

After eight months on leave, our previous ICBC liaison has returned to work. Understandably, after such a long absence, communication has been slow.

Since my last report in October, several issues have been resolved:
1. ICBC brought forward a complaint about a PABC member who was not returning calls in a timely manner, billing for treatments beyond the number approved, and billing for unapproved treatments in the first 12. Rebecca Tunnahilf discussed the matter with the clinic owner who advised they have communicated with all staff to prevent such problems in the future.
2. A member complained that an adjuster was complaining about the amount of the surcharge the clinic was charging and stating they would not reimburse that amount. The adjuster denied doing so, but was advised by their manager that commenting on the amount of the surcharge was inappropriate and unacceptable. However, clients should be advised by the adjuster at the beginning of the claim that they may not get the full amount of the surcharge reimbursed as that is viewed as a special damage and is negotiated.
3. A member advised they would like to bill ICBC for hospital services but did not think they were able. ICBC advised that this is an issue with hospital administration and choice of software programs and that members should discuss this with their hospital administrators. ICBC is not averse to paying for these services as appropriate.
4. A member complained that manual billing to ICBC was rejected. Our ICBC contact confirmed the adjuster was following ICBC policy and that all billings aside from CL20s should be billed through the MSP Teleplan system.
5. A member reported that her revenue was lower than expected because she was treating multiple ICBC clients for which the clinic had agreed to accept a Direction to Pay from the client’s ICBC settlement. It is important that associates review their contracts closely and discuss such situations with the clinic owner to reach a fair resolution. In general, the business affairs committee advises against signing Direction to Pay agreements as it generally takes years to receive payments for such clients and the administrative costs of follow-up are high.

Recent unresolved issues that have been brought to the table by PABC include:

1. Equal representation of physiotherapists and chiropractors in ICBC communication with the public; currently the ICBC website is biased towards information regarding chiropractors.

2. ICBC continues to call supervised exercise programs “Active Programs” and an adjuster recently told a member that physiotherapists are not able to provide such programs; they thought only kinesiologists could do so.

We anticipate quick action on these issues in this new year.

Previous unresolved issues are:

1. Steps to ensure privacy when using email to communicate claims information between adjusters and physiotherapists and physiotherapy clinics

2. Adjusters directing treatment, e.g. recommending a conditioning program with a kinesiologist without consulting with the treating practitioners aside from the GP who, in some cases, works in a walk-in clinic and has poor familiarity with the client and their case.

3. We received multiple complaints that adjusters were unaware of the recent changes with respect to billing for verbal CL20s. Our ICBC contact told us that the bodily injury regional managers were to forward and discuss this information with each of their claim centre adjusting staff. The bodily injury regional managers are in their liaison claim centres weekly. As of late October, ICBC acknowledged that adjuster awareness of the issue continued to be poor and was working to improve it.

4. “Transformational change at ICBC” should improve fees, communication, and claimant, adjuster and physiotherapist satisfaction and outcomes; Rebecca Tunnacliffe is in regular communication with the decision makers in this process but has nothing new to report at this time.

Despite the chaos at ICBC in 2010, we did make some progress. We can now bill for verbal CL20s and it has been confirmed that a doctor’s referral is not required for the first 12 visits. We continue to communicate regularly with ICBC and are optimistic that when the dust settles changes at ICBC will improve the process for claimants, clinics and physiotherapists. We encourage patience; however, please do not hesitate to communicate your concerns, comments or questions to me at belotphysiotherapy@gmail.com or to PABC at info@bcphysio.org. Many commonly asked questions are answered on the PABC website.

Marj Belot earned her MScKin degree in December. She practices at West 4th Physiotherapy in Vancouver.

WorkSafeBC Liaison Report

by Jamie MacGregor, PABC’s WSBC Liaison

As this is my first contribution to Directions as the WSBC Liaison, let me take a minute to thank the outgoing liaison, Mr. Scotty McVicar. Scotty has been the WSBC Liaison for the past three years, with additional time spent on the Business Affairs Committee prior to taking the liaison seat. He has worked tirelessly on behalf of PABC members in dealing with all manner of WSBC concerns that arise. Most notably, Scotty held this position throughout the period of CMS phase-in. Those of you who used his services to have questions answered and issues dealt with in that time know that he was very diligent in representing our concerns, and effective at maintaining good relationships with contacts as WSBC. Scotty has always represented our members professionally and with pride, working hard to promote our profession while seeking to have our issues dealt with efficiently and fairly. I thank Scotty on behalf of our members for his hard work, and personally for his ongoing advice and support in my position as WSBC Liaison.

I would also like to thank the outgoing WSBC Physiotherapy Quality Assurance Manager Mr. Brian Lane. Brian was our contact at the board for two and a half years, again through the tumultuous period of CMS phase-in. Brian was a pleasure to deal with, and he always worked as hard to resolve the issues that we brought to him as we did. He will be missed as our board contact; however, we welcome him back to the world of clinical practice and wish him the best of luck in the New Year in his new position at Orion Health. In the meantime, until his position has been filled at WSBC, there is no acting QA Manager. Please forward concerns or questions to me at belotphysiotherapy@gmail.com or to PABC at info@bcphysio.org. Many commonly asked questions are answered on the PABC website.

New Business

A recent question posed by a member concerned the involvement of Disability Managers as employers’ representatives seeking information and communication about patients on WSBC-approved treatment. This issue raises questions regarding FIPPA, informed consent, differentiation between patient and funder, etc. and is likely to be addressed by the College and PABC in the near future. In the meantime, if you are contacted by a third party disability manager requesting progress reports, functional ability measures, etc. for a patient (WSBC claimant or not), make sure they have provided you with a SIGNED consent from the patient to release information. It is neither your role nor responsibility as the treating therapist to have your patient complete a blank consent-to-release-information form given to you by a disability manager, no matter how persistently they ask or what remuneration...
they offer. If you are questioned on this stance, refer the disability manager to the CPTBC Registrar for confirmation of this position. If you have been provided with a signed consent and choose to complete a progress note or perform functional testing, consider what you would typically bill for this type of reporting and establish an appropriate fee to be invoiced before doing so. This service is outside of the contract with WSBC at present, and should be billed directly to the third party.

Old Business

Over the past few months most questions from members have related to determining claim status, concerns regarding length of time to claim decision (and what to do with your patient while waiting), and (fortunately very few) concerns regarding longstanding unpaid invoices. The answers to many of these questions are found in our contract and the Reference Manual with WSBC. These and other useful links and information (such as a link to check claim status) can be found at www.worksafebc.com. Select ‘health care provider’ on the left, pick Physiotherapy, and you will find many helpful links.

Feedback from the outgoing QA manager and many claims managers has been consistent; greater knowledge of our contract by physiotherapists would greatly reduce the number of calls and questions they receive relating to procedures within the claims management process. It is our responsibility to know the contract, understand the stream system, and know the entitlements and responsibilities that come with treating in the various streams. As one case manager recently told me, calling a case manager five times to ask a question that is dealt with in the terms of our contract (i.e. there are no extensions in Stream 1) simply adds five call logs on to your list that have to be dealt with, does not increase the speed of a response, and does nothing to benefit the claimant. If your call is time-sensitive, it is recommended to leave a message with the case manager, and subsequently attempt to contact the team assistant.

Speaking of the contract...yes, our contract has expired. As many of you know from previous experience, while we await a new contract the old agreement remains in effect without changes.

Jamie MacGregor is a private practise physiotherapist, Certified Hand Therapist, and clinic owner/partner in Priest Valley Manual Therapy Centre in Vernon, BC. Jamie has been on the Business Affairs Committee for two years, and takes over from Scotty McVicar as WSBC Liaison. Contact Jamie with questions or concerns regarding dealing with WSBC at jm_macgregor@hotmail.com.

YOGA – Is it Safe and How Can We Feel Confident Referring our Clients?

by Katrina Sovio, Physiotherapist

Yoga is everywhere! As physiotherapists, many of us are being asked by clients, “Would yoga be good for me?” As a physiotherapist who also practices and teaches yoga, I am often asked by physiotherapy colleagues, “Is yoga safe?”

The entrance of yoga into mainstream culture in the west has come through the physical doorway. What we see now is a plethora of styles as more teachers have introduced their teachings to the west. Newly-opened teacher training colleges have begun churning out instructors, some with little more than a flexible body and a year or two of yoga practice to serve as the foundation on which to build their teaching career. Due to the short duration of these teacher training courses and the lack of anatomy background of many of the instructors, new teachers often complete this training without even a basic understanding of anatomy or injuries. Considering this, we have good reason to be concerned about what is happening in the yoga world and what our clients will experience when they enter a new or revisited yoga practice. Research shows many health benefits to incorporating yoga into daily living, including:

- stimulation of the parasympathetic nervous system through slowing and lengthening the breath, thereby rebalancing the over-activation of the sympathetic nervous system from the hectic pace of our modern lives
- increased body awareness as well as facilitation of acceptance and respect for limitations following recovery from illness and injury
- teaching people how to move with freedom and begin to work back into ranges of movement that may have been previously harmful but now need to be regained in order to return to their lives without constant fear of re-injury

These benefits translate into a healthier individual who is better able to respond to everyday stress, able to heal from injury and illness more efficiently, and less likely to suffer from illness in the future due to increased awareness of their healthy zone of stimulation and activity. Combined, these benefits make people less dependent on us and more capable of helping themselves. They are able to return for treatment because they can sense when they really need the help and guidance, not because they depend on it to function.

For most people, it is best to begin their yoga practice with a gentle hatha yoga class, with an educated teacher who is able to speak with them about their injury and offer appropriate variations. It is important for physiotherapists to be aware of studios that place the focus on the quality of the teachers and on small class size (such as the Studio at Treloar). As a therapist, I recommend trying a variety of classes and teachers yourself so that you have some experience with the practice of yoga. Developing a relationship with a physiotherapist or other health care professional who practices and/or teaches yoga is also beneficial in order to ask them for input on appropriate referrals.

I believe yoga has a real place for complementing our work in helping our clients to return to healthy, balanced, unrestricted lives following injury.

Katrina Sovio is a Vancouver-based physiotherapist and yoga teacher. She practices at both Main Street Physiotherapy and the Studio at Treloar Physiotherapy. ksovio@gmail.com.
Billing/Scheduling Software Programs in BC: A Closer Look  by Patrick Mayne, MPT, BSc(AT)

Most physiotherapy clinic owners agree that having a good scheduling and billing software program is vital to any successful clinic. In order to help members choose the right software program, PABC’s Business Affairs Committee set out to answer the following questions: 1. What software programs are PABC members currently using? 2. How satisfied are members with the programs they are using? 3. What features do the most popular programs have? 4. How do the most popular programs compare?

In a quest to answer these burning questions, Jesse Royer, our fantastic Member Services Coordinator, created an online survey which was distributed to clinic owners, asking the first two questions and requesting their comments on the advantages/disadvantages of these programs. I have compiled and analyzed the responses below. The findings discuss the four most used programs; interestingly the most popular program is not the most highly rated by the survey respondents. While we do not endorse any particular program, we provide the analysis below to help you choose the features best suited to your clinic.

What Software Programs are PABC Members Currently Using?

Of the 355 members (clinic owners) who received the online survey, 143 completed for a response rate of 40%. Based on the survey results, the most common programs used are: 1. Regent Healthcare Systems/SmartSeries Professional (50/143); 2. Clinic Master (20/143); 3. Clinic Essentials (14/143); and 4. In Touch Practice Management Systems (7/143). The chart above shows that the top four rated programs account for approximately two thirds of the software users, with approximately one third of respondents using Regent Healthcare Systems.

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In Memoriam
Peter Huijbregts
1966-2010

We are very saddened by the sudden passing of Peter Huijbregts of a heart attack on November 6th. Peter’s physiotherapy legacy is substantial, and he is well known and respected amongst his peers in BC, in Canada, and internationally for his research and clinical achievements.

Peter earned many professional credentials, including Masters degrees in Physiotherapy and in Manual Therapy, as well as a Doctor of PT. In addition to his practice at Shelbourne Physiotherapy, Peter taught extensively, was an active researcher, and was the editor of several national and international physiotherapy peer-reviewed journals.

Peter actively sought ways to support practice of his PABC peers. This message he sent to PABC in October is typical of the generous and thoughtful missives he regularly sent (you will see many of his publications on the Members Only Site):

I thought you might enjoy the attachment. Co-edited by yours truly. I also wrote 6 chapters in it with two other PABC members contributing: Carol Kennedy and Eri Pettman... Should be out late this year or early next year. (photo below)

Peter leaves behind two children aged 6 and 8 for whom his wife Rap has established an education trust fund. To donate in memory of Peter, send a cheque payable to: Rap Hayre, 1710 Oak Shade Lane, Victoria, BC V8S 2B2, memo: education trust fund.
How Satisfied are Members?
In order to determine the level of satisfaction of the users of the different programs and the features they provide, the online survey asked members to rate their level of satisfaction on a scale of 1 (worst) to 10 (best). The results are grouped and averaged in the table below.

SATISFACTION LEVELS OF THE FOUR MOST COMMONLY USED PROGRAMS
Based on Responses from PABC Clinic Owners in Online Survey

<table>
<thead>
<tr>
<th>Programme</th>
<th>Regent Healthcare Systems</th>
<th>Clinic Master</th>
<th>Clinic Essentials</th>
<th>In Touch Practice Management Systems</th>
</tr>
</thead>
<tbody>
<tr>
<td>N</td>
<td>46</td>
<td>16</td>
<td>11</td>
<td>5*</td>
</tr>
<tr>
<td>Overall Satisfaction</td>
<td>6.8</td>
<td>7.5</td>
<td>7.2</td>
<td>9.0</td>
</tr>
<tr>
<td>Cost/Value</td>
<td>5.8</td>
<td>7.8</td>
<td>6.3</td>
<td>8.25</td>
</tr>
<tr>
<td>General Customer Service</td>
<td>6.2</td>
<td>8.0</td>
<td>7.2</td>
<td>9.0</td>
</tr>
<tr>
<td>Training</td>
<td>6.2</td>
<td>7.6</td>
<td>7.4</td>
<td>9.2</td>
</tr>
<tr>
<td>Trouble Shooting/Support</td>
<td>6.4</td>
<td>7.4</td>
<td>7.3</td>
<td>9.2</td>
</tr>
<tr>
<td>Data Reporting/Statistical Analysis</td>
<td>6.0</td>
<td>8.1</td>
<td>6.1</td>
<td>8.4</td>
</tr>
<tr>
<td>General Ease of Use</td>
<td>6.7</td>
<td>7.9</td>
<td>7.3</td>
<td>9.4</td>
</tr>
<tr>
<td>Ease of Scheduling</td>
<td>6.4</td>
<td>7.8</td>
<td>7.3</td>
<td>9.4</td>
</tr>
<tr>
<td>Ease of Billing</td>
<td>7.0</td>
<td>7.5</td>
<td>6.9</td>
<td>9.2</td>
</tr>
</tbody>
</table>

* Note small sample size

What Features do the Most-Used Programs Have?
Below is a table summarizing some of the features of the four most popular software programs. The list is by no means all-inclusive, and we encourage you to review websites and contact providers for more information. Since only the top four programs are discussed here, and there are other programs on the market (e.g. Clinic Server), members are encouraged to explore those as well. Consult the PABC Members Only website for a complete listing of available software providers.

FEATURES OF FOUR MOST USED BILLING/SCHEDULING SOFTWARE PROGRAMS

<table>
<thead>
<tr>
<th>Programme/ Features</th>
<th>Regent Healthcare Systems</th>
<th>Clinic Master</th>
<th>Clinic Essentials</th>
<th>In Touch</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type</td>
<td>Windows-based</td>
<td>Windows-based</td>
<td>Windows XP, Vista and Windows 7</td>
<td>Windows-based, locally installed but accessible remotely via the web</td>
</tr>
<tr>
<td>Costs - Start Up</td>
<td>?? 0  0 0</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Monthly/ Annual</td>
<td>$780 for first practitioner, $480 for each additional (F/T or P/T) $120 admin fee</td>
<td>$150/ month for unlimited therapists (reduced rate for small/startup clinics)</td>
<td>Clinic + 1 practitioner: $75.00/month Add'l F/T practitioner: $25.00/ mo Add'l P/T practitioner: $15.00/ mo</td>
<td>$145/ site (includes up to 3 stations) Add'l stations: $15/mo each</td>
</tr>
<tr>
<td>Other</td>
<td>Extra charge for training</td>
<td>$150 Data Conversion fee Web-based training $695 (Optional)</td>
<td>Training: $500.00 - $1000.00 (extra charge for training if outside lower mainland) Data Conversion Fee: $125.00 - $350.00</td>
<td></td>
</tr>
<tr>
<td>Customer Service</td>
<td>On-site or web-based depending on clients requests. Available via phone, Internet and onsite (if needed). “Live” support available 5:00am-6:30pm PST, numerous self-help modules included</td>
<td>Live or web-based</td>
<td>Available via the Internet, remote access/telephone</td>
<td></td>
</tr>
<tr>
<td>Data Reporting</td>
<td>See website for details</td>
<td>Business stats, referrer stats, sales stats, patients stats, practitioner stats, trend analysis, revenue “hole” analysis, 4 tier referral analysis, marketing capabilities, Patient web surveys, patient newsletters and much more.</td>
<td>Most reports and patient data can be exported to Excel for analysis. Cost and length of treatment overall and per injury, demographic breakdown, injury to contact to assessment timing, clinical productivity, cancel/no-show rates and more.</td>
<td></td>
</tr>
<tr>
<td>On-line Booking</td>
<td>No</td>
<td>Available in March 2011</td>
<td>Scheduled for 2011</td>
<td>No</td>
</tr>
<tr>
<td>Automatic APPT Reminders</td>
<td>No</td>
<td>Yes. Via Email and SMS Text.</td>
<td>Yes</td>
<td>Yes. Via Email and phone.</td>
</tr>
<tr>
<td>Electronic Medical Records</td>
<td>No</td>
<td>Yes. Typing, talking (integration with Naturally Speaking), handwriting using digital ink tablet PC's. Automated form filling (WCB Reports, insurance forms, doctor letters etc) Scannable forms</td>
<td>No</td>
<td>Yes. All images (e.g. X-rays, scanned intake forms, etc), reports &amp; documents regarding each client are stored directly within the client record for easy access.</td>
</tr>
<tr>
<td>Linked With Exercise Software Programs</td>
<td>No</td>
<td>Yes, linked with Physiotec (additional cost)</td>
<td>Yes</td>
<td>Yes. Extra cost depends upon arrangement with the Exercise Software provider</td>
</tr>
</tbody>
</table>

continued from page 13
How do the Programs Compare?

The four most-used programs are compared below. Please note that the discussion is based primarily on member responses from the online survey.

As Regent Healthcare Systems is one of the older programs, it is no surprise that there are so many users and that it is so established in the industry. This is definitely an advantage since many receptionists are familiar with the program; one member even said that it is “part of standard MOA training”, which would make staff training easier. Survey respondents commented that the program is “easy to use” (rated 6.7/10 in the Satisfaction Levels table). However, members also mentioned there are “lots of random glitches”, “errors occur frequently” and that the “system crashes frequently”. Several mentioned that customer service is poor (rated 6.2/10) with “slow trouble shooting response time”, “too long to wait to get help” and “no live help when you need it”. Some members complained about limited data extraction/ statistical analysis capabilities (rated 6.0/10) and that these features were “not easily customizable” and “extra costs are associated with more detailed analysis”. A few members mentioned that “the program seems antiquated” and “not recently updated”. There were several comments from members saying that they were glad to have switched to other programs.

The second most popular program, Clinic Master, scored very high on all of the categories in the “Satisfaction levels” survey. This program is a clear winner in the customer service department (rated 8.0/10) with comments from members including, “quick response times”, “professional support”, “great at customer service and anticipating our needs in BC”, “support is quick and readily available” and “owner genuinely cares about product/ service…..uses client feedback”. PABC members consider the statistical abilities (rated 8.1/10) of the program an asset with comments such as, “good/in depth statistics”, “variety of reports available” and “ease of reporting”. The special features of the program, such as electronic charting, a link with Physiotec, marketing tools, e-blasts and online modules, all appear to be popular. Comments from members appear to support the company’s claim that “evolution in our product and service is lead by client feedback so that we are able to respond to the ever changing technical community in which we live”. They also claim $400K are invested annually in new features and development. Several PABC members are not only happy with this program but recommend it to others. The main perceived disadvantage of the program is that there are “too many variables when dealing with stats (a little overwhelming)” which might scare away less techno-savvy operators or those seeking a simpler program. Although several users reported “(it is) challenging keeping up with the frequent changes”, they did note that the changes made the program better in the end.

Weighing in at number three is Clinic Essentials. The main advantage of this program is that it is simple (rated 6.3/10 for general ease of use) with an “intuitive design”, “screen layout is easy to see”, “minimal entry info required per patient”. Members commented that “basics are easy to learn”, “quick and easy to train new staff on”, “billing screen easy to understand”. Customer service was rated highly (7.2/10) with comments including, “readily available”, “on top of any glitches anytime we call”, “staff assist in building reports etc. when appropriate”, “excellent service and cooperation”, “the program developer is very willing to work with you to fix/create options that we suggest”. One member said, “I would not change programs without a very good reason at this point”. Users complained about data processing capabilities (rated 6.1/10) including, “not customizable”, “reporting is limited”, “Can’t track patients into subgroups”, “printed PT’s schedule does not identify ICBC, MSP”. Members commented on problems with billing including, “repetitive ICBC billing and rebilling”, “no ‘re-bill all’ function”, “visit count not accurate for ICBC - areas are counted as a visit”, “doesn’t allow specific types of patient counts based on the way each clinic has it set up for billing e.g. how many patients are billed at the student rate, etc.”

In Touch Practice Management Systems ranked fourth as the most popular program. Although this program scored the highest in all categories in the member satisfaction survey, only five members reviewed this program, decreasing the power of the results. Members appeared satisfied with the reporting abilities (rated 8.4/10) with such comments as, “reports are clear and useful”, “month end reports are easy to do”, “good stats”, “admin reports are wonderful tools and information is produced clearly” and also “collects more data…useful for future marketing”. There were also several good comments about the quality of customer service (rated 9/10) and “In Touch always wants to know about (problems) so they can constantly improve the program”. There were not many disadvantages reported by members but members did comment “additional costs for additional workstations is costly” and “a fully functional chart creation tool would be a very good resource to detail marketing and administration reports”. All in all, this program scored high and there was lots of positive feedback.

In conclusion, the clinic owner respondents rated a good scheduling/ billing software program as being quick and easy to use, cost effective, having good customer service and most importantly meeting the needs of the user. The most popular program may not be the best fit or even be the most highly rated, so do your research, find out what best suits you and your clinic’s needs and contact the software providers to arrange a consultation and free demo.

Patrick Mayne graduated from the physiotherapy program at University of Western Ontario in 2008. He moved to BC to begin his practice in Victoria at CBI Westshore. He has completed Level 3 in Manual Therapy and is the head therapist for James Bay Men’s Premiere Rugby. Patrick joined the BAC in September 2010.

BAC thanks Peter Curtain, Dunbar Physiotherapy, for his suggestion that PABC look at software billing systems. Peter was given the first peek at Patrick’s article and said, “It was the most interesting physio article I have read for a decade.”
Unique Opportunities in Public Practice

by Chiara Singh, BScPT, Acting Chair, Public Practice Advisory Committee

When I graduated from UBC many years ago (in fact I was shocked to calculate it was more than 13 years ago), I set out to find my place in public practice. I was happy to find a job as a casual physiotherapist at Surrey Memorial Hospital and have remained happy and proud to work as a physiotherapist at the hospital ever since. Way back then, I saw only two main positions for physiotherapists. You could either be a regular, clinical physiotherapist, or you could be a Section Head/Clinical Practice Leader. There may have been other options out there at the time, but I didn’t know about them or hear about them. Fast-forward 13 years and the landscape in BC is now much different. Sure, we may still have a flattened system with the union, but physiotherapists are pushing the boundaries and using their skills in unique ways. There are now more physiotherapists in leadership positions, professional practice positions, and in research and education within the health authorities. Health authorities are starting to recognize that physiotherapists are not only valuable for their clinical practice, but also have a wide range of skills that can be put to use in other forums. In this way, physiotherapists are becoming integral in the planning and development strategies of health care.

I had the opportunity to ask a few of the PABC members currently working in some of these unique positions a number of key questions to understand what brought them to where they are and how they are using their physiotherapy skills. Here are some comments from: Phil Lawrence (PL), Director, Seniors Program, VCH-Coastal; Pat Camp (PC), Assistant Professor, UBC Department of Physical Therapy, Clinician-Scientist, UBC James Hogg Research Centre, Head, St. Paul’s Respiratory Rehabilitation Program; and Scott Brolin (SB), Director, Rehabilitation and Allied Health, FHA.

What led you to your current position?

PL: I have been in leadership positions in healthcare since 1994. I went back to school in 2000 and graduated from UBC with my PT degree in 2003. I then worked part time in a clinic and part time in a leadership position until 2007 when I became the Practice Leader for PT in Vancouver Acute. I started my current job in September 2010.

PC: I received my physiotherapy license in 1994, completed my Master of Science degree in 1998, my PhD in 2008 and my postdoctoral fellowship in 2010. I did work as a physiotherapist on and off while doing these other degrees. My new position was possible through the mentorship and advocacy of many individuals, including my PhD supervisor, Dr. Peter Paré, who encouraged the powers-that-be to create this clinician-scientist position.

SB: For me it was about having the opportunity to help patients by helping the system. The jump to a practice leader role in a tertiary hospital gave me the opportunity to develop my skills at advocating for change, which ultimately opened up other opportunities to work on a regional level on projects that improved the delivery of rehabilitation across our network of hospitals. Now, as a Director, I have the chance to lead improvements in inpatient and outpatient rehabilitation programs and also in strategic initiatives related to physiotherapy in acute programs. I am fortunate to be able to look across the whole system to see where we can influence better outcomes for our patients through a stronger profession.

What are some challenges you find in your current position?

PL: The balancing act of making progress on the big projects/changes I’m leading and being timely in my responses to the high volume of day-to-day requests/commitments (e-mail, voicemail, meetings, etc.).

PC: 0.20 of my appointment is clinical. I am the head of the respiratory rehab program at St. Paul’s. I see patients in this role, but also am charged with administrative issues and ongoing improvements and expansion. My physiotherapy skills have also helped me with the clinical research skills, as I am working with patients in a research capacity as well.

SB: I still think of myself as a physiotherapist. I have come across other leaders who happen to be physiotherapists and they introduce themselves as ‘used to be a physio’. I still approach my work on the system as I would on an individual patient. I gather what historical information I need to form a subjective assessment of the part of the system I am focusing on, gather what data I need to validate this (my objective assessment), I form opinions about what the problem list is and develop an intervention plan to make changes, which I augment along the way, depending on my ongoing assessment. It may sound like a stretch to say that I am still using my physiotherapy skills in an administrative role, but I see this as a key advantage that the physiotherapy perspective brings to health care leadership.

What physiotherapy skills do you find valuable in your current position?

PL: I draw on my clinical experience all the time (and still have a small caseload).
PC: It is challenging juggling teaching, clinical work, doing my research, supervising students, writing grants and writing papers. The key to success in this position is having your research published, and it takes money to get your research done, so a lot of time is spent writing grants. Unfortunately, most of the applications one writes do not get funded so even though they take a lot of time, the chances of getting funded are less than 50%.

SB: Time — this is my biggest challenge. I spend a great deal of time in meetings, leaving precious little time to get all the work done. Of course there are always the financial pressures that limit some of the possibilities for the professions I am responsible for and I fear I will never have enough time to do all the things I want to do, but that is also the interesting part — finding ways to get as much accomplished as possible with the resources available!

What do you find most rewarding about your position?

PL: Each time we make a change that enhances the services we provide to seniors across Coastal Health.

PC: I love the freedom of being able to decide what research questions are exciting to me. I love seeing a clinical problem and knowing that I have the capacity and the independence to find a solution. I love being in charge of the rehab program and thinking about and implementing novel ways to deliver care. I love trying to integrate research into clinical practice and developing a true academic clinical program.

SB: I continue to be inspired by the amazing people I am surrounded by and have the fortune to work with, many of whom are physiotherapists. I am encouraged that PPAC’s recommendation that PTs take on leadership roles appears to be slowly becoming realized. There is an increasing number of physiotherapists in senior leadership roles in health authorities, in middle management and of course the amazing capacity among our clinical physiotherapists to step up to just about any challenge to come up with a creative solution.

Do you have any advice for physiotherapists looking to transition to a role like yours in the future?

PL: Get involved in some way, as part of your current job, to see if you’re interested in leadership and what type of role interests you. Speak to people in leadership positions to see what it is they like about the work, again to get a sense of what the work is really like. Leadership positions can require a Masters degree related to leadership e.g. MBA, MHA, Masters in Leadership etc. If you are interested in going back to school do lots of research before selecting a degree, including talking to people in the industry/sector you are interested in, so you know which degree/schools they are familiar with.

PC: My role requires advanced graduate degrees and research training, but any PT can get involved in research, from creating a journal club, collecting information for a quality improvement project, collaborating with researchers on a project, or beginning an online or in-person graduate degree. I would be happy to talk to motivated physios about opportunities. It might require an appreciation of research within your department so you can get an hour or two a week to engage in these activities, or else you might need to do some of it on your own time. All depends on your level of interest. You can email me at pat.camp@hli.ubc.ca to discuss!

SB: Don’t wait for ‘more experience’ before you could take on a leadership role. I have seen PTs with amazing capacity for leadership who could easily step into professional leadership or into management. However, I often hear: “Oh, I don’t have enough experience yet” or, “That’s stepping a little too far outside my comfort zone.” Every time I have stepped into a new role, it has always been at a stretch of my past experience, often skipping a level or two in the traditional hierarchy. But we physiotherapists need to be bold and courageous, and take the steps necessary to improve our system to optimize the outcomes of our patients. We are specifically prepared for this role. There is such satisfaction in knowing that changes made affect all the patients that come through the system. It is a skill that physiotherapists are specifically prepared for. The other thing is to find a good mentor. I have lots of people that I draw on for support. As (motivational speaker) Frank C. Bucaro said, “Don’t wait for someone to take you under their wing; find a good wing and climb up underneath it.”

Chiara is the Clinical Supervisor (Mat/Child/Youth and Surgical Program) at the Rehabilitation Services Department-Physiotherapy, Surrey Memorial Hospital.

The Central Interior members held a regional lunch meeting last month.

Wallace Ross of Invermere was in Vancouver as PABC’s delegate on BCMA’s MSK practice committee. Lori Janzen of Terrace is PABC’s delegate on BCMA’s MSK patient committee.

Judy Russell is the Physiotherapist for the Women’s National Soccer Team, shown here in November with Christine Sinclair (L) who kicked the winning goal at the FIFA World Cup qualifying event in Cancun. They head to Germany this summer for the World Cup.
Physiotherapists and Orthotists Working Together – A Success Story

by Veronica Newell, BScPT

Earlier in 2010, I was part of a task force related to funding for orthotics for children with disabilities in BC. At that time, the editor of Alignment, the publication of the Canadian Association for Prosthetists and Orthotists (CAPO) was looking for a follow-up article related to orthotists working with physiotherapist, and my name was suggested as a possible author. The following is a modified version (rewritten for PABC readers), but with the case study unchanged, and the same message. I hope you enjoy the read, it was quite a nice experience to submit the article.

Potential partnerships
As a physiotherapist, do you frequently see clients with orthoses? Have you wondered whether changes to the orthotic supports could significantly impact the client’s gait or other skills? Have you asked yourself whether you should be changing your treatment program to facilitate the success of a new orthosis? As PT’s, we work very closely with occupational therapists and other physiotherapists who manufacture devices for our clients, but we sometimes forget our orthotist partners. Across Canada, there are examples of cutting-edge solutions created by teamwork between an orthotist and a physiotherapist.

Billy’s story
Billy (name changed for privacy reasons) is a five-year-old boy in kindergarten. Like his peers, he is excited about school and new friends, he is keen to try new activities, and he has a wonderful smile. Billy has cerebral palsy, and has complex needs, including equipment and orthoses for mobility. Billy goes to school in Surrey, BC. He has an orthotist named Lourdes da Silva (“Lou”) at Valley Orthocare Ltd. and a school physiotherapist named Valerie Poirier (“Val”), who works at The Centre for Child Development.

Billy has cerebral palsy (spastic triplegia) affecting both legs and his right arm. Overall, the right side of his body is more impaired. He has great cognitive abilities and wants to be as independent as possible. Before starting kindergarten in the fall of 2009, Billy wore a right solid ankle-foot orthosis (AFO) and a left supra-malleolar orthosis (SMO). The purpose for the right solid AFO was mainly to provide stability to that foot and ankle for weight-bearing, as this side required significant support. For his left, an SMO had been adequate, as he had good ankle control and needed mainly foot and heel positioning. He was walking short distances using a posterior walker, a Rifton Pacer with forearm supports, which had been set up by his physiotherapist.

As Billy started using his walker more, his team noticed his left SMO was no longer holding his foot and ankle position adequately. Shortly after starting kindergarten, Lou made Billy a new hinged AFO to replace his SMO. With his new hinged AFO on the right, Ultimate started to move with improved stability and a better base. He started cruising along furniture in the classroom. He was practicing independent standing for action-based songs during class, with a teacher behind for safety. Rather than just short walks in the class, he was using his walker over longer distances in the halls. Val, his school physiotherapist, continued to progress his program and set new goals. Billy and his parents were thrilled with his progress.

Every parent remembers the moment their child first started to walk unsupported. For Billy, this time finally arrived in the late fall of 2009, at 5 ½ years old. His family and team were ecstatic. Billy was walking short distances on his own! Val reassessed Billy at school, and found that he was now ready to be working on skills requiring more ankle mobility, such as getting up and down from the floor, and climbing stairs. Based on these activity goals and the need for more ankle mobility, Lou created an articulated AFO for his right leg, so that he would now be in a pair of hinged AFO’s. Billy’s parents were pleased that the team was so responsive to their son’s needs, as his body and skills continued to change rapidly. Once Billy received his new hinged AFO, he was able to dorsiflex both ankles for squatting, half-kneeling, climbing and descending stairs.

When Val most recently reassessed Billy in March 2010, he was getting up off the floor independently, without using his hands. He was moving with improved balance and speed. He has even started to jump! His success and joy is shared with his family, his classmates, his friends and his team.

Working together
Billy and his family were fortunate to have landed on the caseloads of an orthotist and a physiotherapist who know each other and are experienced in working together. They are committed to teamwork, and find that the solutions arise more quickly when they share their knowledge and their goals. Val says she likes working with Lou, because of the shared problem-solving. “Sometimes Lou will ask me a question about a client, and I’m able to give her information about what’s happening with the orthotic at home and at school. Sometimes I contact her, because the child is having difficulty with tolerating an orthosis, or other problems. The communication works both ways.”

From Lou’s perspective, working with clinical physiotherapists makes her job easier. “When working with physiotherapists, they can see functionally what is working and what is needed next, and then we can figure out how to make that happen… We (orthotists) have such limited time with patients… once every six months at most, whereas the physiotherapists observe them more often to see how the braces are functioning.”

— Veronica Newell, BScPT

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Val and many other physiotherapists have enjoyed working closely with orthotists over the years. The physiotherapist is able to share the specific goals that the client is working toward, in consideration of the orthotic devices available. The physiotherapists are often able to tell the orthotists what happened after the patient was given a new device. For example, when given AFO’s, the child may have somewhat better gait, but can no longer descend the stairs at school. Or perhaps they now have difficulty getting up off the floor or crawling to play with toys. Some of these impacts on activity are preventable through team problem-solving when devices are designed. Others can be recognized shortly afterward by the physiotherapist, and brought to the attention of the orthotist for correction. As Lou says, “It’s a very collaborative effort when you’re approaching the needs of a patient.” Related to pediatrics in particular, she states, “I like working with physiotherapists because they can relay to me what needs to happen as the child is developing. This allows for a more comprehensive assessment.” Val has also seen the success of teamwork, and says that when the orthotist and the PT work together, “the client is happier, the goals are more likely to be met, and the product is more likely to be used.”

From a professional point of view, the two professions share many common values and goals. The website of CAPO (Canadian Association for Prosthetics and Orthotics) shares much language with the website of CPA (Canadian Physiotherapy Association). Both professions seek to assess movement, to understand problems related to the body, and to create solutions that will improve mobility and minimize the impact of impairment. Working separately, each can achieve results for a patient. Working together, they can achieve results faster with more options along the way.

Aside from the clinical richness that comes with a multi-disciplinary approach, there are some additional benefits to the physiotherapist of a good working relationship with local orthotists. Orthotists may be a great source of referral, and can help to identify appropriate clients. Good teamwork and communication will encourage knowledge transfer and improved practice for both the PT and the orthotist.

How to make it work

In order for PTs and orthotists to work successfully together, a few suggestions may go a long way toward a lasting professional relationship.

1. Spend some time to build rapport with orthotists you encounter, particularly if you are likely to share multiple clients.
2. Gain a better understanding of what the orthotists do. Ask them about their experiences and any areas of specialty.
3. Ensure you know how to refer to each other, and what modes of communication work best.
4. If you are problem-solving around a specific complex client (e.g. neurological client with history of orthotic intolerance), you may want to consider attending an orthotist appointment with your client. If this is not possible, make phone contact and talk about the role of orthotics. Always ensure you have proper consent from the patient to communicate about them to the orthotist.
5. Make sure that the client is able to share PT goals with the orthotist, or that you can assist with this communication. These goals will frequently be mobility focused, and may impact the decision of what product to design. Is the goal related to stability and balance? Is the goal related more toward symptom relief? Or perhaps stability is going to be sacrificed slightly, if the goal is more related to movement in a variety of positions.

6. Consider frequent quick communication with the orthotist, as questions and problems arise. These moments taken to share information and question each other can save time in the long run.

As health care teams continue to strive for best practice in ways that are cost effective and efficient, take a moment to consider the role of your patient’s orthotist. This professional can work with you toward a greater understanding of what is happening in the life and body of your patient. It is exciting to watch client goals being more rapidly met through teamwork related to orthotic intervention. Together we can solve problems, help each other, and create new potential.

Veronica Newell is the Director of Physiotherapy at Surrey’s Centre for Child Development. We thank her physiotherapy colleague David Dalley for alerting us to the Alignment article, which Veronica kindly agreed to rewrite over Christmas for PABC. ♦

MPT Student Convocation

The class of 2010 graduated into our profession in November. At the reception, PABC ‘pinned’ each grad with a nametag with their new title, Physiotherapist. (see photo page 25)

PABC Awards were also granted to:
• Bradley Jawl: PABC Prize (highest standing in case-based course)
• Ryan Hill: PABC Leadership (has contributed to the profession in a unique and innovative way)
• Jonathan Coelho: Amanda Reid and Rick Hansen Award for promoting the profession.
Effective practice is inextricably linked with safe practice. Continuing education, however, typically tends to focus on effectiveness — learning about which interventions are effective — and significantly less attention is paid to learning about safe practice. The importance of increasing the emphasis on safe practice cannot be overstated; even interventions with proven effectiveness can be inappropriate to use if there are issues related to their safety. Up-to-date awareness of and adherence to both contraindications and safety regulations are critical components of competent practice.

Arguably, the use of electrophysical agents (EPAs) (ultrasound, low light laser therapy, transcutaneous electrical nerve stimulation, hot packs, ice etc.) is one of the most relevant areas of PT practice wherein education regarding safe practice is as important as education regarding effective practice. In November 2010, all CPA members received a special issue entitled “Contraindications and Precautions: An Evidence-Based Approach to Clinical Decision Making in Physical Therapy” with their fall edition of Physiotherapy Canada. This resource, written with my co-authors Dr. Pamela Houghton (University of Western Ontario) and Dr. Ethne Nussbaum (University of Toronto), provides clinicians with an evidence-informed guide to safe practice. Compiled from over 300 references, this unique resource provides clinicians with information and recommendations on the contraindications and precautions for EPAs in four important areas:

1. Consensus of experts: A summary of the consensus of eight North American experts and the recommendations from the expert-informed guidelines of the Australian Physiotherapy Association and the Chartered Society of Physical Therapists.
2. Serioness of potential adverse reaction: Information regarding the most plausible degree of adverse reaction
3. Rationale: The physiological rationale for each contraindication and precaution
4. Research evidence: The level of evidence supporting each contraindication and precaution

Members are encouraged to consult this resource to answer their clinical questions regarding safe application of EPAs. The key information required to decide whether it is safe to use EPAs in the presence of conditions such as malignancy, pacemakers, impaired cognition and impaired sensation is easy to find in user-friendly tables. Please take the time to familiarize yourself with this important resource.

A terrific example of safe practice related to safety regulations for EPAs was recently published in the Interior Health Knowledge Translation Casebook 2010. PABC member Anita Olsen, Manager of Rehabilitation Services in Shuswap, provided a detailed description of the process that Interior Health underwent to determine whether they were meeting the required standards of practice for application of LASER (see page 22). An audit of six acute care facilities of practice for application of LASER resulted in a temporary ban on the use of LASER until a number of criteria could be met including institution of appropriate policies and procedures, development of checklists and the use of maintenance logs. The final outcome was safe practice for the use of LASER in this health authority. Well done!

The take-home message of both these publications is clear. Safe practice, particularly for use of EPAs, is required for effective practice.

Knowledge Broker Projects Update

2010 was an incredible year and chances are 2011 will be even better! Here is what was accomplished and what you have to look forward to in 2011.

TJAOM - Total Joint Arthroplasty: Enhancing use of outcome measures.
PABC’s Phil Lawrence, Fatima Inglis and Tracy Wong, together with Susan Carr and Greg Noonan, completed a chart audit to identify what PTs document about their use of outcome measures in total knee arthroplasty, across the spectrum of prehab, inpatients, outpatient, and rehab settings. The results are posted on the PT KB webpage.

Maureen Duggan undertook a focus group exploring the barriers and facilitators for the use of outcome measures in TJA.

The group working on the survey exploring how PTs use outcome measures in TJA is currently analyzing the data from the survey and will soon be writing up the results for publication. An inventory of outcome measures, with information on what part of the continuum of care they are appropriate for, is available on the PT KB webpage. The survey group consists of PABC’s Dave Troughton, Catherine McAuley, Marie Westby, Maureen Duggan, Irene Goodis and Dr. Darlene Reid, together with Ronda Field, Wendy Watson, and UBC MPT students Danielle Balik, Andrea Voros, Lauren Welch and Veronica Naiing.

SAFEMOB – Safe mobilization of the acutely ill patient

PABC members Drs. Darlene Reid and Elizabeth Dean, together with Frank Chung, Simone Gruenig, Rosalyn Jones, Jocelyn Ross and Maylinda Urbina, with input from clinicians across BC, developed a two-page tool to assist clinicians in identifying what to assess, when to consider not mobilizing, what to monitor and how to progress mobilization of the acutely ill patient. This tool was supported with a webinar presented by Rosalyn Jones (recorded and available for review) and
with an inventory of other resources to help clinicians make decisions regarding safe mobilization in acute care settings.

**Skin & wound prevention, assessment and treatment**

All PABC members received post-it notes in the fall with the logo “PTs and Skin — We’ve got you covered.” In addition, an education session for wound healing (Theory and Application of the use of Ultrasound and Electrical Stimulation) is recorded and available on the PABC website. An inventory of other resources (websites, articles etc.) has also been posted on the website to support this area of practice. Kudos to the team for its great work (PABC’s Nancy Cho, Rochelle Graham, Sarah Rowe and Michelle Jacobs, together with Leah Keiffer, Rebecca Packer, Leslie Hopkins, Emily Motyka, Heather Newsome, Angela Ng, Sondra Ng, Oksana Peczeniuk, Devon Tyler & Fiona Wright).

**Wheelchair provision in progressive neuromuscular disorders**

A team of PTs and OTs (Lori Roxborough, Janice Evans, Cheryl Sheffield, Debbie Scott-Kerr, Maureen Story, Susan Garret, Lorelyn Meisner, Shannon Sproule, Roslyn Livingstone, Sara Pike, Susan Stacey and Catherine Husken) is continuing its work on updating guidelines on the provision of wheelchairs across the lifespan in progressive neuromuscular disorders. Stay tuned for the completed project in 2011.

**AECOPD - Safe and effective exercise prescription in acute exacerbation of COPD**

Dr. Pat Camp is leading a team, including Dr. Darlene Reid, Beth Hornblower, Frank Chung, and UBC MPT students Paolo Macapagal, Debbie Kan, Colin Beattie, Taz il Yoon, and Param Bakshi, to develop the recommended parameters to ensure safe and effective exercise prescription in acute exacerbation of COPD. The two-part project includes a systematic literature review and a Delphi process to develop consensus from a blinded group of stakeholders. The team is busy with the systematic review and will start the Delphi process with academics, clinicians and patients in the New Year.

**Other great opportunities**

Several educational opportunities were presented and recorded, including recordings of presentations by international speakers on the topic of cancer rehab (available on the PABC website). In January, March and May we will use the popular webinar format to present a series of journal clubs. Join us from the comfort of your own home! (for more details, see the article by librarian Deb Monkman in this newsletter).

In conjunction with the Public Practice Committee, we are collecting and will soon post clinically relevant practice information such as summaries of the literature on stretching, range of motion, icing, etc. Please feel free to send us any information that you find particularly useful which may help your colleagues.

Finally, don’t forget to check out the Research Collaboration Registry. Approximately 100 PTs have registered themselves as potential research partners (academics, clinicians and decision-makers) in various practice areas (i.e. cardiorespiratory, orthopaedics, neurology, etc.).

A big thank you to all those who have been involved with the above projects and resources. If you haven’t yet had the opportunity to be involved, 2011 can be your year — feel free to contact me anytime at alison.hoens@ubc.ca!

**Safe Handling of Patients: Guidelines**

*by Tanya Kessling, BMR PT SHOP Task Force Chair*

Did you know that one in six physios changes work settings or leaves the profession due to work related musculoskeletal injuries? [1]

Yikes! In my previous position as MSIP Advisor with VIHA I was regularly shocked with statistics of injuries related to patient handling. As physios, we are passionate about helping others, and it seems this has put us at risk for injuring ourselves. With the help of Rebecca Tunnadiffe and Alison Hoens, I decided to create a PABC task force to develop strategies to help members prevent injury to themselves during patient handling in facilities. The SHOP (Safe Handling of Patients) task force has been working together since September with two main goals:

1. To build awareness of the risks of patient handling. The objective is to help members identify tasks which are high risk and commonly associated with injuries.

2. To create an on-line toolkit of resources. The objective is to provide public practice members with tools which provide direction on procedures, equipment etc. which will reduce risk of injury with patient handling.

The SHOP task force consists of PABC members from all Health Authorities, a PT representative from WSBC, and more. They are: Cathy Hazzard, Kathryn Snider, Sarah Rowe, Suzanne Watson, Tara Pollock, Barb Purdy, Joanne Moorhen, Peter Goyert, Alison Hoens and our leader Rebecca. A big thank you to all of them for their time, energy and passion! If you have any tools that you think would benefit the membership in regards to SHOP please contact me at tkessling@physiobase.com.

In the meantime, stay tuned for SHOP e-alert #1 in the New Year. These will be going out to the Public Practice Ambassadors to distribute to public practice colleagues.

*continued on page 22*
NEW CLINICS

Laura Patrick expanded Kids Physiotherapy, Vancouver’s first pediatric physiotherapy clinic at 210-3369 Fraser Street, designed exclusively for children. Laura said: “This location is not only going to be more accessible for our clients from around Vancouver, but is also fully wheelchair accessible and custom fitted just for kids.” There are two large treatment rooms and an expansive gross motor studio area, as well as a therapeutic dog – Gallagher the Goldendoodle!

Treloar Physio opened a new venture, the Pilates Studio, where pilates instructors with physio or kin backgrounds, modify programs for groups and individuals.

Waymen Wong has opened another clinic, Burquitlam Physiotherapy, plus two satellite clinics, bringing his clinic total to 4. He is also welcoming his third child into the family in February.

Jessie Wu, Byron Chan, and Rob Iwasaki have teamed up to form PhysioWorks in Vancouver. The new clinic is a progressive multidisciplinary effort offering physiotherapy, massage therapy, and quality care through customized treatment programs. They are committed to promoting and supporting healthy active lifestyles in our community. Find them at www.ptworks.ca and follow us on Facebook or Twitter @PhysioWorksBC!

References

Tanya Kessling hails from Winnipeg and now lives in Campbell River with her physio hubby. They are part owners in Rehab in Motion clinics in Campbell River. Tanya recently resigned from Vancouver Island Health Authority after six years of musculoskeletal injury work to focus on her work at the clinics and to pursuing her advanced manipulative training.

Development of Safe Laser Use: Evidence in Action  by Anita Olson, BSR

In the fall of 2009, the Interior Health (IH) Professional Practice Councils (PPC) were asked by Darlene Arsenault (Director of Rehabilitation and PPO leader) to write an article based on evidence based practice for the IH Research Capacity Team. As co-Chair of the IH Physiotherapy Professional Practice Council (IH PT PPC), I took on the project. The article was titled “The Use of Laser by Rehabilitation Services” and was published in March 2010 in the IH Knowledge Translation Casebook: Sharing Stories of Evidence-Informed Practice.”

Within IH, quality care, patient and staff safety are priorities and laser safety practices are considered a risk. The Canadian Standards Association and the American National Standards Institute have developed standards for the safe use of laser in Health care facilities. WorkSafe BC uses these standards for measuring safety and it is recommended that all organizations apply these standards to laser practices.

In 2008, Kelowna General Hospital reviewed the literature to support the use of laser treatment within IH facilities. Also in 2008, the IH Internal Audit department conducted a laser safety audit to determine if the IH facilities using medical lasers were adhering to the accepted safe standards of practice. Six acute care facilities were audited and laser practices were reviewed for Class 3 (PT departments) and Class 4 (medical) lasers.

The audit was given to the Rehabilitation Services Program administrators, and the impact on the use of lasers was swift and dramatic. All IH Physiotherapy departments were asked to stop using laser as a treatment modality until they met the CSA standards and had met the recommendations of the audit. The challenge was given to the IH PT PPC to ensure the recommendations were implemented.

All of the recommendations for the safe use of lasers were addressed as follows:

1) Practical Guidance and Record Keeping
   - IH Laser policy was written
   - CSA Standards document is available online for staff
   - Laser safety checklist was written
   - PT laser log was developed

2) Equipment
   - Laser maintenance records need to be kept

3) General safety
   - Laser safety signage needs to be posted
   - Laser specific area necessary
   - Laser specific goggles inside and outside treatment area
   - Fire extinguisher in the treatment area

4) Standard Operation
   - Alcohol preps need to be removed from the room
   - Laser keys are kept in a locked area

5) Laser Safety officers
   - Areas in IH to have trained Laser safety officers and laser safety committees

6) User certification
   - Laser users were required to have completed a one day basic training in-service. All users of Lasers in IH received this in-service. Training for Laser Safety officers was also given at this time.

In summary, IH Physiotherapy departments had little or no laser safety practices or policies in place and required significant improvements to meet the required standards. The work done by the IH PT PPC ensures that IH staff using lasers are following evidence-based practices, will be providing consistent procedures across IH and are meeting CSA standards. This will ensure the safe use of lasers for both the patient and the employee.

Anita Olson is the Manager of Rehabilitation and Respiratory Services, and the Professional Practice Lead for Physiotherapy with Shuswap Health Services
New Year’s Resolution to Increase Professional Development

by Andrea Reid, MScPT, Diploma Sport Physiotherapist, FCAMT, C.G. IMS, PABC Education Manager

Was your resolution to dedicate more time to your continuing professional development? Did you resolve to start an in-service education program at your clinic? PABC will give you the easiest in-service ever! All you’ll need is a computer, a projector and a few snacks and you’ll be a hit. Just sign up for the podcast of the Spring 2011 lecture series, download the 80-min talk and press play.

Coming up this spring is our three-part lecture series “Women’s Health? NO WAY…this is for everyone!” Well known local experts Meena Sran, Diane Lee, Pat Lieblich and Becky Weaver will discuss how topics often thought of as “women’s health” can affect both genders. Conditions like osteoporosis, diastasis rectus and continence are not only problems in women, but men too! Learn basics of management and also when to refer your patients on to a specialist.

The New Year has brought more GOOD NEWS from your education committee! We thought long and hard about how to serve you better this year. We came up with a few ideas you’re sure to like. First, we’ve dropped the price of the podcasts from $40 to $30 so you can afford to buy a latte and a muffin to enjoy while you watch the lecture. And second, we’ll bring you two lectures a season instead of three, because we know everyone is tight for time.

Coming up in the fall lecture series will be “Kid’s in pain? Something’s wrong!” Our experts will review common childhood “don’t miss” musculoskeletal conditions, and make recommendations for kids who are involved in lots of physical activities.

PABC is offering a double-dose of spring courses in specialist areas. This March, PABC has teamed up with the Pacific Dental Conference to bring Mariano Rocabado to Vancouver. He’ll do a full-day lecture and a 2.5-hour practical over Friday/Saturday, open to dentists and physios (see the back cover for details).

In April, Pat Lieblich and Penny Wilson will offer their course, “Continence & pelvic floor re-education in the female patient”. For those interested, a bursary is available for a part of your registration fee provided you agree to do some community education following the course. The details are available on the PABC website.

We’ll have more course information for the fall ready in the next few months. As always, we’re eager to hear your education feedback and suggestions. Contact me anytime at education@bcphysio.org.

Member Kudos for PABC’s Last Course

I enjoyed the 1-day format, and had a chance to spend a day at BodyWorld as a PABC freebie. Good education weekend. MY

It was an awesome day and thank you for all your organization, good lunch and great speakers. I made some condensed notes and passed them onto the GPs and Nurses in my clinic. DL
Strategic Moves at UBC

by S. Jayne Garland, Head of Physical Therapy Department, UBC

The Department has adopted a strategic plan to guide us over the next five years. The plan includes commitments to excellence in four main areas: student learning, research, work environment and community engagement. In focusing on community engagement, our hope is that we will strengthen the connection between the UBC Department of Physical Therapy and its alumni and friends. We think it is important to increase clinician involvement in research. Research has its greatest potential impact when undertaken in conjunction with clinicians; not only is physiotherapy practice more effective when informed by scientific evidence, but the scientific questions we choose to pursue are more relevant when informed by clinical practice. Inspiring clinicians to participate in research and inspiring researchers to seek and include clinician and client input in research should be a core function of an academic physiotherapy program. We also want to promote physiotherapy contributions to healthy living. Physiotherapists are well positioned to be leaders in chronic disease management. Non-invasive interventions including health education and physical activity/exercise (health behaviour change) are the evidence-based interventions of choice (often superior to pharmacological and surgical interventions) for the prevention and management of lifestyle risk factors and the management of their chronic manifestations. Another arm of our community engagement mission will be to maintain the strongest support program in Canada for internationally-educated physical therapists. By assisting internationally-educated physiotherapy (IEP) professionals to gain the credentials to practice in Canada we add to the richness of clinical practice and increase the supply of physiotherapists for the community. We welcome your participation in and feedback about any aspect of our program. If you would like more information on the Department’s strategic plan, visit our website at http://www.physicaltherapy.med.ubc.ca/Home.htm.

There are exciting new Clinical Education initiatives in the UBC Department of Physical Therapy. Starting with our Level 1 placements in January of 2011, we will be using a new Automated Matching process in HSPnet. This will give our students a greater voice in where they would like to go on placement. Currently selections are made by the ACCE, with consideration going to student preference in geographic location wherever possible. From January 10, 2011, students will be able to see the available offers in HSPnet, and enter up to five choices into the HSPnet system. Matches will then be made by the computer. Never fear however — all placements will still be overseen and moderated by the ACCE and students will still be required to complete placements around the province and in the required areas (Acute, Rehab, Geriatrics/Home Care, Outpatients, Interprofessional, and an elective).

Also new to Clinical Education for our students is the simulated patient suctioning lab which will begin for placements in January at the Centre of Excellence for Simulation Education and Innovation. The second year MPTs will be the first class to use the simulations prior to graduation to gain proficiency in the reserved act of suctioning. The skills include oral (with and without an artificial airway), nasopharyngeal (with and without an artificial airway), and tracheal (closed and open circuit) suctioning as well as evidence-based practice standards for suctioning procedures to select the most appropriate treatment for the patient.

In April, another student-run clinic, the Neuromusculoskeletal (NMS) Program Student-run Clinic, will open at GF Strong Rehabilitation Centre. This student placement will give students the opportunity to work in an interdisciplinary team, to integrate skills from multiple areas of learning with complex patients, and to contribute to peer learning. The primary team of the NMS clinic is composed of clinicians from Occupational Therapy, Speech Language Pathology, Physiatry, Social Work, Dietary, Recreation Therapy and Nursing.

The MPT Survival Guide

by Patricia Otukol, MPT1

I came up with a lot of words to describe the first four months of PT school, most of them contradictory. Fun but stressful. Exciting but exhausting. Timeless and time-consuming. It’s been a rollercoaster, with its own highs (like finishing your first OSCE) and lows (like waiting for your first OSCE), but we’ve all made it through successfully. Many of you out there in the PT community may have forgotten what it is like to be a lowly student — maybe it has been a long time since you’ve completed courses, or maybe you’re about to go back for continuing education. The following is a brief Class of ‘12 survival guide.

1. Use all resources available to you: Resources include, but are not limited to: Professors, Teaching and Lab Assistants, Wikipedia, other students, and PT’s you’ve met on clinic visits or shadow placements. At UBC, we’re lucky enough to be surrounded by very knowledgeable PTs from the community — an invaluable addition to our learning experience.

2. Sleep wherever you can, whenever you can: Ask any PT student, a plinth can be your best friend. Whether you’re tired of sitting upright at a desk or just need to shut down for a 25-minute power nap, relaxing on a plinth can give you the extra push needed to make it through a late-night session study. Bonus points if you manage to find yourself a hospital bed to nap on. Just remember to take off your shoes!

3. Don’t forget about your health: We are, after all, healthcare professionals. Many of us this year have been hit by bugs, fatigue, or have just been feeling run down. It’s...
important for us to realize our body’s limitations, even if that means taking a whole weekend off of studying. There are MPTs who manage to balance their school, fun, and fitness perfectly. And there are those of us who’ve gained 10 pounds or so, but that’s what New Year’s Resolutions are for, right?

4. Take every opportunity to apply your learning: There’s nothing better than learning a skill in class, then going out on a placement and seeing that skill performed in the field. In addition to shadow placements and clinic visits, take advantage of volunteer opportunities as research subjects and with health initiatives around the Lower Mainland to reinforce what you’ve learned so far.

5. Don’t forget to have FUN: It’s quite simple - if you’re laughing, you’re not crying. When I asked the Class of ’12 about their thoughts for the first Block 5, I’m the new guy on the PABC team, so I thought I’d give a bit of an update on the Coordination and Communication corner of the office. This position evolved from the former Technology Lead, which is where the second half of this article’s title (as well as my title) comes in — communication. PABC keeps several channels of communication open with the membership, and on any given day I may send and receive emails, make and take phone calls, post on PABC’s facebook and twitter profiles, even write conventional letters (you know — on actual paper!) and send faxes. I’ve been working closely with Deb Monkman, the PABC librarian, to use the social media strategy set forth by the Knowledge Team, and we’re glad to see a lot of PABC members in the social media realm as well.

The coordination of services for the membership is just as multi-faceted. We work hard to provide the membership with programs, information, good customer service, advocacy, and general assistance. Without a doubt, the easiest member service for me to provide is friendly customer service. Perhaps it is my background as a librarian, but I love finding answers to questions, and members seem to love it too! When my phone rings or an email comes in, my favorite part is after we’ve figured out a solution for the problem and the member says something like, “Oh thanks — that’s what I was looking for!” or “Okay, I see it now” or “Yep, that’s everything” or “Oh PABC is wonderful, and I’m going to send a box of chocolates to the office right now!” (Okay, I made that last one up, but we do love chocolate.)

One request that I get quite regularly is from members of the public looking for a physio. This is a simple process that yields positive results for the individual needing care, the physio who has the ability to help them get better, and the Association, because we get to act as a bridge between the two. Just a reminder though: the Find-a-Physio directory is based on information provided by the physiotherapists and their clinics. That means we should always have the most up-to-date contact info, areas of expertise, and services available for each physiotherapist and clinic in our directory. This is especially pertinent right now, as we’re just a few months away from our revamped website.

Speaking of that new site, some members have asked about what the new site will offer, so I’ll touch on that here. The first point is the Find-a-Physio (FaP) feature. Our current FaP process allows users to search by several different pieces of information: name, city, clinic, types of physio, etc. Our new FaP will have all the same functionality, but with more bells and whistles. We’ll have the ability to search by locations within cities, such as an address or intersection, so that members of the public can find the physio that is most convenient for them. The new site will also have expanded member profiles, so that physios have the option to enhance their PABC persona with some of their accomplishments. This could be areas of expertise, research interests, published articles, even alma mater. And rest assured, all the great information that is currently available on www.bcphysio.org will still be available on the new site.

I’ll close now, and just say that the months I’ve been working at PABC have been terrific! I’m looking forward to meeting those members that I haven’t yet, and I encourage you to let me know when you can’t find something on our site or if there’s anything you think I can help with.

Cheers! Jesse

BABIES

Gabrielle Campbell had her second daughter on December 12th. Soleil was 8 lbs.

Joanna & Ryan Sleik had their firstborn, Ruby Grace, on September 3, weighing in at a mere 4 lbs 15 oz. The Sleiks practice in Kimberly.

www.bcphysio.org
What Members are Doing

Dolores Langford (she wrote “A Year in Recovery” for Directions last year, about working in Mental Health and Addictions), on finding a complexity of pain issues in mental health patients, applied for a Masters (MSc) in Pain Management in an international venture from the University of Edinburgh, UK and the University of Sydney, Australia. She hopes to use this to help set up a Pain Management program for women with trauma/addiction issues, upon completion.

Margaret Chafe volunteered at the PABC booth at a recent Fraser Health education day. She was reported to be “very enthusiastic about PABC”, and when two younger physios told her they were “not sure” about joining PABC, Margaret responded: “How could physios not join after reading the latest newsletter!”

Paige Larson, Deep Cove and North Shore Physio clinics, won the North Van Chamber of Commerce Business Person of the Year award in November!

A little birdie told us that Dan Mueller is wearing his heart on his sleeve, including this signature in his work emails: “Dan Mueller, BScPT, MScPT, Proud Member of CPA & PABC”.

Erl Pettman was awarded the ‘Karlenborn – Teach I Must Award’ by the American Academy of Orthopaedic Manual Therapy (AAOMT). Says Erl, “Quite a surprise for me since you have to be a member of the American Academy to receive one of their awards. To be a member of the American Academy you have to be an American PT. It seems that somehow they managed to ‘bend’ the rules and I was made a member of the AAOMT (without my knowledge) so they could bestow me this very prestigious award. I must be the only Canadian so honoured. I feel truly blessed. I have been awarded an ‘Outstanding Achievement Award in Education’ from the CPA, the ‘Golden hands’ Award from the Canadian Ortho Div and the ‘Kaltenborn — Teach I Must’ Award from the AAOMT. Time to retire I think.”

And a tidbit on the Golden Hands award — Erl presented the first ever award (then called the ‘The Dave Lamb Memorial Award’) to Cliff Fowler at the 10th annual Ortho Div conference in Halifax 1999. Pictured are the first and latest recipients: The first hands (shown) were a white alabaster impression of John Oldham’s hands. Very poignant since Dave Lamb, Cliff Fowler John Oldham and Erl were all very close friends. Other BC recipients of this national award include John Oldham, Marylin Atkins, Diane Lee, Therese Lord. There have been just two non-BC recipients.

The first and latest recipients of the Golden Hands Award, Cliff and Erl.

Jr Justesen, Parkway Physio, is now a partner with the University of Calgary in clinical gait analysis. Says Jr, “our goal is to create the largest database of running injury research and to bring an evidence based gait analysis system from the lab to real life.”

Patrick Embley sojourned to Hamilton recently to take intensive training in a pioneering rheumatology ultrasound training study at McMaster University. He was one of only two physiotherapists in Canada to be involved. Patrick’s work here in BC is ground-breaking in the treatment of arthritis.

Sungod ‘Staches, L-R: Mike Hales, Travis Wolsey, David Fleming, Kevin Schalk and Ryan Murray

Sungod Sports + Orthopaedic Physiotherapy Clinic’s, David Fleming and Travis Wolsey were Ironman triathletes this year. Travis completed Ironman St. George, UTAH and they both completed Ironman Canada in August. In November, all the Sungod Physio men have embraced Movember and bore moustaches to raise awareness and funds for prostate cancer, amassing $2200 just with a little facial hair.

Eddy Betinol, The Joint Physio clinic, hosted a Movember event, “Balls of Steel” 24 Hour Ball Hockey which helped raise $13,000 and counting. Says Eddy, “Considering that this was a first time event, the community was absolutely generous with both financial and infrastructure support so that the tournament’s success was absolutely beyond our expectations. I know men’s health isn’t the most dramatic nor pressing social issue but I think these small steps give us an opportunity to gently nudge our community to a more proactive approach towards health in general.”

Congratulations to Maureen Duggan and Clare Faulkner who just graduated from UBC’s Rehabilitation Science Online Programs with Master degrees Rehab Science (MRSc)

Teresa Liu Ambrose’s latest study on strength training for seniors (Archives of Internal Medicine) made the front page of the Vancouver Sun in December, and was also in the Province newspaper as well as many medical news web-sites! Says now-retired UBC professor Dr. Susan Harris, “In my 20 years at UBC, I can’t ever remember when a faculty member’s research was front page news.”
ADNC Neurofeedback Centre of BC would like a physiotherapist to join our team of professionals to deliver seamless services to patients using EEG Biofeedback, Massage, Naturopathy, Psychology, and therapeutic tutoring as a means to manage and overcome symptoms. Our clients experience symptoms of abuse/PTSD, addictions, aggression, anger, anxiety, behavioural concerns, brain injuries, headaches, insomnia, obsession, pain, stroke, bruxism/TMJ, trauma, etc. The physiotherapist would be managing and overseeing any physical therapies patients could benefit from. Anyone interested in learning how Biofeedback can effectively be integrated into a physiotherapy career can contact us at (604)730-9600 to discuss how we could collaborate.

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WWW.MGINS.CA

Privately Sponsored Courses
Details at www.bcphysio.org - Courses/Events - Select the Private Courses/Events tab

February
- Building Better Bones, Melioguide, On-line course, on-going course dates
- CBIA: The Study of Human Movement, Vancouver
- Advanced Pain Management, Modern Treatment for People with Chronic Pain, Rossland, BC
- Balls, Bands and Balance by Karen Orlando, Vancouver
- Neuro Developmental Treatment and Bobath: an introductory course on the treatment of adult hemiplegia, Vancouver
- Intro to Traditional Chinese Medicine & Meridian Therapy for Physiotherapists & Healthcare Practitioners, Victoria
- Paediatric Update Symposium, Vancouver

March
- Clinical Reasoning, Advanced Level, IBITA certified course, The Bobath Concept, Vancouver

April
- Understanding our Connective Tissue System: Complaints after Breast Cancer Treatment, Kelowna & Vancouver
- Fit Fore Golf: Scientific Approach to Golf Rehab, Kelowna
PABC Professional Development 2011

Evening Lecture/Podcast Series

Spring 2011 – Women’s Health? NO WAY...this is for everyone!

Scared of breaking? The latest in osteoporosis diagnosis and management
February 3: with Dr. Meena Sran, PT, PhD
This lecture provides current diagnostic methods (including fracture risk assessment) and management strategies (including medications), and exercise that is most effective for bone preservation and fall prevention.

Don’t ignore the problem. Discuss incontinence issues with confidence
March 2: with Becky Weaver and Pat Lieblich
This lecture will introduce you to: discussing and assessing incontinence with your clients; the types of urinary incontinence in women and men; prevalence in society; evidence-based treatment; and when to refer to a pelvic floor physiotherapist.

Split down the middle? Tips for managing diastasis rectus abdominus
April 5: with Diane Lee, BSR, FCAMT, CGIMS
Learn to identify and treat the related non-optimal muscle synergies seen in clinical practice among both men and women.

Location/time: Gordon and Leslie Diamond Health Care Centre 2775 Laurel Street, Vancouver BC, 7:00 – 8:30 pm
Podcasts: distributed to registrants one week following the live lecture
Fees: PABC members: $40 (students $10 - in person only), podcast $30; future members: $60; Podcast “group” rate per site: PABC members $60; future members $120

Weekend Courses

Spring 2011

Craniomandibular: craniovertebral centric relation. Synovial TMJ and occlusion
March 11/12 with Mariano Rocabado
Friday March 11th 8:30 – 11:00 am and 1:30 – 4:00pm (lecture)
Saturday March 12th 10:00am – 12:30pm OR 1:30 – 4:00pm (hands-on)
Vancouver Convention Centre
This is a joint endeavor by the Pacific Dental Conference (www.pdconf.com/) and PABC. If you have questions about registration, contact Andrea at education@bcphysio.org

Continence & pelvic floor re-education in the female patient
April 8/9/10 with Pat Lieblich and Penny Wilson
Friday, April 8th 8 – 5:30; Saturday, April 9th 8:30 – 5; Sunday, April 10th 8 – 4
BC Women's Hospital, Vancouver

To register for courses or lecture/podcast series, follow these three easy steps:
1. www.bcphysio.org and click Courses/Events on the top right
2. read the descriptions; scroll down to “To Register .... Click Here”
3. click “sign up” on the course or lecture you’re interested in

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