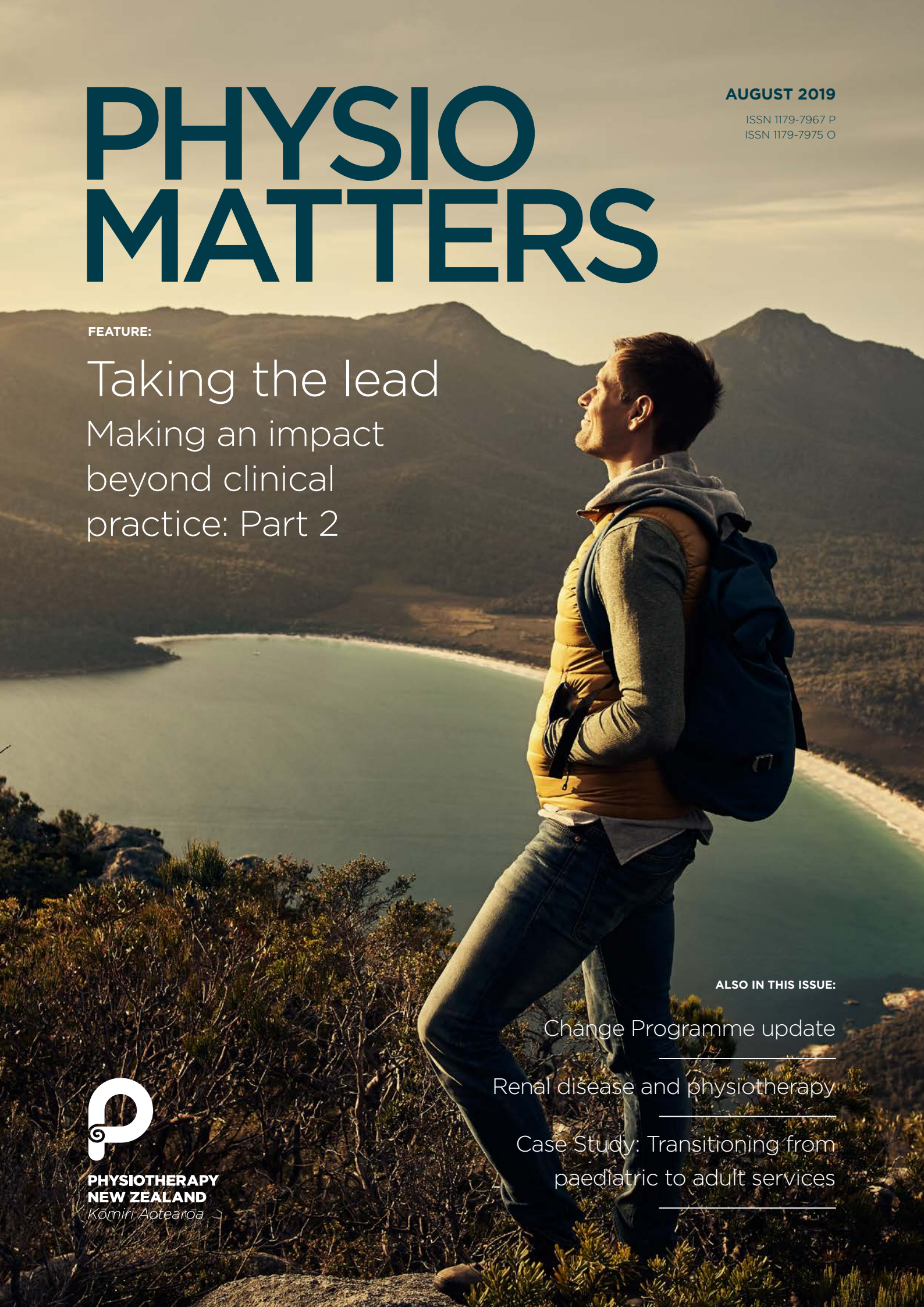
PHYSIO MATTERS

AUGUST 2019
ISSN 1179-7967 P
ISSN 1179-7975 O



FEATURE:

Taking the lead

Making an impact beyond clinical practice: Part 2

ALSO IN THIS ISSUE:

Change Programme update

Renal disease and physiotherapy

Case Study: Transitioning from paediatric to adult services

PHYSIOTHERAPY NEW ZEALAND
Kōmiri Aotearoa

AUGUST 2019

Editorial and Advertising

- Send editorial items and advertising to the Editor, erica.george@physiotherapy.org.nz
- Send course information to pnz@physiotherapy.org.nz
- Advertising rates and specifications are on our website.
- If this date falls on a weekend or a holiday, please supply by the closest working day before.
- Members may read Physio Matters on our website and follow workable links.

Booking Deadlines

October 2019 – 20 Aug / **December 2019** – 21 Oct / **February 2020** – 20 Dec 2019 / **April 2020** – 20 Feb / **June 2020** – 20 Apr / **August 2020** – 20 June

PRESIDENT'S COLUMN

Hitting 'refresh'

A year of transition

LIZ BINNS

Kia ora. Firstly, I'm sure I'm not the only one who enjoyed the refreshed format of Physio Matters when the June issue arrived! Thank you to our PNZ Office team for their work on this. It was well overdue and reflects the importance of Physio Matters in connecting the profession.

'Refresh' is the word I would choose to describe this year to date: our year of transition. Taking stock of the organisation and making it the best it can be to deliver tangible, meaningful benefits to members is what this year is all about. Included in the refresh are some finer improvements to what members can access by being part of PNZ, which you may not have noticed. It got me thinking about what you can do to get the most out of your membership:

- Opt into a Branch and Tae Ora Tinana
- Download the PhysioLog app to track CPD (Continuing Professional Development)
- Check out the resources CPD page of the website
- Join a Special Interest Group

Why am I highlighting this? Members don't always take advantage of everything on offer from PNZ. To ensure you're in a Branch that suits you, members are asked to opt into a Branch. This means you're in their group and on their mailing list. No longer are you allocated to a Branch according to geography. At the PNZ Executive meeting one of the standing papers is a membership report, identifying total membership as well as Branch and Special Interest Group numbers. We're unsure why but all Branch numbers are down. My guess is in our collective haste to get the early bird rate, this box was left unticked. Was that you? It'd be great if you can please check. I'm looking forward to the next membership report in the hope that all Branch numbers go up.

Refreshed too is the Kaitiaki of our te Tiriti o Waitangi partner Tae Ora Tinana. At Tae Ora Tinana's recent hui I had the pleasure of joining the farewell of three founding Kaitiaki: Ann McKellar, Kate Haswell and Lynda Kirkman. I also met with new Kaitiaki Witana Petley (Dunedin), Emma Webb (Palmerston North), Keistin Woodman (Kaikohe), Bridget Watson (Wellington) and Miranda Buhler (Dunedin). They join existing Kaitiaki Maarama Davis (Wellington), Grant Mawston (North Shore) and Ulima Tofi (South Auckland). Keep an eye out for profile pieces, panui and Tae Ora Tinana web page updates.

Members can also continue to use the PhysioLog app to track CPD and access resources through the PNZ website. We know that CPD services are important to members and that you value doing this online. With the website update having happened this year and app still available, be sure to make the most of your membership. And as always, don't forget to join a Special Interest Group. These are essential for CPD relevant to your chosen career.

Ngā mihi nui
Liz Binns
President

PNZ OFFICE

What's new in physiotherapy

Highlighting our current work programmes

SANDRA KIRBY

Tena koutou katoa. It has been great to see so many physiotherapists engaged with the Roadshows over the last few weeks. These events are jointly hosted by the Physiotherapy Board of New Zealand, Accident Compensation Corporation (ACC) and PNZ. It is a credit to all three agencies that information can be shared at the same time. Other professional groups look enviously at this degree of cooperation between regulator, funder and professional body.

For PNZ, our response to the theme 'What's new in physiotherapy?' was to highlight some of our current work programmes, particularly the awareness campaign, the clinical governance framework and the CPD resources available through PNZ. It seems timely to provide all members with a synopsis of these areas of our work.

Our Professional Development Committee project for this year has been the development of the clinical governance framework and we are currently seeking your input into this resource. We have based this on the resource developed by the Health Quality and Safety Commission (HQSC). The HQSC guide is a great evidence based resource and the PNZ development aims to translate this resource into every clinics "must have" guide. Clinical governance is an all of practice approach that aims to improve safety as well as improving the quality of services and care provided. We are developing a toolbox so that members can select the tools, processes and activities that suit their size and context. This guide should also help those clinicians working under the ACC Physiotherapy Contract to meet the clinical director requirements. Please check out the PNZ website for more information.

Our website is a key communication channel for us in reaching our members and the public. Last year we focused on restructuring the existing website content and function. We set out to make the site more engaging and easier to find what you were looking for. Your feedback tells us we have mostly succeeded. The major project for the year ahead is to review our Find a Physio section. This is a big task as we reconsider how physiotherapists and businesses promote themselves and their areas of practice.

An invite to complete the 2019 remuneration survey should appear in your emails over the coming months. We have committed to repeating this annually and will use this as we continue our reviews into workforce issues. We are also in the midst of the review of workforce attrition and retention – one of the issues flagged last year as a key workforce concern. Results will be available later this year.

We know the Roadshow events were mostly over-subscribed. For those people who were interested but couldn't make it to an event, the Physiotherapy Board will be releasing an online webinar.

We have a few changes inside the PNZ team. You may have seen that we have been recruiting for a new Professional Advisor. Next month we will be sadly farewelling Sue Doesburg who has been the quietly competent physio brain in our team. We have welcomed Julie Kerr in the role of SIG Administrator for PAANZ, Occupational Health and the Hand Therapists. On the family front we celebrated with our Marketing and Communications Manager Nick Thompson and his partner as they welcomed triplets into their family. We also celebrated with our Operations and Business Services Manager Peter Christie on the arrival of his first grandchild in the same month. Very special events in anyone's life.

Ngā mihi
Sandra Kirby
Chief Executive

FEATURE

Making an impact beyond clinical practice: Part Two

In the final part of our series on physiotherapists who have now moved into high-profile roles within the New Zealand health sector, Esther Bullen profiles Stafford Thompson, ACC's (Accident Compensation Corporation's) new Manager of Clinical Services.

Stafford Thompson:
Taking the lead

Google "Stafford Thompson" and you're left in no doubt about his dedication to and success in endurance running. In 2017, Stafford won the Three Peaks Mountain Race for the fifth consecutive time. The event is not for the faint-hearted – traversing the Flagstaff, Swampy and Mount Cargill summits over a 26km route around Dunedin.

That self-professed competitive nature has also seen the 38-year-old rise swiftly through the ranks professionally, from his first job as rotational physiotherapist at Dunedin Hospital in 2001 to Manager of Clinical Services at ACC. Does this make his appointment a coup for physiotherapy? "I wouldn't call it a coup," says Stafford, who took up the role last September. "I like to think that a physiotherapist can add significant value. So this shows credibility for physiotherapists – our profession is being recognised for its skill set, its knowledge and the contribution that we make to health."

Choosing the physiotherapy path

For Stafford, making a difference ranks highly as a career motivation, and saw him pursue physiotherapy in the first place. "I naturally enjoy exercise and sport, and I wanted to be involved in a profession that can make a positive impact on people." He chose to specialise in pain management, clinical education and rehabilitation from serious injury.

A job in the mining town of Mt Isa in outback Northwest Queensland, Australia, in 2007 allowed Stafford to experience his first leadership role. There, at North West Hospital, he managed the physiotherapy service. While the town of 18,000 is a 10-hour drive from the coast, the hospital's catchment area is bigger than the size of New Zealand but with an entire population of only 40,000. "I wanted to stretch myself professionally, experience something different and make the biggest, positive difference I could," explains Stafford. "I thought working in outback Australia would be something different, and it certainly was."

One year later and back in New Zealand, Stafford worked as a professional practice fellow at the University of Otago before becoming manager of the Allied Health Unit at the Southern District Health Board. He worked there for four years managing a team of over 100 before joining ACC six years ago, cutting his teeth as a clinical advisor, and then as Manager of Allied Health Advisors.

Leading ACC's Clinical Services team

In his new role at ACC, Stafford manages around 120 staff with a broad range of clinical backgrounds. This includes physiotherapists, nurses, occupational therapists, psychologists, GPs, occupational physicians, orthopaedic surgeons, general surgeons, sports physicians and neurologists. The primary role of Clinical Services is to provide advice on claims to case managers to help guide the appropriate treatment pathway for people who are injured.

"We have a hugely experienced group of people within clinical services, so I have to make sure those people are able to have a significant and positive influence on ACC. Ultimately, we want to contribute significantly to ACC's goals of minimising the incidence and impact of injury." In essence, that involves providing accurate and consistent advice to providers about access to ACC, and entitlements to treatment and rehabilitation.

While Stafford's management roles have not been hands-on in a clinical sense, Stafford continues to draw on his clinical expertise. "I'm using my training as a physiotherapist, my clinical knowledge and best practice to help, particularly working in the area of clinical review."

Physiotherapists as leaders in health

It is that training, skill set and experience that sets up physiotherapists for leadership roles within health, and Stafford says physiotherapists should not limit themselves. "I would ask all physiotherapists not to underestimate the range of skills they've gained through their training and in the context of their everyday work, which actually have broad applicability. A person with a physiotherapy background could add benefit to a wide range of leadership roles, not just within physiotherapy."

With the increased focus on primary healthcare, Stafford says it is essential that physiotherapists are involved at management level. "Given that physiotherapists are a key part of the health community and play a significant role in primary care, it's important that we are part of that. Also, physiotherapists bring an important skill set given their training and clinical experience around function, well-being and exercise. All of those things are well known to have a significant impact on the health of the population."

As for Stafford's future, only time will tell how far physiotherapy will take him.

"I would ask all physiotherapists not to underestimate the range of skills they've gained through their training and in the context of their everyday work, which actually have broad applicability."

PNZ Business Symposium

Beyond 2019

JILL DAWSON

Tickets for this year's Business Symposium on 1 November at Jet Park Hotel in Auckland are quickly being snapped up, proving that this will be our biggest event for 2019. Tickets are still available but spaces are limited so we recommend securing your place as soon as possible. Events Coordinator Jill Dawson gives us the details.

Designed to inspire and provide practical insights for business owners and managers, the 2019 Business Symposium will provide all businesses, large and small, with relevant commercial information and practical takeaways which can be implemented in day to day operations.

Focussed on the theme 'Beyond 2019', the one-day Symposium will be looking to the future for physiotherapists – taking into account current and future trends in the profession.

Stephanie Pride

We are excited to have Dr Stephanie Pride – a professional futurist with extensive experience and a deep commitment to innovative practice – as our keynote speaker. She has worked in New Zealand, Australia and the United Kingdom in the public, private and not-for-profit sectors as well as academia.

With a career that spans from operations to strategy and a background that includes both arts and sciences, Stephanie has a long track record of working across sectors and disciplines. She is experienced at tailoring futures services to the needs of any client and building capacities for strategic thinking. In 2009, she established StratEDGY Strategic Foresight, New Zealand's leading specialist futures consultancy. StratEDGY has delivered future projects, keynotes and training for clients from public, private and not for profit sectors across all areas for work from the future of tax to the future of forests.

In the health field, most recently she led off the MAS Talks series to medical professionals in 2017, addressed both GPCME General Practitioners' conferences in 2018 and was interviewed by New Zealand Doctor magazine for a cover story on the future of health.

Stephanie's futuring in New Zealand prior to setting up StratEDGY included designing and leading the SSC Futures Programme for the New Zealand state sector and driving system change as Chief Advisor for the NZ-OECD (Organisation for Economic Co-operation and Development) Schooling for Tomorrow project.

Focussed on the theme 'Beyond 2019', the one-day Symposium will be looking to the future for physiotherapists – taking into account current and future trends in the profession.

Stephanie has worked in an international capacity serving on the board of the international Shaping Tomorrow Foresight Network and locally on the board of the New Zealand Futures Trust. She is a member of the Association of Professional Futurists and the World Future Studies Federation.

Joining Stephanie presenting in November are Nick McDonald from Likeable Lab, Ilze Walton from HumanKind, Una Diver from Ernst & Young and representatives from ACC. Keep an eye out for our Business Symposium themed October issue of Physio Matters for a complete rundown of the day.

For further information, feel free to get in touch with me at jill.dawson@physiotherapy.org.nz. See you there!

On our way

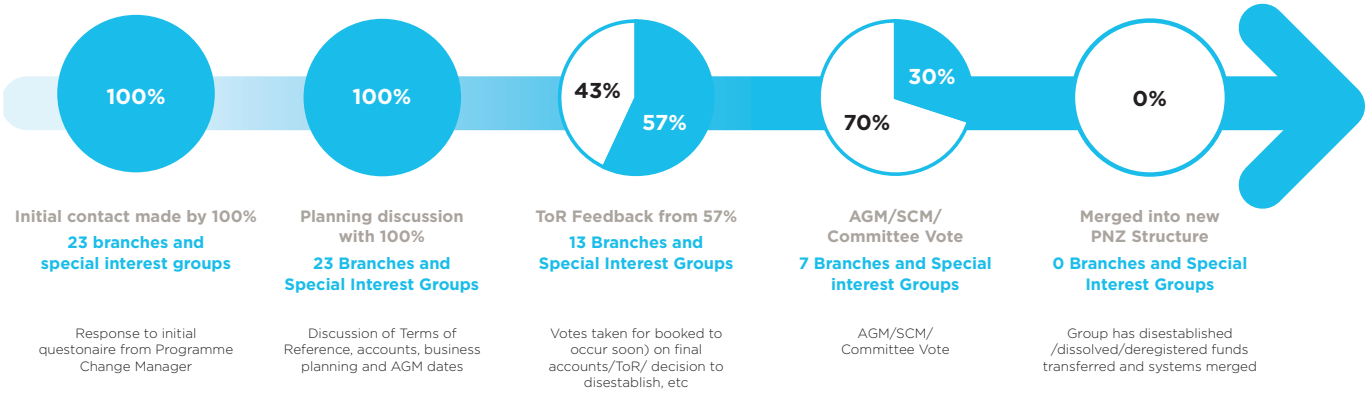
Working towards a united PNZ

KIM ELAND

PNZ Project and Change Manager Kim Eland updates us on how the Change Programme is progressing.

A lot has happened in the world of the PNZ Change Programme since my last update in April.

Back then, the conversations were really only starting around the steps each group needed to take and the documentation that needed to sit behind those steps. Now, we're a good deal further ahead, as the picture below shows:



The first two circles show that we now have engagement with each Branch and SIG around the country, allowing full discussion and consideration of their particular needs. And whilst the final circle is yet to join suit, we have a handful of groups almost at the point of unification, with seven groups having already successfully taken the vote to their members.

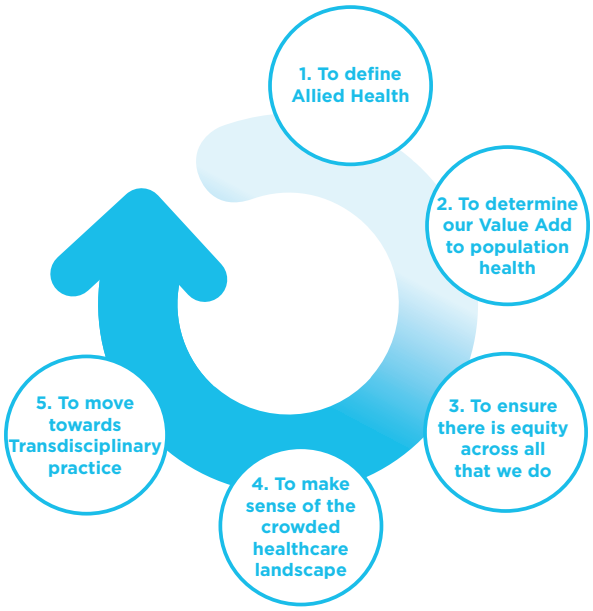
It would be fair to say we've had a few challenges to date – mainly in terms of being able to develop a clear set of steps for all to follow – the ultimate realisation being that we simply couldn't apply a 'one size fits all' approach. Instead, we now have six core variations on a process, with a handful of additional steps thrown into some of those processes for good measure! And this is because you're all different – whether in legal structure, constitution, financial health, functions, or systems being used. However, despite those differences, we want to ensure that the parts of the process involving your vote remain as consistent and transparent as possible across all groups. You all have an equal right to understand what's happening and to have your say.

As part of that, the last few months have provided countless opportunities for us to engage with Committees and members at Branch/SIG meetings around the country – sometimes in the form of face-to-face presentations, but more often as less formal Q&A sessions. Whether being there in person or dialling in, these meetings are hugely valuable in terms of hearing

first-hand the concerns that are still out there and (hopefully) being able to give direct reassurance; but also in terms of hearing people's ideas for the future of PNZ and witnessing the positivity that is growing out there.

Certainly, as our discussions continue with Committees around the development of business plans and budgets, there's growing reassurance that your usual activities will continue unabated. But more importantly, there's increasing excitement around future activities that Committees could potentially be exploring, to further benefit members under a unified structure.

And on a greater scale, the timing couldn't be better for PNZ to become a truly unified voice in New Zealand. At our Leadership Day in June, we were privileged to hear Dr Martin Chadwick speak, in his role as newly appointed Chief Allied Health Professions Officer at the Ministry of Health. During this presentation, the following five challenges were put to the audience and to physiotherapy as a profession:



And throughout, the messages were clear: the profession needs a strong framework for growth; it needs to be organised as a group; and it needs to prove to the Ministry what physiotherapy can bring to the table, in addressing the accessibility and equity issues identified in the New Zealand Health Strategy and driving the current review of New Zealand's Health and Disability Systems.

The Ministry has no appetite to listen to disjointed and disparate groups. It needs a workforce that is structured, organised and unified in its purpose to bring better services to New Zealanders. What better time to finally realise the strength and force of 4000 unified physiotherapy professionals, all offering a broad range of skills and experience?

To paraphrase someone far wiser than me: "When the voices of those who rarely speak are finally heard by those who rarely listen, great things can happen". A 4000-strong voice should be heard loud and clear in any future discussions we have with New Zealand's funders and policy makers.

So please take part in any discussions that are happening within your own groups and take time to read through the Change Programme page and related FAQs on our website. And the offer remains on the table: if your group is due to have a meeting in the next few months and you feel it would help to have someone from the PNZ Office join in the conversation, let us know. Experience tells me that a single face-to-face discussion can often replace a lot of emails and weeks of anxiety!

You can contact me any time about the Change Programme on 021 0235 3602 or kim.eland@physiotherapy.org.nz.

In focus

Helping you to improve your practice and patient care

DR MARK LASLETT

This month Physiotherapy Specialist and Consultant in Musculoskeletal Diagnosis and Therapy Dr Mark Laslett takes us through the growth of physiotherapy as a profession and what a Physiotherapy Specialist can do to help you improve your practice and patient care.

The New Zealand Manipulative Physiotherapists Association (NZMPA) celebrated its 50 year anniversary on 15 June this year. It was a timely reminder of where post-basic physiotherapy training in New Zealand started. In 1968, the Otago Physiotherapy School (now the University of Otago School of Physiotherapy) was the only such School in New Zealand and post graduate education was not being considered. So, it was up to a few leading clinicians who passionately believed advanced education in musculoskeletal physiotherapy was needed, to establish the Diploma in Manipulative Therapy. Robin McKenzie was the first spinal section instructor and Brian Mulligan was the first extremity joint instructor. For at least seven years these two individuals travelled the length and breadth of the country teaching mobilisation and manipulation for only the cost of travel and accommodation. They and the founders of that Association were passionately dedicated to expanding our profession's repertoire, and thus set in motion post graduate education for physiotherapists in New Zealand. In true Kiwi fashion, they decided to ignore protestations of difficulty and tradition, rolled up their sleeves and did the job anyway.

I vividly recall attending my first meeting of the Advisory Committee for the Auckland School at Auckland Technical Institute (now Auckland University of Technology) in Grafton Road in 1982. The Chairman was orthopaedic surgeon Ross Nicholson and half the committee members were medical specialists. When the then-President of the New Zealand Society of Physiotherapists (now PNZ), Michael Lamont raised the question of when physiotherapy education would become a university degree, there was a stony silence. Nicholson commented that he could see no point in physiotherapy moving to a university education.

Discussion as to why this was deemed important ensued with our medical specialist colleagues (anatomist, rheumatologist, neurologist and orthopaedist) agreeing that physiotherapists do not need to do research because medicine did all that was required and then would tell us what to do. Thankfully our profession ignored the paternalist advice of senior medical academics and clinicians, and New Zealand is now the first country in the world to formally recognise and license physiotherapy specialists under the same legislation that registers medical practitioners, nurses and other health care providers. Furthermore the minimum academic qualification is a relevant university Master's degree – just a pipe dream less than 40 years ago.

In 1968, the Otago Physiotherapy School (now the University of Otago School of Physiotherapy) was the only such School in New Zealand and post graduate education was not being considered. So, it was up to a few leading clinicians who passionately believed advanced education in musculoskeletal physiotherapy was needed, to establish the Diploma in Manipulative Therapy.

Since 2013, the Physiotherapy Board of New Zealand has recognised eight Physiotherapy Specialists. Six in musculoskeletal physiotherapy, one in pain therapy and the other in pelvic health. Since then we have been working hard to achieve the same status as medical specialists with the ACC. You are now able to refer your difficult cases to Physiotherapy Specialists in the same way as you do to medical specialists.

So, why refer to a Physiotherapist Specialist? Here are the reasons:

1. Physiotherapy Specialists know what you do with patients. This means that when you tell us what you have done and what the outcome was, we actually know what the treatment consisted of.
2. When you decide that your management is either not working or not appropriate, we don't conclude that physiotherapy treatment has 'failed'. Collegial referral is not evidence of failure, but professionalism.
3. We generally prefer to refer back to the referring physiotherapist for ongoing care, rather than hold on to the patient or refer elsewhere. You don't automatically lose the patient when you make the referral. We may have some specialist skills and knowledge, but most cases we see need a change in perspective or therapeutic direction, rather than treatment you cannot provide.
4. We encourage the referrer to attend the consultation. This fosters several important values. Most importantly it encourages collegial collaboration and assists the referrer from a continuing education perspective. The referrer can also see directly what the specialist has done and can receive ongoing diagnostic and treatment advice face-to-face. This is very educational, and probably also able to be used as CPD points.

As yet, we will not have rights to arrange high tech imaging. This is something that PNZ and the specialist group are working on.

To see more about what Physiotherapy Specialists can do to improve your practice and patient care, you can see my short presentation at the NZMPA 50th anniversary symposium online at youtu.be/NkHxBGx9R5E. Dr Angela Cadogan also gave an excellent presentation on the role of physiotherapy specialists. She may find time to make that available in the public domain as well.

Physiotherapy New Zealand

Executive Member Nominations

PHYSIOTHERAPY NEW ZEALAND
Kōmiri Aotearoa

Are you passionate about leading your profession into the future?

Nominees are sought to join the PNZ Executive and influence the direction of physiotherapy in New Zealand. This is a unique and exciting opportunity to make a difference, ensuring a representative governing executive focused on what will benefit physiotherapists most.

You may be exactly what the PNZ Executive needs, if you:

- **can demonstrate a broad knowledge of the physiotherapy profession,**
- **are skilled in strategic planning and implementation,**
- **have strong industry networks,**
- **represent a diverse profession and/or**
- **are experienced in organisational governance.**

PNZ Executive

As the national membership organisation for physiotherapists, PNZ provides advocacy, education, information and services to benefit over 4,000 members and the wider profession. The Executive are responsible for guiding the strategic direction of PNZ, shaping how value is delivered to members and the organisation's future direction. There are three PNZ Executive vacancies to be filled this year, one of which is a designated Māori seat. Current PNZ members are encouraged to consider nomination to ensure a representative and skilled Executive.

Requirements

Candidates must hold an Annual Practicing Certificate, be full PNZ members with good standing in the profession and bring skills to shape the strategic direction of PNZ. The Executive are tasked with evaluating issues and presenting a perspective on behalf of members, as well as representing PNZ and advocating on its behalf. Specific capabilities include:

- Strong evaluative skills and ability to work within a group structure.
- Effective communication and interactive skills.
- Demonstrated leadership qualities.

If you are interested in this role a discussion with President Liz Binns is recommended – president@physiotherapy.org.nz.

Nominees for the Māori PNZ Executive seat must be supported by Tae Ora Tinana. Talk to the kaitiaki taeoratinana@physiotherapy.org.nz

Time Commitment

PNZ Executive meetings occur five times a year. Executive members should also be available to represent PNZ at other meetings and events across the organisation, such as at the PNZ Annual General Meeting.

Nomination

Please complete and submit the PNZ Executive nomination form available at pnz.org.nz by **30 August 2019**. PNZ members will vote on nominees by electronic ballot, as defined in the PNZ Rules.

Keeping you updated

New client service model and Physiotherapy Services Contract redesign

MELISSA BARRY

Clinical Partner for Accident Compensation Corporation (ACC) Melissa Barry lets us know what's happening with the roll-out of the new client service model and provides us with a summary of the main changes for the 2019 ACC Physiotherapy Services Contract Redesign.

ACC is rolling out a new client service model to improve the client experience

At ACC we're changing the way we work to improve the quality of service we provide. We've concluded the consultation process on our new case management model and we're now planning for a national rollout. The new model for managing claims aligns with our wider Health Services Strategy; it is designed to improve the client experience by better matching the level of case management support to a client's needs.

All 25 of our existing locations will remain open, and clients with more complex needs will continue to be able to access one-to-one assistance where it supports their recovery. New roles will be created in hubs across Auckland, Hamilton, Wellington, Christchurch, and Dunedin. These hubs will work with the 94 per cent of clients who don't usually need face-to-face support when recovering from less severe injuries, such as sprains, strains and fractures. Clients experiencing these types of injuries will have a trained recovery team available to provide a more consistent and responsive experience.

We're also aiming to improve interactions with providers by introducing specialist administration teams. This sits alongside changes we've already made to claim lodgements, and changes to client payment systems which simplify and speed up financial support for clients who need it.

We will roll out this new way of working with clients in five stages, beginning in Timaru, Dunedin, Alexandra, and Invercargill from mid-September. The remaining four stages will continue from early 2020 (anticipated dates following):

September 2019	Dunedin / Timaru / Alexandra / Invercargill
February 2020	Hamilton / Tauranga / Whakatane / Rotorua / Gisborne / New Plymouth
March 2020	Christchurch / Nelson / Greymouth
April 2020	Auckland / Whangarei
June 2020	Wellington / Hastings / Palmerston North / Hutt Valley / Masterton / Porirua

To hear more about the new model and what's happening across ACC, make sure you're signed up for our quarterly electronic newsletter, Your ACC Pānui. To receive Your ACC Pānui in your inbox, email us at YourACCPanui@acc.co.nz.

2019 update to the Physiotherapy Services Contract

Since 2017 ACC has been working with the Physiotherapy Expert Reference Group on a redesign of the physiotherapy services contract over three years. Phase One of the contract redesign was implemented in the contract variation on 1 August 2018. Phase Two is now complete, with the next contract variation planned for 1 August 2019. Phase Three is currently being planned and we will continue to work with the sector in developing this over the coming year.

This article focuses on the Phase Two changes that will take effect from 1 August 2019: Pricing Structure Changes, DHB Prices, Physiotherapy Specialists, and Clinical Governance.

Pricing Structure

The price for the initial consultation (PT01), follow-up consultation (PT02), group consult rate (PTCG), offsite initial (PT21) and follow-up rates (PT22) were increased by 4.9 per cent to adjust for inflation and incorporate

the MECA changes. The 2019 service schedule that will have the details of these changes will be available on the external website from 1 August 2019. Rates were introduced for Telehealth and Orthotics, and are outlined below:

Service item code	Service Item	Definition	Price (excluding GST)
PTTH	Telehealth Follow-up consultation	Telehealth Follow-up consultation via video conference only.	$23.71 per consultation
PTE2	Moon Boot	Moon boot prescription and supply	Up to $100.00 maximum contribution
PTE3	Knee Brace	Knee brace prescription and supply	Up to $100.00 maximum contribution

District Health Board (DHB) prices

ACC has increased the rates we pay to DHBs as they are not able to charge a co-payment as permitted under the physiotherapy services contract. This initiative was to ensure that the needs of our most vulnerable clients, and clients with significant injury needs can be met within this setting.

The DHB prices are included within the 2019 Contract variation as outlined below:

Service item code	Service Item	Definition	Price (excluding GST)
PT31	Initial consultation DHB	Initial consultation – assessment treatment and completion of documentation	$64.54 per consultation
PT32	Follow-up consultation DHB	Follow-up consultation	$45.56 per consultation

Physiotherapy Specialists

We are pleased to announce that Physiotherapy Specialists are now included within the 2019 Contract Variation. You can refer clients to Physiotherapy Specialists for diagnosis, specialist advice, and treatment planning. This is a fully funded service. Details for the initial and follow-up rates are below:

Service item code	Service Item	Definition	Price (excluding GST)
PTS1	Initial Consultation	Initial consultation including the assessment, treatment and completion of documentation	$400.00 per consultation, flat fee.
PTS2	Follow-up Consultation	Follow-up consultation	$200.00 per consultation, flat fee.

Clinical Governance

In 2018 the Clinical Director Requirement was introduced into the Physiotherapy Services contract.

The purpose of this role is to have a more experienced physiotherapy practitioner provide: oversight of treatment providers and review cases prior to the 16th treatment; in-service training and provider induction; interact with ACC clinical staff regarding cover; and act as a conduit for discussing performance concerns with ACC Engagement and Performance Managers.

Following the introduction of the Clinical Director requirement within the 2018 Contract Variation, ACC and PNZ are working together to develop a resource to guide physiotherapists taking on a Clinical Director role. This piece of work will be linked to the Clinical Governance Framework PNZ is developing for the profession, and we look forward to co-designing this resource together.

Moving from Cost of Treatment Regulations (CoTR) to a Contract

The Physiotherapy Services Contract is an open contract. If you meet the requirements you're eligible to apply. If you're interested in learning more, please register on the GETS website under gets.govt.nz, and search for physiotherapy to get an application pack.

Performance Indicator / Dashboard reporting

Every year ACC provides most professions delivering services under the Cost of Treatment regulations with a dashboard. The dashboard summarises their contribution to managing the injury related needs of our clients. Dashboards are only issued to providers who have a verified e-mail address with ACC. The dashboards for physiotherapists are due this month. We'll also be creating a dashboard for contracted providers. If you did not receive a dashboard in 2018, or are new to practice and unsure if you have a verified email address, email the team at registrations@acc.co.nz with your name and provider number and request verification of your e-mail.

Also this month, ACC's annual provider monitoring reporting will take place for physiotherapy (contract and regulations providers). You may be contacted by one of our Engagement and Performance Managers to support this year's reporting.

Physiotherapy Roadshows

Jeremy Ly (Primary Care Portfolio Lead) and I presented at the Physiotherapy Roadshows this year. We appreciated your insights and conversation at the sessions in Wellington, Auckland, Christchurch, Dunedin and Hamilton, on how physiotherapy fits into the future direction of ACC and provided an update of the 2019 Physiotherapy Contract changes.

You can email Melissa at Melissa.Barry@acc.co.nz

Rubbing shoulders in Geneva

Congress from a PNZ member perspective

JOANNE WILLIAMS

PNZ member and Operations Leader for the New Zealand Defence Force Joanne Williams reflects on her time at the World Confederation of Physical Therapy (WCPT) World Congress in Geneva earlier this year.

It was at PNZ's Physiotherapy Conference when I heard that the WCPT Congress for 2019 would be in Switzerland, and it immediately got me thinking. Why not go, I thought? I love international conferences, I'd love to revisit Europe. And here I am, three years later, looking back at my first WCPT congress.

Firstly, I was amazed at the number of delegates. There were 4300 of them – all of whom it seemed attended the fantastic opening ceremony, where Emma Stokes and others spoke so passionately about the profession and the days ahead. The ceremony included a parade of nations similar to an Olympic Ceremony – except rather than walking behind their flag, names of the attending countries, the size of their membership and the number of delegates in attendance were shown. As each country lit up the screen, respective delegates let out a resounding cheer from the audience. New Zealand lit up with more than 35 delegates, and the Swiss stood out with having a quarter of their membership in attendance. The Swiss horn and flag waving routine warmed us up for the amazing choreography and dance routine that followed, after which the performers received a standing ovation. Everyone was so moved by their performance. There was also a presentation of the Mildred Elson Award, given to a humble Anne Mosely for her work developing the Physiotherapy Evidence Database (PEDro). This is now a well-used database providing physiotherapists with evidence based research at our fingertips.

It was easy to become overwhelmed by the plethora of choice when deciding which sessions to attend – symposia, discussions, networking, seminars, and indaba. One piece of advice from a more experienced delegate was, "pick a room and just listen to all the various topics", rather than spending too much time trying to move about – particularly within sessions at such a large venue.

You do need to spend some time planning what sessions you want to go to in advance in order to get yourself organised … which in hindsight was a rookie mistake on my part! (In my defence I was switching off from technology during my holiday leading up to Congress.)

On the second morning I was dismayed to find that the popular sessions had filled very quickly, leading to me missing out on them, despite arriving before the scheduled start time. Having only a limited number of discussion groups with facilitators was a unique feature different from other large conferences I've attended, but it did mean that the numbers were restricted and adhered to.

The wonderful thing about Congress is the sheer global view it provides. There were 131 countries represented with 61 per cent of speakers being women, and 65

Joanne (right) with two fellow delegates at the WCPT World Congress in Geneva.

per cent of the delegates, chairs and speakers coming from 91 countries – a fair representation of the global physiotherapy community. At my pre-Congress course run by Jeremy Lewis (highly recommended), I was the only attendee with English as a first language. During the sessions it was easy to see that there are vast differences in how physiotherapy operates around the globe and patients' ease-of-access to it (or lack thereof). There are physiotherapists practicing who do not always have internet access, do not get free (if any) access to research or evidence-based practice – and some are working in situations where patients have such limited access, it may be a year before they get to be seen by a physiotherapist. A management session I attended saw me at a table with delegates from five different countries, each bringing a different perspective and health system to work within to the table. Another session I attended on occupational health was similar – we all worked in the same profession but in completely different roles, each with their own challenges and different health systems.

It reiterated to me how lucky we are in New Zealand. We have access to ongoing CPD (Continuing Professional Development) at our fingertips; we have internet access and free databases; we have autonomy of practice. Patients have direct access – and whilst there are always imperfections with all health systems, we are lucky to work in a health system that in general allows us to be at the forefront of our profession on the world stage. Reflecting this, there were a number of New Zealand physiotherapists taking centre stage within some of the sessions, including Jon Warren, Leigh Hale, Ben Darlow, Melissa Davidson, and Janice Mueller. They were also joined by New Zealand born physiotherapists now living and practicing elsewhere, such as Peter O'Sullivan and Jeremy Lewis.

Both Peter O'Sullivan and Jeremy Lewis had a series of short videos taken after their session at Congress where they discussed the need to reframe management of chronic musculoskeletal conditions. They spoke passionately about moving from a 'fix it' model to a management model – one that empowers the client, and in doing so achieves better health outcomes. I'd urge you to listen to these short interviews by searching their names on wcpt.org.

Similarly, another paper presented reviewed the literature examining patient and clinician beliefs around imaging for low back pain. They found both patients and clinicians felt imaging was a useful tool in locating their source of pain – something from the pain research we know is not necessarily the case, and perhaps contributes to another finding that chronic sufferers believe that imaging would prove their pain to be real. They also mentioned the need for ongoing conversations and changing the way we practice to reduce the use and cost unnecessary imaging, whilst educating clients on better options for managing their condition. The slogan they would use in a public health campaign? 'Scan your options, not your back'.

Imagine how much physiotherapy we could provide for the cost of orthopaedic consultations, high tech imaging, or surgery to achieve good sustainable outcomes. Running throughout Congress 2019 was the notion of physiotherapy as a low-cost option. Low cost in comparison to specialists, and surgical interventions. High value in terms of what it can deliver when done well. Several papers were presented demonstrating efficacy of different physiotherapy interventions that delivered a cost benefit. Given that healthcare resources are only going to become more limited, we need to develop these models of care and move away from costly interventions that don't achieve the desired outcome.

The wonderful thing about Congress is the sheer global view it provides. There were 131 countries represented with 61 per cent of speakers being women, and 65 per cent of the delegates, chairs and speakers coming from 91 countries – a fair representation of the global physiotherapy community.

I will finish with one last theme and a heart-warming story from Congress 2019. There is evidence in physiotherapy that exercise and activity benefits all patients – with musculoskeletal pain, disability, following cancer, post cardiac event – and at any age. The best success story I heard was from one of the attendees at the managers' session I attended. He was there supporting his physiotherapy team as they presented a poster on the benefits of hydrotherapy for autism. He told a story at hydrotherapy session of how an aide at the side of the pool was instructed by the physiotherapist to find the mother of a child attending the session – this was in order for her to come and listen to her child sing his ABC during one of the exercises. When the aide found the little boy's mother in the waiting room, the mother said: "You must have the wrong child; my child is non-verbal and doesn't even know his ABC". She was astounded to believe it was her child. How's that for the power of physiotherapy?

OF SPECIAL INTEREST

Looking after body and mind

The importance of sleep

LARA BOWERING

Physiotherapy in Mental Health Special Interest Group member Lara Bowering discusses the importance of sleep when it comes to physical and mental wellbeing.

When is the last time you had a good eight hours of sleep? If you have to think longer than a few seconds about this answer, which let's admit, could be a large portion of us, then please read on. Good sleep isn't just better... it is essential!

We are designed to spend over one third of our lives sleeping, and yet it has been one of the least understood parts of our biological make up until more recently. If, like me, you have found yourself riding the wave of busyness, deprioritising sleep and assuming the more time spent awake the more productivity can happen in life, then you are not alone. In the West, both career, lifestyle and schooling timetables cause us to default to a sub-standard opinion of just how important sleep quantity, as well as quality, really is.

The World Health Organisation (WHO) deems sleep the foundational of the three pillars of health, with diet and exercise being the other two. A statement made during the 2019 World Sleep Day read that 'for most adults, getting seven to eight hours of sleep tonight might be the most important thing we can do to improve our future physical and mental health'. So just how significant is sleep for human wellness and what are the implications for us as practitioners?

The science at a glance

Our sleep patterns occur due to two main reasons; levels of adenosine that builds in the brain during the day and reduces as we sleep and our in-built circadian rhythm. While sleeping, there are various stages and cycles of brain activity including non-rapid eye movement (NREM), of which there are four stages, and rapid eye movement (REM), the sleep state in which we dream. Much like a graduated gym workout or a planned progressive treatment regime, all stages are equally important and intertwine to create an effective system of self-treatment that produces the desired outcome on waking in the morning. During REM the brain is highly reactive and this is when your body and brain are busy storing memories, processing and recalibrating emotional components of the day, regulating mood and also learning. During NREM your brain waves slow down and this is the time when human growth hormone is released, memories are further processed, neurons are generated, muscles are repaired and the immune system is restored. Toxic debris is also cleared away for effective brain functioning the following day, one of these toxins being amyloid protein, the poisonous build-up that is associated with Alzheimer's disease.

Our brain and body is far from 'resting' while we sleep. We are in fact actively recovering, restoring and mentally debriefing after the day's activities.

Common misconceptions people think about sleep

- Five hours of sleep each night is sufficient
- Falling asleep anywhere is a sign of contentment
- You can adapt to having less sleep
- Snoring is annoying but harmless
- Drinking alcohol helps you sleep
- It does not matter what time of the day you sleep, as long as you sleep
- Remembering dreams is a sign of good sleep

The issues

Society, more specifically in the West, is reducing our sleep priority. Studies show that between a third and two thirds of us do not get enough hours of sleep per night. Just one night of inadequate sleep leaves us with an undesired sub-standard level of physical and mental health in the morning, which then becomes our new baseline for the following day. We function with a lesser attention span, poorer learning and poorer memory and recall, which turns the concept of pulling an all-nighter to ace the test completely on its head. Sorry to

all the physio students out there! Also more bad news… unfortunately no amount of sleeping in at the weekends restores the imbalance we create during the week due to late nights and early mornings… we simply cannot catch up on sleep.

Some of the most striking implications of poor sleep is in the area of mental health. Due to the recalibration of the brain during sleeping hours in order for us to process emotion, our ability to function on a socioemotional level is affected each and every day by our sleep; how we interact as well as how we react. It is not a surprise then to find out that mood swings, paranoia, depression, anxiety and dementia are all linked to poor sleep. If we add in a circumstance such as trauma or painful injury into the equation, we can understand why there can be huge implications upon the rehabilitation journey.

What about some info for the cardiac rehab therapists? Well, studies show that those who reduced their sleep from seven to five hours or fewer a night were almost twice as likely to die from cardiovascular disease, likely due to the sympathetic nervous stimulation which causes continued high blood pressure. Did you know when we lose an hour of sleep during daylight savings there is always a spike in cardiac arrests the following day?

And for the interest of our paediatric physios, sleep, like exercise and nutrition, is essential for metabolic regulation in children. There is evidence for a link between sleep duration and childhood obesity as well as huge implications on learning and memory.

What about our elite sports individuals who we assume are at their prime? Well high performance therapists, you'll be interested to note that poor sleep leads to an increase in injuries, a decrease in peak and sustained muscle strength, a decreased aerobic output and a decrease in the body's ability to cool itself during and after exercise.

Poor sleep is also linked to weight gain due to the poor regulation of hormones that affect appetite and food intake and even with the strictest of regimes, weight loss in sleep deprived individuals occurs from lean mass, not the desired fatty tissue.

For our community and medical based therapists, it is worth noting that less than a week of poor sleep puts a completely healthy person's blood sugar at the level of being pre-diabetic. And a lack of sleep also severely weakens the immune system; for those of you getting your flu jab this season, it is worth noting that reduced sleep in the days running up to getting your flu shot can reduce your immune response by up to a whopping 50 per cent.

We can safely say, no matter what area of expertise you work, sleep affects health and wellbeing.

Looking forward

So what is the good news? Well, all the effects of poor sleep are preventable. As physiotherapists we are taught that prevention is key and I believe we play a vital role in the education of patients regarding the importance of sleep.

My own personal challenge has been deciding to make this a priority in my own life, reflect on my own sleeping habits and sleep hygiene with a view to being more sympathetic when I ask my clients to look at their own circumstances.

Our biggest challenge is to first accept for ourselves, and then raise awareness in our clients and communities, that the problem of poor sleep quantity and quality is in fact an epidemic and that sleep is the most under-prescribed, most effective free treatment for many illnesses we encounter.

New Zealand Journal of Physiotherapy

Read the latest issue of the New Zealand Journal of Physiotherapy (NZJP) online now, featuring a guest editorial by Dr Hilda Mulligan. Here's a taste of what you'll find inside the July 2019 issue (Volume 47: Issue 2).

The physiotherapy management of patients undergoing abdominal surgery: A survey of current practice

Julie Reeve, Lesley Anderson, Yousef Raslan, Claudia Grieve, Jenna Ford, Livvy Wilson

Patients in New Zealand undergoing major surgery to the abdomen commonly receive physiotherapy to prevent post-operative complications and to maximise their recovery. The scientific literature around the effectiveness and cost-effectiveness of physiotherapy treatments is developing rapidly, and physiotherapists worldwide should be encouraged to compare their own practice with current evidence, to ensure they are providing the best treatment for their patients. This study establishes the current physiotherapy management of patients undergoing surgery to the abdomen in all publicly funded surgical centres across New Zealand and compares the findings with international recommended best practice. In doing this, we hope that New Zealand physiotherapists will review their own practises and make alterations where necessary, to ensure they fit with best practice guidelines and improve the quality of care for their patients undergoing major abdominal surgery.

Individuals' experiences of the consequences of anterior cruciate ligament reconstruction surgery

Mandeep Kaur, Daniel Cury Ribeiro, Jean-Claude Theis, Kate E. Webster, Gisela Sole

We interviewed 10 individuals who had undergone anterior cruciate ligament reconstruction (ACLR) up to 10 years earlier about their experiences of the injury, surgery, rehabilitation and influences on their daily lives. The results showed that ACLR can lead to long-term fear of re-injury and of potential consequences of subsequent long rehabilitation period on family, work, sports and other commitments. They described fluctuating confidence during physical activities and ongoing knee-related problems, also scoring low on quality of life scales. ACLR can lead to long-term behavioural manifestations. Maintenance programmes may be indicated to improve and maintain knee health, confidence and self-efficacy.

Knowledge and perceptions of cardiopulmonary resuscitation amongst New Zealand physiotherapists

Daniel Harvey, Daniel O'Brien, Kevin Moran, Jonathon Webber

Cardiopulmonary resuscitation (CPR) is an essential life-saving skill shown to save lives and improve outcomes of survivors. The purpose of this study was to explore the knowledge and perceptions of CPR amongst New Zealand physiotherapists (n=688).

View online or download
www.pnz.org.nz/journal

Older and more experienced physiotherapists were more likely to rate their CPR ability as effective; however, there were significant gaps in CPR knowledge in older physiotherapists. This study highlights the current low frequency of CPR training and the high likelihood of having to perform CPR in an emergency (1 in 5) as being a risk for physiotherapists in their care of patients.

How to improve leisure environments for children with movement impairments in Aotearoa/New Zealand?

Parimala Kanagasabai, Hilda Mulligan, Hemakumar Devan, Brigit Mirfin-Veitch, Leigh Hale

All children love to play or engage in sports activities in their leisure time. We conducted a mixed-method study (a nation-wide survey followed by interviews) to explore the challenges of children with movement impairments and their families to taking part in leisure activities. We found a mismatch between a child's ability and existing leisure activity opportunities in various settings such as the community, school and neighbourhood. In collaboration with recreational professionals, we call for physiotherapists and occupational therapists to proactively create and offer adaptive and inclusive leisure activity programmes to children of all ages and abilities in Aotearoa/New Zealand.

What encourages physical activity in individuals' with amputation?

Prasath Jayakaran, Meredith Perry, Marko Kondov, Tessa McPherson, Leigh Sutherland, Adela Wypych

Physical activity is well-known for its benefits in general well-being and quality of life. However, individuals with lower limb amputation do not engage in physical activity as much as adults with intact lower limbs. Our previous survey of individuals with amputation in New Zealand identified that 81% have a reasonable level of mobility but only 30% were physically active. This suggests that other than physical ability, psycho-social aspects (e.g. fear, isolation and environmental barriers) may also play a role in these individuals' engagement with physical activity. We have followed-up our previous findings with qualitative methodology exploring the attitudes, beliefs and barriers for physical activity in people with below-knee amputation.

RESEARCH

Case Study

Transitioning from paediatric to adult services

DACE JOHNSON

Australian College of Physiotherapists Australian Physiotherapy Association (APA) paediatric physiotherapist Dace Johnson presents a case demonstrating the assessment and interventions of person/environment interactions with a youth post-childhood acquired brain injury after discharge from a paediatric health service.

This case study, of an 18-year-old post-childhood acquired brain injury male who presented with concerns regarding headaches and footwear, aims to outline assessment and intervention of complex person/environment interactions. The challenges inherent in the transition to adult services are also explored.

Physiotherapy intervention was based on assessment using the International Classification of Function, Disability and Health (ICF) and systems frameworks and current postural control theories for mobility dysfunction. Intervention focused on monitoring/reducing headaches, managing lower limb spasticity, in-shoe orthotic review, and increasing trunk and lower limb strength, flexibility and balance. Education and a home program targeting prevention of secondary impairments was integral to treatment sessions. Headaches, walking efficiency, optimal footwear, and orthotic prescription were positively addressed. Spasticity and balance function remained unchanged.

Person/environment interactions are particularly important at transition phases such as late adolescence and exiting from a health service. Evidence based guidelines for assessment and intervention for youth with childhood acquired brain injury and transition are limited in this field of clinical practice. Paediatric and adult physiotherapists must become more aware of possible strategies to ensure a smooth transition.

Introduction

Traumatic brain injury (TBI) is the most common cause of acquired disability in childhood (Katz-Leurer & Rotem, 2017). In Australia, the incidence of significant paediatric TBI is seven per 100,000 per year, and many individuals live into adulthood (Mitra et al., 2007). There are minimal long-term follow up and treatment efficacy studies on childhood acquired brain injury (Katz-Leurer & Rotem, 2017). However, evidence from research with persons with cerebral palsy (CP) may provide a guideline for interventions (Katz-Leurer & Rotem, 2017, Novak 2014). Person/environment interactions regardless of health condition are important to assess throughout the lifespan – especially at late adolescence and transitioning from a health service (Kingsnorth et al., 2011). Transition from paediatric to adult services is a risk period for poor clinical outcomes if not appropriately managed (Campbell et al., 2016). Lack of services and evidence to guide development of transitional care for individuals with childhood onset physical disabilities contributes to this problem (Campbell et al., 2016).

Research studies in adult CP populations suggest mobile individuals with bilateral involvement are at risk of walking decline by their early 20s, associated with lower limb weakness, spasticity, increasing body pain, physical fatigue, poor balance and falls (Brunton & Bartlett, 2017; Morgan & McGinley, 2014; Kim & Park, 2010; Ross et al.,

2016). Low life satisfaction and decreased function were also associated with these symptoms (Vogtle, 2014). Research suggests that practicing functional, relevant, closed chain tasks and decreasing spasticity with medication are effective intervention strategies for aging individuals with CP and mobility concerns (Verschuren et al., 2008; Goyle et al., 2016). Recent research on childhood onset acquired brain injury (ABI) and adult ABI also suggests practicing functional relevant closed chain tasks are effective intervention strategies to maintain/improve mobility (Baque et al., 2016).

Client and family concerns during transition from paediatric to adult services may be complex. Physiotherapy intervention begins with identifying and prioritising a client's concerns and goals, and is fundamental to their satisfaction and effective service delivery (Screiber & Palisano 2017; Charrette et al., 2016; Australian Commission on Safety and Quality in Health Care, 2011). The contemporary approach to assessment and intervention of mobility dysfunction is task orientated and based on ICF and systems frameworks (Shumway-Cook & Woollacott, 2017). Education is a vital component of intervention as it encourages and supports self-management and prevention (Screiber & Palisano, 2017). Transition to adult services and adult tasks includes self-management of one's health condition and requires education, an important requirement for successful transition which can be difficult with individuals with a childhood acquired brain injury (Screiber & Palisano, 2017; Soo et al., 2014).

This case study will demonstrate assessment and interventions of person/environment interactions with a youth post-childhood acquired brain injury after discharge from a paediatric health service.

Case Study

The client (BH) is an 18-year-old male. BH initially presented to physiotherapy with concerns regarding headaches and recent advice he had received from his local shoe repairer regarding asymmetrical left (L) shoe wear. His goals were to decrease/eliminate his headaches and to reduce the need for frequent repair to the toe of his L shoe. BH attends reviews with a private paediatric physiotherapist biannually. BH has a diagnosis of ABI which occurred at 18 months of age. On subjective assessment, BH denied any bodily pain or falls but advised he was experiencing frontal/temporal headaches and his lower limbs felt tight.

History

BH was term born and developing age-appropriate skills when at 18 months of age he suffered a penetrating right (R) eye injury with associated brainstem injury. He subsequently developed meningitis and hydrocephalus which required insertion of a ventriculoperitoneal shunt. About five years later he required a posterior fossa decompression and de-tethering for spinal syrinx. BH has had numerous shunt replacements over the years, the latest undertaken in July 2016. Since his injury, BH had been involved intermittently with a tertiary hospital multidisciplinary paediatric rehabilitation team, private neurosurgeon, ophthalmologist and paediatric physiotherapy service. Due to his age, BH has been discharged from the paediatric health service and continues to access physiotherapy from his private paediatric physiotherapy provider as there is no other public service to access. His discharge included a written summary detailing current medical information but minimal participation information and no neuropsychological assessment. Recent reviews by his neurosurgeon and ophthalmologist confirmed that BH's shunt was functioning appropriately and vision was unchanged. BH does demonstrate bilateral fixed planovalgus deformities, postural scoliosis and a leg length difference of 2cm (shortened L tibia).

BH lives at home with his parents and two siblings. He has completed high school and is studying at TAFE part time. He works one day/week in an office administration role and volunteers one day/week in a similar role. His pattern of spasticity is similar to an individual with CP with bilateral lower limb involvement (spastic diplegia: L more involved than R). His gross motor skills present similar to an individual with CP Gross Motor Classification III (Gross Motor Function classification system, 2007). He walks independently on level ground with a single hiking pole and catches public transport independently. He attended a local gym, with a program focusing on upper limb strength, until his study commitments increased. He wears bilateral customised in-shoe orthotics to assist with comfort. He does not wear glasses. BH has no difficulties with communicating but occasionally has trouble relating medical history and responding to complex questions; subsequently parental contact was made to clarify key information. BH's mother advised that he stopped taking Baclofen about two years ago, but could not recall why. He attends physiotherapy appointments alone but requires parental support during medical appointments. He enjoyed rowing but ceased due to the lack of available trained coaches. BH drinks alcohol socially and takes no medication.

Outcome measures

Person/environment interactions may be complex, necessitating multiple detailed assessments to identify compromising factors (pain, fatigue, balance). Based on BH's presentation and concerns, in conjunction with medical specialist reports, the following assessments (see Tables 1 and 2) were implemented.

Five outcome measures were used to measure body structures/functions. Verbal Numerical Rating Scale (VNRS) is 11-point scale (0-10) for self-report of pain for individuals 10 years and older. Research supports its use with adults with CP (Vogtle et al., 2014). Strength can be assessed using manual muscle testing (Kim & Park, 2010) and functional assessment (Chan et al., 2013). In this paper, joint range of movement was assessed and only joints demonstrating passive restriction have been recorded. Active ankle dorsiflexion was used to evaluate Selective Motor Control (SMC) (Boyd & Graham, 1999). Tardieu scale was used as a clinical measure of spasticity. Large difference between fast and slow passive stretch (R1- R2) is interpreted as evidence of increased spasticity. In this paper, only differences between R1-R2 are recorded.

Activity and participation were evaluated using seven outcome measures. General Well-Being Scale Young Adult Report (18-25) (PedsQL18-25) is a generic instrument used to assess an individual's (with chronic health conditions) perceptions of health-related quality of life. A higher score reflects better health related quality of life (Varni et al., 2007). The Canadian Occupational Performance Measure (COPM) is an individualised, client-centred outcome measure designed to identify problems and detect change in a client's perception of occupational performance over time (Law et al., 2014). Timed Up and Go (TUG) is a clinical assessment of balance and functional mobility in ambulatory adults with lower limb spasticity and children with CP (Chan et al., 2013; Carey et al., 2016). Shorter times indicate better functional mobility Chan et al., 2013). Treatment Direction test (TDT) is a clinical assessment used to decide if an intervention (e.g., a new orthotic) is likely to succeed. In this case, it involved the application of low-Dye tape for excessive and/or prolonged foot pronation patterns and assessed tissue stress. It is a client specific outcome measure (Vicenzino, 2004).

Pain Disability Index (PDI) is a brief self-report measure of pain interference in daily life in adults. Research supports its use with adults with CP (Malone & Vogtle, 2010). The Fatigue Impact and Severity Self-Assessment (FISSA) is a valid and reliable measure for youth and adults with CP. It identifies activities that may be compromised by fatigue. A low score suggests fatigue has minimal impact (Brunton & Bartlett, 2017). Berg Balance Scale is a reliable and valid tool for clinical assessment of balance in adolescents (12-18 years) with CP. Lower scores suggest poorer balance (Jantakat et al., 2014).

Table 1. Body structure function

Headache (FID) (VNRS)	**3/week; 3/10; at computer**		**0/10**	
Leg tightness (VNRS)	5/10		2/10	
Strength	**L**	**R**	**L**	**R**
Hip extensors	4	3	4	3
Hip abductors	2	2	2+	2+
Plantar flexors	2	3	2+	3+
Endurance	**L**	**R**	**L**	**R**
Trunk – planks (secs)	15	10	25	20
	L	**R**	**L**	**R**
SMC dorsiflexors	1	1	1	1
Passive joint range of motion (PJROM)	**L**	**R**	**L**	**R**
Hip external rotation E	20	45	25	45
Hip F	120	120	150	150
Knee F	130	150	125	140
Spasticity LL R1/R2 (X)	**L**	**R**	**L**	**R**
Ankle PF	20 (3)	20 (3)	20 (3)	20 (3)
Knee F	40 (3)	40 (3)	20 (2)	25 (2)
Knee E	50 (2)	50 (2)	25 (2)	10 (2)
Hip adductors	15 (2)	15 (2)	25 (2)	25 (2)

FID – Frequency, intensity, duration; R1 Resistance – first catch R2 Resistance second catch end of range; R1/ R2 – total range of motion difference between R1 and R2. (Tardieu scale) is grade 0 – 5. 0 – no resistance through passive movement, 1 – slight resistance through course of passive movement,

2 – clear catch at precise angle, 3 – fatigable clonus (< 10 seconds); SMC – 0 – no movement when asked t2-dorsiflex foot, 1 – limited dorsiflexion using mainly extensor hallucis longus and/or extensor digitorum longus to 4 – isolated selective dorsiflexion

See 'Outcome measures' for further details.

Table 2. Activity and participation

TUG (secs) Shoes + current orthotics	16.5	13.9	PedsQL General Well Being Scale	27/28
	Week 3		COPM	1
PDS	10/70			
FISSA	31/160			

Intervention/management program

Initially BH complained of frontal headaches, lower limb tightness and left shoe wear. Body structure and function measures demonstrated leg length discrepancy (shortened L tibia 2cm) and lumbar spine postural scoliosis (convex to R).

Assessment of other body structures/functions indicated increased computer use and posture as the likely cause of headaches: guidance as to appropriate computer set up, use, and postural awareness was provided. Decreased lower limb range, decreased trunk endurance and lower limb strength, lower limb spasticity, poor ankle selective motor control, and leg length difference were contributing to his subjective leg tightness and asymmetrical shoe wear. At week three of the intervention program, BH advised of falling while stepping onto a bus. Possible contributors to his fall were explored (alcohol use, distraction, pain and/or fatigue): all indicators suggested a trip, necessitating further assessments. Berg Balance Scale score (41/56) demonstrated poor balance: subsequently balance tasks were included in his program (see Table 2). The current lack of valid self-management assessment measures demanded questioning regarding BH's management of his condition(s). The need to rephrase and simplify certain questions, as well as confirm certain subjective history and medication details with a parent, suggests possible executive functioning difficulties. His recent fall led to an altered rehabilitation program including balance practice and targeting lower limb strength, as well as balance education (see Table 3 for outline).

Left shoe wear intervention commenced by assessing foot and lower limb alignment and prescribed in-shoe orthotics, using a treatment direction test with de-loading foot tape (Vicenzino, 2004). A Timed Up and Go (TUG) was used to measure TDT efficacy. Tape application, applied to reduce foot over pronation, decreased TUG scoring, suggesting orthotic adjustment would positively influence foot alignment. Activities to strengthen trunk and lower limb were performed on a Pilates reformer (in supine), followed by alternate side plank holds. Education regarding his gym and home program for lower limb flexibility, as well as other likely impairments causing shoe wear, was provided. Balance activities consisting of standing and stepping over obstacles at floor level, were instigated in Week 3 of the program. Contact details for indoor rock climbing venue were provided as a leisure option to engage with friends and to promote strength and endurance.

Table 3. Clinical reasoning.

Frontal, temporal headache	Poor posture at computer	Headache frequency Pain VNR Scale
	Poor self-management and executive functioning (EF) and problem solving	Direct questions
Shoe scuffing	Poor foot alignment	TDT; TUG; self-report shoe scuffing
	LLD	Self-report of shoe scuffing
	LL weakness	Number of standing heel raises, self-report shoe scuffing
	LL spasticity/leg tightness	MAS, self-report shoe scuffing
	Asymmetrical trunk weakness (postural scoliosis) and affecting LLD	Side plank hold duration
	Poor self-management and EF and problem solving	Direct questions
Feelings of leg tightness	LL spasticity	Tardieu Scale
	Muscle tightness of LL	Self-report; PJROM LL
Feelings of dissatisfaction with active recreation	Lack of information and opportunity to trial rock climbing	COPM
	Decreased EF and problem solving	COPM
Fall on bus step	Decreased balance	Berg Balance scale
	Pain	Pain self-report
	Fatigue	Fatigue self-report
	LL weakness	Standing heel raises
	LL spasticity	Tardieu Scale

On reassessment at six weeks, BH advised that headaches were eliminated following advice, decreasing leg tightness, but unchanged shoe wear. TUG scores had decreased and trunk endurance, demonstrated by increased duration of side plank holds, had improved. Spasticity, lower limb strength and balance measures demonstrated no change. The physiotherapist initiated referral to a medical specialist for spasticity review, and a podiatrist for orthotic review, with recommendations for increased medial arch support as TDT had demonstrated. BH's LLD was remeasured in standing with blocks and his shoe required a .5cm decrease due to improved postural symmetry.

Discussion

As individuals with paediatric acquired conditions now live longer transition services from paediatric to adult care and/or adult focused community services are increasingly necessary (Katz-Leurer & Rotem 2017; Campbell et al., 2016). The transition from paediatric to adult services is a risk period for poor clinical outcomes and low client/family satisfaction if not effectively managed (Campbell et al., 2016). Anticipatory guidance is the process of educating individuals about future planning (Orlin et al., 2014). Research confirms that the ideal transition service, including anticipatory guidance on self-determination and self-management of conditions, should be implemented over a four-year period. Such service should include a youth- and family-centric approach that encourages active participation, real world experience, and the development of environmental and community supports (Katz-Leurer & Rotem, 2017; Kingsnorth et al., 2011; Campbell et al., 2016).

Successful transition outcomes are influenced by individual and contextual factors: the individual's impairments, person/environment interactions, and the associated activity limitations. It has been suggested that clients seek services, not for their medical diagnosis, but for improving their participation (Orlin et al., 2014). The thorough assessment of specific compromised activities and identification of occupational performance issues assists collaborative goal setting and subsequent interventions (Law et al., 2014; Malone & Vogtle, 2010).

BH had been discharged from paediatric services without documented participation and occupational performance assessments: these were undertaken as part of his review (see Table 2 and 3). His fall, during intervention phase, necessitated a balance assessment (see Table 2). His low score suggested he was at high risk for losing his independent walking. Possible contributors considered were lower limb weakness and/or spasticity, poor trunk strength and reduced balance skills.

Person/environment interactions, regardless of health condition, must be continually assessed. Person-specific assessments include evaluating musculoskeletal and neurological systems. Causal relations between impairments of spasticity, strength and function in CP population or adults with lower limb spasticity due to other diagnosis remains unclear but in a study of children with CP, proposed spasticity had a significant negative effect on function, while strength had a significant positive effect (Kim & Park, 2010). While BH made minor strength gains, his generalised lower limb spasticity persisted, confirming

medical review was required. Research in CP population advises oral Baclofen can reduce spasticity and signs and symptoms can worsen with drug withdrawal (Goyal et al., 2016). BH has a current MAS 2-3 and stated he was not currently taking any anti-spasticity medication. As he can no longer access a paediatric neurologist, referral to a private adolescent/adult neurologist will be pursued to assess and manage his spasticity as necessary.

Clients undergoing long-term rehabilitation require their choice of treatment options, as client satisfaction improves compliance, motivation, and effective service delivery (Australian Commission on Safety and Quality in Health Care, 2011). BH's strengthening program included the use of Pilates equipment (reformer bed) following a stated preference. A physiotherapy assistant or exercise physiologist to assist BH with his gym program would be beneficial – this supervision could be attained and funded under a chronic disease management plan. Balance control relies upon biomechanical and postural responses (Goyal et al., 2016; Shumway-Cook & Woollacott, 2017). BH's limited balance should be addressed through use of specific task-orientated/functional strengthening activities (i.e., step-ups required for bus transfers as opposed to step over activities).

The therapist must always consider the possibility of cord tethering, due to BH's past history of hydrocephalus and spinal syrinx. Signs and symptoms include fatigue, headache, increasing leg stiffness and spasticity, reduced range of motion (lower limb), altered/increased scoliosis with associated back pain, bladder/bowel and/or sensory changes. BH currently does not present with any signs and symptoms of a tethered cord.

Contextual factors within any person/environment interactions remain a critical component of assessment. Personal factors involve self-management of the condition and includes the concept of wellness and secondary prevention. This necessitates education. Research reports that individuals with an ABI often experience difficulties with EF, such as problem-solving and abstract thinking (Soo et al., 2014). BH demonstrates difficulties with EF, which may limit self-management. This, however, does not impact his ability to complete assigned home rehabilitation programs (with simple written instructions). Future, more complex programs may require additional photographs or support from a physiotherapy assistant/exercise physiologist. BH could benefit from neuropsychological review to evaluate EF. Anticipatory guidance in the form of education regarding postural awareness (in all positions), probable contributors to shoe scuffing, and general wellness strategies was provided. BH was given details of a local indoor rock-climbing venue to provide leisure-based strengthening opportunities (see Table 3).

Environmental factors also involve contact and coordination across multiple care providers which necessitates well-articulated health system strategies and includes the presence of transition clinics and dedicated multidisciplinary follow up programs (Campbell et al., 2016). The process is complicated by the lack of available transition services. BH's private paediatric provider received a discharge report from BH's tertiary paediatric rehabilitation service. The therapist advocates improved service coordination involving collaborative goal setting with BH, his family, and involved service providers, three-five years before final separation from paediatric services (Jeglinsky et al., 2012).

To assist individuals with a lifelong disability, research suggests that in addition to direct input for impairments, indirect strategies be employed (Jeglinsky et al., 2012). These include consultation and collaboration with medical and nonmedical staff to facilitate assessment and management of impairments; wellness promotion by providing anticipatory guidance and education to promote self-management; and the establishment of niche transitional practices (Jeglinsky et al., 2012). BH continues his physiotherapy input at a private paediatric physiotherapy provider which has developed and evolved in response to the changing needs of paediatric clients, such as BH, in the current health system. It represents a 'lifespan' model of clinical service delivery (Campbell et al., 2016; Morgan & McGinley, 2014). Furthermore, the practice collaborates with BH, his parents, and members of his team – including adult specialist medical, allied health, and non-medical staff – to provide, coordinate, communicate, and document assessment and intervention across all ICF domains.

Conclusion

Transitioning an adolescent from a paediatric healthcare service to the adult environment necessitates ongoing assessment of each individual's impairments alongside their person/environment interactions. Physiotherapists in all practice settings must embrace the lifespan approach, as contemporary practice settings limit the scope and capability of assessment and intervention. This case study affords a vital opportunity to advance research into the role and scope of physiotherapy during the adolescent transition from a paediatric health service. This will ensure timely, cost effective continuity of care for the adolescent moving to adult health care services.

This case study first appeared in the March 2018 issue of InMotion. Reprinted with permission. Email inmotion@physiotherapy.asn.au for references.

APA Paediatrics Physiotherapist Dace Johnson is a final year candidate for specialisation by the Australian College of Physiotherapists. She is a casual lecturer at Griffith University Brisbane and works in private practice at Movement Solutions Physiotherapy. She has many years' experience working with paediatric clients in health and disability sectors.

OF SPECIAL INTEREST

Renal disease and physiotherapy

Prevention and management

WINIFRED WING HO

PNZ member Winifred Wing Ho tells us about the role physiotherapy can play in the management of chronic kidney disease.

Chronic kidney disease (CKD) is an important health issue in New Zealand and the total number of people with CKD is unknown but according to the Ministry of Health (MOH) national consensus statement for management of CKD in primary care (MOH, 2017), there is a prevalence of seven to ten per cent of the adult population in New Zealand. Data from the 2017 annual report by the Australia and New Zealand Dialysis and Transplant Registry (ANZDATA), indicated there was a total of 4,658 New Zealanders who were on renal replacement therapy (RRT) and/or had undergone kidney transplantation, of whom 615 patients were new to these interventions.

Māori, Pacific and Indo-Asian people have much higher rates of diabetes, hypertension, proteinuria and glomerulonephritis, which are risk factors to CKD and/or end stage kidney disease (ESKD), than other ethnic groups in New Zealand (MOH, 2017; Joshy et al., 2009; ANZDATA, 2017). Māori and Pacific people also have a shorter life expectancy, poorer health literacy, and poorer compliance to medical intervention and advice than other ethnic groups in New Zealand (ANZDATA, 2017; Collins, 2010). They have a lower average low socio-economic status and higher prevalence of smoking and obesity, which are independent risk factors for proteinuria, thus increasing overall renal risk (Collins, 2010; Stewart et al., 2004). However, a recent qualitative study carried out by Walker and colleagues (2017) identified that, from the patients' perspectives, they felt they were failed by the system. This study investigated Māori patients' experience and perspectives of CKD, and found that patients' complained about their concerns not being listened to, and they had missed the opportunities for preventative care. The common signs and symptoms of kidney disease are muscle and joint pain, muscle weakness and fatigability, breathlessness, tiredness, lack of energy, frailty, and reduced physical function. (Painter & Kuskowski, 2013; Bonner et al., 2009; Johansen et al., 2000; Koufaki & Kouidi, 2010).

It follows that this population group has a poor quality of life (Guerini Rocco et al., 2006). There are studies that have shown that physical inactivity is associated with higher rate of mortality in patients with CKD (Chen et al., 2008; O'Hare et al., 2003; Johansen et al., 2013) and also with an increased risk of hospitalisation. Patient-specific exercises programmes are effective in addressing some of these risk factors (Heiwe & Jacobson, 2011; Howden et al., 2012; Koufaki et al., 2013) and international recommendations and guidelines have been developed to encourage lifestyle changes and increased physical activity (MOH, 2017; Royal College of Physicians, 2012; KDIGO, 2013). However various studies have found barriers to exercise including fatigue, shortness of breath, lack of motivation, endorsement of too many medical problems and not having enough time to exercise are the common complaints from patients with end-stage kidney disease (ESKD) (Stack and Murthy, 2008; Delgado & Johansen, 2012).

There are some useful resources for people with kidney disease available online – check out kidneys.co.nz and kidney.org.au

Whilst physiotherapy does not treat kidney disease, it can definitely help with the management of these renal risks to prevent or delay kidney damage progression as well as the signs and symptoms of kidney failure. Physical activity, particularly one with a strength training component, can benefit people with kidney disease (Hernandez et al., 2018). As physiotherapists we should advocate for clients and their rights to health care, advise and educate clients to promote good health and refer to relevant health professionals should that be out of the physiotherapists' scope.

People with chronic kidney disease can have a better quality of life and less health burden if the relevant health professionals can engage their clients by providing information, advice or even prescribed an exercise programme to them as appropriate.

As physiotherapists, we can help renal clients with better quality of life.

Email erica.george@physiotherapy.org.nz for references

Southern Physiotherapy Symposium 9

8 – 10 November 2019
Heritage Hotel, Queenstown

The philosophy of the Southern Physiotherapy Symposium is to combine clinically-relevant, evidence-based content with a weekend of fun and social activities. The programme will include a dynamic mix of both nationally and internationally recognised speakers addressing the diversity of contemporary clinical practice.

Keynote Speakers:

Professor Peter O'Sullivan*, *School of Physiotherapy and Exercise Science, Curtin University, Australia*. Professor O'Sullivan's research interests include the development, classification and targeted management of persistent musculoskeletal pain disorders, including low back pain.

Professor Susan Whitney, *School of Health and Rehabilitation Sciences, University of Pittsburgh, USA* Professor Whitney has been generously sponsored by the School of Physiotherapy, University of Otago in recognition of the Otago University 150th Anniversary.

Professor Whitney's research interests relate to persons with mild head injury, vestibular disorders and falls.

Professor Ewa Roos, *Department of Sports Science and Clinical Biomechanics, University of Southern Denmark* Professor Roos is an internationally leading researcher and change agent in the field of musculoskeletal health. One of the principal outcomes from her research has been the development of the Good Life with osteoarthritis in Denmark (GLA:D®) project for people with knee and hip pain.

Tania Clifton-Smith, *Co-founder of the Bradcliff Breathing Method and Director of Breathing Works Ltd*. Tania works as a clinician with a particular interest in children, athletes and the anxious client.

Dr Lou Atkins, *Centre for Behaviour Change, University College London*. Lou is a researcher, trainer and consultant in behaviour change intervention design and evaluation. She co-authored the book 'The Behaviour Change Wheel – A Guide to Designing Interventions'.

Invited Speakers: Dr Ben Darlow* Dr Richard Ellis* Dr Hilda Mulligan* Prof Debra Waters

* Denotes School of Physiotherapy, University of Otago alumni or staff who have been generously sponsored by the Otago Southland Physiotherapy Trust in recognition of the University of Otago's 150th Anniversary

Registration Fees (GST not applicable): Register via the PNZ events page.

Symposium (Saturday 9 and Sunday 10 November)		
Category	**Before 27.09.19**	**After 27.09.19**
A. Otago-Southland PNZ members	$270	$320
B. Other PNZ members	$380	$400
C. Non-PNZ members	$480	$520
D. New Graduates (up to 2 years post-graduation)	$100	$100
E. Physiotherapy Students	$50	$50
Pre-conference Workshops (Friday 8 November; 9am – 5pm)		
Category	**Workshop I:** Professor Peter O'Sullivan Making Sense of Low Back Pain – a Functional Cognitive Approach	**Workshop II:** Professor Susan Whitney Differential Diagnosis and New Treatment Interventions for BPPV
F. Otago-Southland PNZ members	$150	$150
G. Other PNZ members	$180	$180
H. Non-members	$225	$225

Registrations close 21 Oct 2019. Attendance at pre-conference workshops requires registration for the symposium also. If booking accommodation at the Heritage Hotel please use the SPS9 promo code and link provided on the PNZ events page. For further terms and conditions see www.pnz.org.nz

GENERAL NOTICES

Sharing experiences

Palliative Physiotherapists Education Day

JO GRAHAM

Jo Graham of Mary Potter Hospice invited physiotherapists working in hospices and palliative care around New Zealand to come to Wellington on 31 May for an inaugural day's get-together. The purpose of the day was to share research, education, build relationships and to establish a peer group for those working in this complex area.

Ten physiotherapists from Christchurch, Nelson, Wellington, Tauranga, Auckland and Wellington attended. Some of the physiotherapists worked only in an Inpatient Unit and others worked primarily in the community.

Topics presented and discussed included non-pharmacological management of breathlessness, and of pain (such as acupuncture and TENS), exercise and rehabilitation in the palliative setting, moving and handling, and management of oedema/lymphoedema.

Attendees also brought leaflets and other printed resources from their workplaces, discussed practices, policy and procedures, and their experiences of developing a physiotherapy service in the hospice environment. There ensued some very lively discussions and enthusiastic sharing of tips and clinical pearls of wisdom from collaborative years of experience.

Following this event, an email group has been set up for questions, problem-solving and further sharing of information and resources. It is hoped going forward that this can be an annual event.

If you would like to join the email group or find out more about upcoming Palliative Physiotherapists Education Days, you can get in touch with Jo at Jo.Graham@marypotter.org.nz.

Back Row: Janine Mortimer – Auckland Hospital; Lynda Atkinson – Mercy and West Auckland Hospices; Sue Lee – Waipuna Hospice; Elaine Shields – Nelson Tasman Hospice; Joanna Hegarty – Nurse Maude Hospital; Moira McDougall – Nurse Maude Hospice; Clarice Chung – Totara Hospice.

Front Row: Pippa Grant – Mercy Hospice; Jo Graham – Mary Potter Hospice; Nicky Brown – Harbour Hospice

High Velocity Thrust Update 2019

19 October 2019
Christchurch

An excellent update course presented by Michael Monaghan and available to those that are practicing using cervical spine HVT or those who may have recently completed the NZMPA COMT programme.

As HVT is a restricted activity under the HPCAA, CPD is required by the Physiotherapy Board of New Zealand.

Non NZMPA members most welcome. Do get your registration in promptly as minimum numbers are required and there are limited spaces.

For more information or to book, contact NZMPA on admin@nzmpa.org.nz / www.nzmpa.org.nz

HVT Update Course Fee:	
Non-Members	$250.00
NZMPA Members	$210.00

PHYSIOTHERAPY NEW ZEALAND
Kōmiri Aotearoa
Manipulative Physiotherapy

NZMPA

"Note to all using cervical spine HVT that this is a restricted activity under the HPCAA the prerequisite being two fold;

You have completed a course of training specific to ensure competence in such activity and to show ongoing competence by completing some relevant professional development programme.

This is such a programme.

I encourage you attend."

Michael Monaghan

Cardiothoracic Rehabilitation Workshop

12 and 13 October 2019
Auckland

Cost:		
CTSIG member	**PNZ member**	**Non PNZ member**
$300.00	$350.00	$425.00

Future proofing physiotherapy in the cardiorespiratory space: A comprehensive and interactive two-day workshop facilitated by Professor Julie Redfern.

Julie Redfern is a Professor of Public Health, a practicing Physiotherapist, Deputy Director, Westmead Applied Research Centre, Westmead Clinical School, University of Sydney and a Professorial Fellow at the George Institute for Global Health.

Featuring presentations by Dr Sarah Mooney and Sarah Candy and additional sessions on inpatient and outpatient cardiac patient care, case studies and discussion panels.

PHYSIOTHERAPY NEW ZEALAND
Kōmiri Aotearoa
—
Cardiothoracic

Workshop Objectives

- Evaluate current Pulmonary and Cardiac rehabilitation models and formulate ideas for the future
- Gain an understanding of how to implement eHealth strategies to support lifestyle changes into everyday practise
- Reflect and discuss the future of the cardiothoracic physiotherapist and our place in future healthcare models and career pathways
- Gain an insight into a cardiac patient journey

Register online via the PNZ events page.

Cancellation policy – a full refund if cancellation occurs within a month of course, 50% refund if cancellation occurs within two weeks of the course and no refund will be given if cancellation occurs after 31st September.

PNZ Business Symposium Beyond 2019

Friday 1 November
Jet Park Hotel in Auckland

Held every two years, the Business Symposium is our largest business-focused physiotherapy event. Attracting the profession's business leaders, speakers, brands and influential stakeholders, this one-day symposium is designed to inspire and provide practical insights for business owners and managers.

Beyond 2019 is focussed on looking to the future for physiotherapists – taking into account current and future trends in the profession.

Don't miss out!
Register online now at pnz.org.nz

PHYSIOTHERAPY NEW ZEALAND
Kōmiri Aotearoa

DISTANCELEARNING

POSTGRADUATE

University of Otago

Musculoskeletal and Pain Management

Pain is one of the most common reasons for people to see a health professional. It is a main feature of many health conditions, and the impact of pain on peoples lives is broad and invasive.

If you have ever wondered why pain is so complex, or how to help people manage their pain more effectively, the postgraduate papers in Pain and Pain Management available via distance learning will provide you with a good foundation for practice.

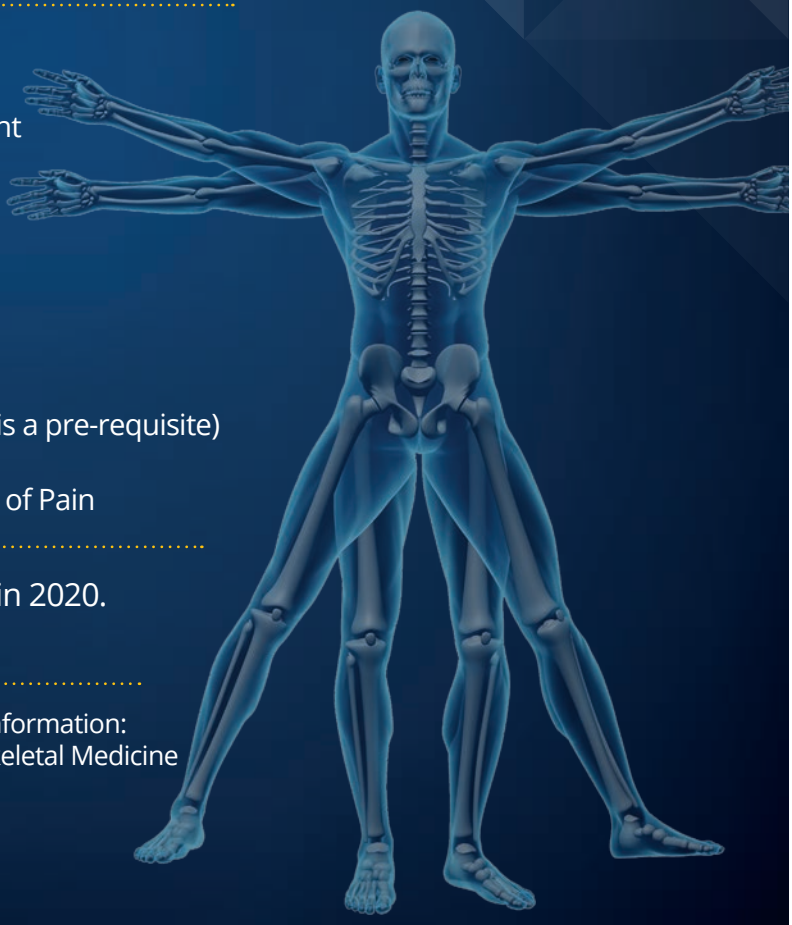
Postgraduate qualifications of interest to Physiotherapists:

The PG Certificate/Diploma/Masters in Health Sciences
endorsed in Musculoskeletal Management

The PG Certificate/Diploma/Masters in Health Sciences
endorsed in Pain and Pain Management

Some of the topics covered include:

- MSME 704 Introduction to Pain
- MSME 708 Introduction to Pain Management
- MSME 705 Regional Disorders (Spine)
- MSME 706 Regional Disorders (Limbs)
- MSME 707 Musculoskeletal Management
- MSME 711 Pain Assessment
- MSME 710 Recreational and Sports Injuries
- MSME 702 Musculoskeletal Tissues
- MSME 703 Musculoskeletal Disorders
- PAIN 701 Neurobiology of Pain (MSME 704 is a pre-requisite)
- PAIN 702 Biomedical Management of Pain
- PAIN 703 Psychosocial and Cultural aspects of Pain



Applications now being accepted for study in 2020.
Closing date 10 December 2019.

Contact the Programme Administrator for further information:
Department of Orthopaedic Surgery and Musculoskeletal Medicine
University of Otago, Christchurch
Tel: +64 3 364 0469
Email: msmandpainstudies.uoc@otago.ac.nz
Web: otago.ac.nz/msm-pain-management

Our programmes are endorsed by the International Association for the Study of Pain

UOC3886-0719