Agenda
Full Board Meeting

August 10, 2023
Board Room #2
10:00 a.m.

Call to Order – Mira H. Mariano, PT, Ph.D., Board President

- Welcome and Introductions
- Mission of the Board
- Emergency Egress Instructions

Approval of Minutes (p. 4-16)

- Board Meeting – May 11, 2023
- Formal Administrative Hearing – May 11, 2023
- Special Meeting – June 26, 2023

Ordering and Approval of Agenda

Public Comment

The Board will receive public comment on agenda items at this time. The Board will not receive comment on any pending regulation process for which a public comment period has closed or any pending or closed complaint or disciplinary matter.

Agency Report – Arne Owens, Director

Staff Reports

- Executive Director's Report – **Corie E. Tillman Wolf, JD, Executive Director**
- Discipline Report **– Melanie Pagano, Deputy Executive Director**
- Licensing Report – **Sarah Georgen, Licensing and Operations Supervisor**

Board Counsel Report – Brent Saunders, Senior Assistant Attorney General

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Committee and Board Member Reports

- Board of Health Professions Report **– Rebecca Duff, PTA, DHSc**
- FSBPT Leadership Issues Forum Report - **Mira H. Mariano, PT, Ph.D.**

Legislative and Regulatory Report – Erin Barrett, Director of Legislative and Regulatory Affairs

- Report on Status of Regulations (p. 18)

Board Discussion and Actions – Erin Barrett and Corie E. Tillman Wolf (p. 20-112)

- Repeal of Guidance Document
  - 112-7, Board Guidance on Physical Therapists and Individualized Educational Plans in Public Schools
- Adoption of Revisions to the Electronic Meeting Policy (Virginia Code § 2.2-3708.3)

- Consideration of Petition for Rule-making (Gianfortoni)
- Review and Affirm Approval of Credentialing Agencies for Graduates of Non-Accredited Schools (18VAC112-20-50)

New Business

- Physical Therapy Apps – Licensee Question

Elections

Next Meeting – November 9, 2023

Meeting Adjournment

This information is in **DRAFT** form and is subject to change. The official agenda and packet will be approved by the public body at the meeting and will be available to the public pursuant to the Code of Virginia.

Approval of Minutes

Draft Minutes
Full Board Meeting

May 11, 2023

The Virginia Board of Physical Therapy convened for a full Board meeting on Thursday, May 11, 2023, at the Department of Health Professions, Perimeter Center, 9960 Mayland Drive, 2nd Floor, Board Room #2, Henrico, Virginia.

BOARD MEMBERS PRESENT

Mira H. Mariano, PT, PhD, President
Arkena L. Dailey, PT, DPT, Vice-President*
Tracey Adler, PT, DPT*
Rebecca Duff, PTA, DHSc*
Melissa Fox, PT, DPT*
Elizabeth Locke, PT, PhD*
Susan Szasz Palmer, MLS

BOARD MEMBERS NOT PRESENT:

None

DHP STAFF PRESENT FOR ALL OR PART OF THE MEETING

Erin Barrett, Director of Legislative and Regulatory Affairs
Sarah Georgen, Licensing and Operations Supervisor
Barbara Hodgdon, PhD, Deputy Director, Healthcare Workforce Data Center
James Jenkins, RN, Agency Chief Deputy
Laura Mueller, Senior Licensing Program Coordinator
Matt Novak, Policy and Economic Analyst
Arne Owens, Agency Director
M. Brent Saunders, Senior Assistant Attorney General, Board Counsel
Yetty Shobo, PhD, Director, Healthcare Workforce Data CenterCorie Tillman Wolf, Executive Director

**Participant indicates attendance to count toward continuing education requirements*

OTHER GUESTS PRESENT:

Tom Bohanon, Virginia Physical Therapy Association
Paige Roberts
Edith Curry, Richard Knapp & Associates, PC

CALL TO ORDER

Dr. Mariano called the meeting to order at 10:01 a.m. and asked the Board members and staff to introduce themselves.

With seven Board members present at the meeting, a quorum was established.

Dr. Mariano read the mission of the Board, which is also the mission of the Department of Health Professions.

Dr. Mariano reminded the Board members and audience about microphones, computer agenda materials, breaks, sign-in sheets, and attendance for continuing education requirements.

Ms. Tillman Wolf then read the emergency egress instructions.

APPROVAL OF MINUTES

Dr. Mariano opened the floor to any edits or corrections regarding the draft minutes for meetings held between October 25, 2022, and November 29, 2022, including a Board meeting and Formal Hearing held on November 1, 2022, Telephone Conference meetings held on October 25, 2022, and November 29, 2022, respectively.

Ms. Tillman Wolf requested an edit to the Board Meeting minutes held on November 1, 2022. A correction was necessary on page six of the minutes under the “FSBPT Updates” to reflect Dr. Dailey’s attendance at the FSBPT Regulatory Training for Board Members held in August 2022.

Upon a **MOTION** by Dr. Duff and properly seconded by Dr. Adler, the Board voted to accept the minutes as amended. The motion carried unanimously (7-0).

ORDERING OF THE AGENDA

Dr. Mariano opened the floor to any additional items to add to the agenda.

Upon a **MOTION** by Dr. Locke, and properly seconded by Dr. Dailey, the Board voted to accept the agenda as presented. The motion carried unanimously (7-0).

PUBLIC COMMENT

The Board did not receive any public comment.

AGENCY REPORT

Mr. Owens thanked the Board of Physical Therapy for their service to the profession.

Mr. Owens highlighted the ongoing study commissioned by the Health Workforce Development Authority to identify workforce employment shortages in the Commonwealth. He provided an update to the Virginia Behavioral Health Transformation Plan, entitled “Right Help, Right Now” in which Mr. Jenkins would be participating over the next three years.

Mr. Owens said that DHP was actively working to identify strategic efforts to increase employee engagement, overall satisfaction, retention, and recruitment.

Mr. Owens also spoke to the 2023 General Assembly and stated that DHP was preparing for the next session with a focus on the budget for the Fiscal Year 2024 to 2026 biennial years.

With no questions, Mr. Owens concluded his report.

PRESENTATION

2022 Workforce Reports – Physical Therapist and Physical Therapist Assistant – Yetty Shobo, PhD, Director, and Barbara Hodgdon, PhD, Deputy Director, Healthcare Workforce Data Center

Dr. Shobo and Dr. Hodgdon provided the 2022 Workforce Reports for Physical Therapists and Physical Therapist Assistants.

The Board discussed the workforce reports.

Upon a **MOTION** by Dr. Dailey, properly seconded by Dr. Locke, the Board voted to accept the 2022 Workforce Reports for Physical Therapists and Physical Therapist Assistants as presented. The motion carried unanimously (7-0).

STAFF REPORTS

Executive Director's Report – Corie E. Tillman Wolf, J.D., Executive Director

Ms. Tillman Wolf welcomed Melanie Pagano as the new Deputy Executive Director and Florence Venable as the new Discipline Operations Supervisor for the Board. Ms. Tillman Wolf stated that Ms. Pagano was not in attendance at the meeting due to a prescheduled obligation.

Board Updates

Ms. Tillman Wolf provided board updates, noting the end of the renewal cycle on December 31, 2022. She also noted that all Board forms were updated to reflect new legislation to remove questions related to mental health conditions or impairment.

FSBPT Updates

Ms. Tillman Wolf provided updates on Board Member and staff participation in committees and workgroups through the Federation of State Boards of Physical Therapy (FSBPT). She reported that she participates in the Council of Board Administrators (CBA) Strategic Planning Task Force and Finance Committee. She also reported that Dr. Mariano participates in the Boundary Violations Committee and Dr. Dailey recently finished her appointment to the Ethics and Legislation Committee.

Ms. Tillman Wolf reported on the upcoming FSBPT meetings to include the 2023 Annual Meeting scheduled for October 19-21, 2023, in Jacksonville, Florida, and the Leadership Issues Forum (LIF) meeting scheduled for July 14-16, 2023, in Alexandria, Virginia.

PT Compact Updates

Ms. Tillman Wolf provided updates to the PT Compact stating that in December 2022, the PT Compact Commission entered a Memorandum of Understanding with the FSBPT to formalize their linked relationship. She reported that the PT Compact will have ongoing staffing and financial support to ensure its future success.

She reported on the ongoing compliance efforts from compact jurisdictions and noted Virginia's continued compliance with PT Compact requirements.

Ms. Tillman Wolf announced a PT Compact webinar on June 14, 2023, to promote the use of the Education Module by Physical Therapy and Physical Therapist Assistant Program Educators.

Ms. Tillman Wolf reported on the national status of the Physical Therapy Compact, including new states that have enacted legislation or have begun issuing privileges. She reported that thirty-four jurisdictions have passed legislation to join the Compact and that twenty-nine jurisdictions are currently issuing privileges.

Ms. Tillman Wolf reported on the revenue generated by PT Compact privilege purchases to the Board since its enactment in 2020.

Ms. Tillman Wolf provided information related to the active privileges in Virginia and the correlation of surrounding states for the mobility of licenses, noting that 588 active privileges were in Virginia as of May 10, 2023.

2023 Board Meetings

Ms. Tillman Wolf noted the remaining 2023 Board meeting dates.

- August 10, 2023
- November 9, 2023

Notes and Reminders

Ms. Tillman Wolf provided reminders to Board Members to keep board staff informed of participation in committees or workgroups, as well as any travel needs for FBSPT participation as travel authorization is required.

Ms. Tillman Wolf thanked the Board Members for their continued hard work and dedication.

Ms. Tillman Wolf answered questions from the Board regarding PT Compact privileges.

With no further questions, Ms. Tillman Wolf concluded her report.

Discipline Report

As of May 10, 2023, Ms. Tillman Wolf reported the following disciplinary statistics:

- 33 Patient Care cases
    - 1 at Informal Conferences
    - 1 at Formal Hearing
    - 11 at Enforcement
    - 20 at Probable Cause
    - 0 at APD

- 2 Non-Patient Care Cases
    - 0 at Informal
    - 0 at Formal
    - 1 at Enforcement
    - 1 at Probable Cause
    - 0 at APD

- 4 cases at Compliance

Ms. Tillman Wolf reported the following Total Cases Received and Closed:

- Q3 2020 – 13/18
- Q4 2020 – 7/6
- Q1 2021 – 8/12
- Q2 2021 – 12/19
- Q3 2021 – 12/8
- Q4 2021 – 20/7
- Q1 2022 – 11/12
- Q2 2022 – 9/8
- Q3 2022 – 15/18
- Q4 2022 – 3/10
- Q1 2023 – 15/21
- Q2 2023 – 13/18
- Q3 2023 – 10/8

With no questions, Ms. Tillman Wolf concluded her report.

Licensure Report – Sarah Georgen, Licensing and Operations Supervisor

Ms. Georgen presented licensure statistics that included the following information:

Licensure Statistics – All Licenses

Ms. Georgen presented licensure statistics that included the following information and trends in license count:

License	Q2 2023	Q3 2023	Change +/-
Physical Therapist	10,022	8,878	-1,144
Physical Therapist Assistant	4,093	3,615	-478

Total PT's and PTA.'s	14,115	12,493	-1,622
Direct Access Certification	1,427	1,437	+10

Criminal Background Check Statistics 2022

Ms. Georgen provided the Criminal Background Check statistics for 2022 that included the following information and trends since 2020:

	PT	PTA	Total
Total Applicants	**737**	**227**	**964**
CBC Record Not Disclosed	4	4	8
Self Disclosed	7	2	9
Total Convictions	11	6	17

Examination Statistics

Ms. Georgen presented the Physical Therapist examination statistics from October 2022 to April 2023 administrations and provided information on the examination trends.

Ms. Georgen also presented the Physical Therapist Assistant examination statistics from October 2022 to April 2023 administrations and provided information on the examination trends.

License Renewals

Ms. Georgen provided information regarding the Board's outgoing communications regarding licensure renewals provided in 2022. She provided the following information regarding the 2022 licensure renewals:

License	Renewed	Not Renewed	Renewed %
Physical Therapists	8,400	1,242	87.12%
Physical Therapist Assistants	3,456	511	87.12%

Continuing Education Audit

Ms. Georgen provided information regarding the continuing education audits conducted by the Board.

Customer Satisfaction

Ms. Georgen reported the customer satisfaction statistics for Q2 2022 to Q3 2023.

Ms. Georgen summarized the written comments from the customer satisfaction survey sent to new licensees.

Call Trends

Ms. Georgen provided a brief report on the call trends from 2019 to 2022. She stated that an average of 5,500 calls are received by the Board each year.

Updates for Expense Reimbursement Vouchers

Ms. Georgen provided information on changes to the Internal Revenue Service (IRS) Standard Mileage Rate increase effective January 1, 2023. She provided information to the Board Members on using an optional Virginia Department of Accounts Remittance Electronic Data Interchange (REDI) system for pending deposit notifications.

With no questions, Ms. Georgen concluded her report.

BREAK

The Board took a break at 11:13 a.m. and reconvened at 11:20 a.m.

COMMITTEE AND BOARD MEMBER REPORTS

Board of Health Professions Report – Rebecca Duff, PTA, DHSc

Dr. Duff stated that the Board of Health Professions has not recently met and did not have a report to provide.

With no questions, Dr. Duff concluded her report.

FSBPT Ethics and Legislation Committee – Arkena Dailey, PT, DPT

Dr. Dailey reported on her participation on the Ethics and Legislation Committee, as well as on the Boundary Violations Committee. She reported on the recent completion of updates to the model practice act by the Ethics and Legislation Committee.

With no questions, Dr. Dailey concluded her report.

FSBPT Boundary Violations Committee – Mira Mariano, PT, PhD

Dr. Mariano reported that the Sexual Misconduct and Boundary Violations Committee was tasked with identifying barriers to reporting violations to regulatory boards. She said that the Committee was developing resource materials for stakeholder groups including patients, providers, and boards.

Dr. Mariano answered questions from the Board regarding her report.

With no further questions, Dr. Mariano concluded her report.

LEGISLATIVE AND REGULATORY REPORT

Ms. Barrett provided an update on pending regulatory actions and the status of bills of interest in the General Assembly. The Board briefly discussed these updates.

With no questions, Ms. Barrett concluded her report.

BOARD DISCUSSION AND ACTIONS

Adopt Revisions to Guidance Document 112-4, Board guidance on requirement for licensure for instructors in a physical therapy program

Ms. Barrett provided an overview of suggested revisions to Guidance Document 112-4.

Upon a **MOTION** by Dr. Dailey, properly seconded by Ms. Szasz Palmer, the Board voted to adopt the revisions to Guidance Document 112-4, Board guidance on requirements for licensure for instructors in a physical therapy program as presented. The motion carried unanimously (7-0).

Repeal of Guidance Document 112-11, Board guidance on functional capacity evaluations

Ms. Barrett provided information to the Board regarding the recommendation to repeal Guidance Document 112-11 made by the Laws and Regulations Committee.

Upon a **MOTION** by Dr. Adler, properly seconded by Ms. Szasz Palmer, the Board voted to repeal Guidance Document 112-11, Board guidance on functional capacity evaluations as presented. The motion carried unanimously (7-0).

Adopt Exempt Regulatory Action Pursuant to SB1005/HB2359

Ms. Barrett provided information to the Board regarding proposed amendments to 18VAC112-20-121, Practice of dry needling, as a result of legislation enacted during the 2023 General Assembly Session to amend statutory language related to direct access (SB 1005/HB 2359).

Upon a **MOTION** by Dr. Adler, properly seconded by Dr. Dailey, the Board voted to amend 18VAC112-20-121 of the Board Regulations Governing the Practice of Physical Therapy as presented by exempt action, effective July 1, 2023. The motion carried unanimously (7-0).

Discussion – Updated Direct Access Patient Attestation and Medical Release Form – Effective July 1, 2023

Ms. Tillman Wolf provided information to the Board regarding the updated direct access patient attestation and medical release form, effective July 1, 2023, to conform to the previously discussed legislative amendments to the statutory language related to direct access.

Ms. Tillman Wolf answered questions from the Board notifications to licensees and website updates.

BOARD COUNSEL REPORT – M. Brent Saunders, Senior Assistant Attorney General

Upon a **MOTION** by Dr. Dailey, the Board convened in a closed meeting pursuant to §2.2-3711(A)(8) of the Code of Virginia for the purpose of consultation with legal counsel regarding specific legal matters requiring the provision of legal advice by such counsel, specifically the Henrico County Circuit Court proceedings in the matter of Scott Roberts, PT, and potential regulatory action relating to the performance of invasive and sensitive area procedures. She moved that Mr. Saunders, Ms. Tillman Wolf, Ms. Barrett, and Ms. Georgen attend the closed meeting because their presence in the closed meeting was deemed necessary and would aid the Board in its consideration of this topic. The motion carried unanimously (7-0).

Having unanimously certified that the matters discussed in the preceding closed session met the requirements of § 2.2-3712 of the Code of Virginia, upon motion by Dr. Dailey, the Board reconvened in open session.

BOARD MEMBER RECOGNITION

Dr. Mariano recognized Dr. Adler and Dr. Dailey for their service and dedication to the Board of Physical Therapy from 2015 to 2023. She announced that their second terms would expire on June 30, 2023, and provided brief remarks on each of their incumbencies. Dr. Mariano presented Dr. Adler and Dr. Dailey with plaques to recognize their service.

NEXT MEETING

The next meeting date is August 10, 2023.

ADJOURNMENT

Dr. Mariano announced that the Board would conduct one Formal Hearing following the meeting with Board Members Adler and Locke excluded.

Dr. Mariano called for any objections to adjourn the meeting. Hearing no objections and with all business concluded, the meeting adjourned at 12:34 p.m.

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Corie Tillman Wolf, J.D., Executive Director

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Date

UNAPPROVED

VIRGINIA BOARD OF PHYSICAL THERAPY
FORMAL ADMINISTRATIVE HEARING MINUTES

May 11, 2023	**Department of Health Professions Perimeter Center** **9960 Mayland Drive** **Henrico, Virginia 23233**

CALL TO ORDER:	The formal hearing of the Board was called to order at 1:06 p.m.
MEMBERS PRESENT:	Mira H. Mariano, PT, PhD, Chair Arkena Dailey, PT, DPT Rebecca Duff, PTA, DHSc Melissa Fox, PT, DPT Susan Szasz Palmer, MLS, Citizen Member
MEMBERS NOT PRESENT:	Tracey Adler, PT, DPT, CMTPT Elizabeth Locke, PT, PhD
BOARD COUNSEL:	M. Brent Saunders, Senior Assistant Attorney General
DHP STAFF PRESENT:	Sarah Georgen, Licensing and Operations Supervisor Corie Tillman Wolf, Executive Director Florence Venable, Discipline and Operations Supervisor
COURT REPORTER:	Juan Ortega Court Reporting
PARTIES ON BEHALF OF COMMONWEALTH:	Jennifer Challis, DHP, Senior Investigator Chris Bowers, Intake Admission Coordinator, Health Practitioners' Monitoring Program
MATTER:	**Ashley Duncan, PTA.** **License No.: 2305-203258** **Case No.: 218758**
ESTABLISHMENT OF A QUORUM:	With five (5) members present, a quorum was established.

DISCUSSION:	Ms. Duncan did not appear before the Board in accordance with the Notice of Formal Hearing dated March 14, 2023. Ms. Duncan was not represented by counsel. The Board received evidence and sworn testimony on behalf of the Commonwealth regarding the allegations in the Notice.
CLOSED SESSION:	Upon a motion by Dr. Mira Mariano and duly seconded by Dr. Rebecca Duff, the Board voted to convene a closed meeting, pursuant to §2.2-3711(A)(27) of the Code of Virginia, for the purpose of deliberation to reach a decision in the matter of Ashley Duncan, PTA. Additionally, she moved that Mr. Saunders, Ms. Venable, and Ms. Georgen attend the closed meeting because their presence in the closed meeting was deemed necessary and would aid the Board in its deliberations.
RECONVENE:	Having certified that the matters discussed in the preceding closed session met the requirements of §2.2-3712 of the Code, the Board reconvened in open session.
DECISION:	Upon a motion by Dr. Mira Mariano and duly seconded by Dr. Rebecca Duff, the Board moved to ***Indefinitely Suspend*** Ashley Duncan's right to renew her license to practice as a Physical Therapist Assistant. The motion carried.
VOTE:	The vote was unanimous (5-0).
ADJOURNMENT:	The Board adjourned at 1:47 p.m.

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Corie Tillman Wolf, JD, Executive Director

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Date

UNAPPROVED

VIRGINIA BOARD OF PHYSICAL THERAPY
SPECIAL MEETING MINUTES

June 26, 2023	**Department of Health Professions Perimeter Center** **9960 Mayland Drive** **Henrico, Virginia 23233**

CALL TO ORDER:	The special meeting of the Board, convened for the purpose of determining the appropriate sanction to impose against Scott Roberts, P.T., based upon the Finding of Facts and Conclusions of Law upheld by the Henrico County Circuit Court in Case No. CL22-3001, was called to order at 9:00 a.m.
MEMBERS PRESENT:	Mira H. Mariano, PT, PhD, Chair Tracey Adler, PT, DPT, CMTPT Melissa Fox, PT, DPT Elizabeth Locke, PT, PHD Susan Szasz Palmer, MLS, Citizen Member
MEMBERS NOT PRESENT:	Arkena L. Dailey, PT, DPT Rebecca Duff, PT, DHSc
BOARD COUNSEL:	M. Brent Saunders, Senior Assistant Attorney General
DHP STAFF PRESENT:	Melanie Pagano, Deputy Executive Director Corie Tillman Wolf, Executive Director Florence Venable, Discipline Operations Supervisor
COURT REPORTER:	Colleen Gregory-Gettel, CTR, Veteran Reporting, Inc.
PARTIES ON BEHALF OF COMMONWEALTH:	Anne Joseph, Adjudication Consultant
MATTER:	**Scott Jonathan Roberts, PT** **License No.: 2305-203258** **Case Nos.: 203438, 210912**
ESTABLISHMENT OF A QUORUM:	With five (5) members present, a quorum was established.

DISCUSSION:	Mr. Roberts appeared before the Board in accordance with the Board's notice dated May 18, 2023, and was represented by Richard J. Knapp, Esquire. The Board heard arguments on behalf of the parties.
CLOSED SESSION:	Upon a motion by Dr. Mira Mariano and duly seconded by Dr. Szasz Palmer, the Board voted to convene a closed meeting, pursuant to §2.2-3711(A)(8) of the Code of Virginia, for the purpose of deliberation to reach a decision in the matter of the appropriate sanction to impose against Scott Roberts, PT based upon the Finding of Facts and Conclusions of Law upheld by the Henrico County Circuit Court in Case No. CL22-3001. Additionally, she moved that Ms. Tillman Wolf, Ms. Pagano, Mr. Saunders, and Ms. Venable attend the closed meeting because their presence in the closed meeting was deemed necessary and would aid the Board in its deliberations.
RECONVENE:	After unanimously certifying that the matters discussed in the preceding closed session met the requirements of §2.2-3712 of the Code, the Board reconvened in open session.
DECISION:	Upon a motion by Dr. Adler and duly seconded by Dr. Fox, the Board moved to ***Indefinitely Suspend*** Scott Roberts' license to practice Physical Therapy for not less than two years from the date of the Board's March 15, 2022 Order. The motion carried.
VOTE:	The vote was unanimous (5-0).
ADJOURNMENT:	The Board adjourned at 11:12 a.m.

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Corie Tillman Wolf, JD, Executive Director

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Date

Legislative and Regulatory Report

Board of Physical Therapy
Current Regulatory Actions
As of July 6, 2023

In the Governor's Office

None.

In the Secretary's Office

VAC	Stage	Subject Matter	Date submitted*	Office; time in office	Notes
18VAC112-20	NOIRA	Regulatory Reduction	11/2/2022	Secretary 223 days	Regulatory reduction action
18VAC110-20	Fast-Track	Changes to comply with Compact rules	5/6/2022	Secretary 311 days	Changes to licensure for Canadian applicants to comply with Compact requirements

At DPB/OAG

VAC	Stage	Subject Matter	Date submitted*	Office; time in office	Notes
18VAC112-20	Exempt/ Final	Exempt action to implement SB1005 and HB2359	7/2/2023	OAG 4 days	Must be submitted to the Registrar by September 29, 2023 to qualify as exempt

* Date submitted for executive branch review

Recently effective or awaiting publication

None.

Board Discussion and Actions

Agenda Item: Repeal of Guidance Document 112-7

Included in your agenda package:

- Guidance Document 112-7; and

- Va. Code § 54.1-3482, updated July 1, 2023 by Chapters 136, 137, and 183 of the 2023 Acts of Assembly.

Staff Note: Due to the changes in direct access made by the General Assembly in the 2023 Session, this Guidance Document is no longer needed.

Action needed:

- Motion to repeal Guidance Document 112-7.

BOARD OF PHYSICAL THERAPY

Physical Therapists in Public Schools and Direct Access

The Board periodically receives questions regarding physical therapists in the school setting and the provisions related to direct access. The Board refers to the direct access provisions of Virginia Code § 54.1-3482 (B) and (C), which state as follows:

> *B. A physical therapist who has completed a doctor of physical therapy program approved by the Commission on Accreditation of Physical Therapy Education or who has obtained a certificate of authorization pursuant to § 54.1-3482.1 may evaluate and treat a patient for no more than 60 consecutive days after an initial evaluation without a referral under the following conditions: (i) the patient is not receiving care from any licensed doctor of medicine, osteopathy, chiropractic, podiatry, or dental surgery, a licensed nurse practitioner practicing in accordance with his practice agreement, or a licensed physician assistant acting under the supervision of a licensed physician for the symptoms giving rise to the presentation at the time of the presentation to the physical therapist for physical therapy services or (ii) the patient is receiving care from a licensed doctor of medicine, osteopathy, chiropractic, podiatry, or dental surgery, a licensed nurse practitioner practicing in accordance with his practice agreement, or a licensed physician assistant acting under the supervision of a licensed physician at the time of his presentation to the physical therapist for the symptoms giving rise to the presentation for physical therapy services and (a) the patient identifies a licensed doctor of medicine, osteopathy, chiropractic, podiatry, or dental surgery, a licensed nurse practitioner practicing in accordance with his practice agreement, or a licensed physician assistant acting under the supervision of a licensed physician from whom he is currently receiving care; (b) the patient gives written consent for the physical therapist to release all personal health information and treatment records to the identified practitioner; and (c) the physical therapist notifies the practitioner identified by the patient no later than 14 days after treatment commences and provides the practitioner with a copy of the initial evaluation along with a copy of the patient history obtained by the physical therapist. Treatment for more than 60 consecutive days after evaluation of such patient shall only be upon the referral and direction of a licensed doctor of medicine, osteopathy, chiropractic, podiatry, or dental surgery, a licensed nurse practitioner practicing in accordance with his practice agreement, or a licensed physician assistant acting under the supervision of a licensed physician. A physical therapist may contact the practitioner identified by the patient at the end of the 60-day period to determine if the practitioner will authorize additional physical therapy services until such time as the patient can be seen by the practitioner. After discharging a patient, a physical therapist shall not perform an initial evaluation of a patient under this subsection without a referral if the physical therapist has performed an initial evaluation of the patient under this subsection for the same condition within the immediately preceding 60 days.*
>
> *C. A physical therapist who has not completed a doctor of physical therapy program*

Repeal

> *approved by the Commission on Accreditation of Physical Therapy Education or who has not obtained a certificate of authorization pursuant to § 54.1-3482.1 may conduct a one-time evaluation that does not include treatment of a patient without the referral and direction of a licensed doctor of medicine, osteopathy, chiropractic, podiatry, or dental surgery, a licensed nurse practitioner practicing in accordance with his practice agreement, or a licensed physician assistant acting under the supervision of a licensed physician; if appropriate, the physical therapist shall immediately refer such patient to the appropriate practitioner.*

The direct access provisions apply regardless of the setting of the physical therapist, including the school setting. The direct access provisions are not limited by the nature of the services or evaluation, for example, whether the student is to be considered for or receive services pursuant to an Individualized Education Plan (IEP) or a 504 Plan.

The Board notes that Virginia Code § 54.1-3482(G) relates to the provision of physical therapy services without referral or supervision. The language in subsection (G)(iii) refers only to students with IEP plans:

> *G. However, a licensed physical therapist may provide, without referral or supervision, physical therapy services to … (iii) special education students who, by virtue of their individualized education plans (IEPs), need physical therapy services to fulfill the provisions of their IEPs…*

Repeal

§ 54.1-3482. Practice of physical therapy; certain experience and referrals required; physical therapist assistants

A. It shall be unlawful for a person to engage in the practice of physical therapy except as a licensed physical therapist, upon the referral and direction of a licensed doctor of medicine, osteopathy, chiropractic, podiatry, or dental surgery, a licensed advanced practice registered nurse practicing in accordance with the provisions of § 54.1-2957, or a licensed physician assistant acting under the supervision of a licensed physician, except as provided in this section.

B. A physical therapist who has completed a doctor of physical therapy program approved by the Commission on Accreditation of Physical Therapy Education or who has obtained a certificate of authorization pursuant to § 54.1-3482.1 may evaluate and treat a patient without a referral under the following conditions: (i) the patient is not receiving care from any licensed doctor of medicine, osteopathy, chiropractic, podiatry, or dental surgery, a licensed advanced practice registered nurse practicing in accordance with the provisions of § 54.1-2957, or a licensed physician assistant acting under the supervision of a licensed physician for the symptoms giving rise to the presentation at the time of the presentation to the physical therapist for physical therapy services or (ii) the patient is receiving care from a licensed doctor of medicine, osteopathy, chiropractic, podiatry, or dental surgery, a licensed advanced practice registered nurse practicing in accordance with the provisions of § 54.1-2957, or a licensed physician assistant acting under the supervision of a licensed physician at the time of his presentation to the physical therapist for the symptoms giving rise to the presentation for physical therapy services and (a) the patient identifies a licensed doctor of medicine, osteopathy, chiropractic, podiatry, or dental surgery, a licensed advanced practice registered nurse practicing in accordance with the provisions of § 54.1-2957, or a licensed physician assistant acting under the supervision of a licensed physician from whom he is currently receiving care; (b) the patient gives written consent for the physical therapist to release all personal health information and treatment records to the identified practitioner; and (c) the physical therapist notifies the practitioner identified by the patient no later than 14 days after treatment commences and provides the practitioner with a copy of the initial evaluation along with a copy of the patient history obtained by the physical therapist.

C. A physical therapist who has not completed a doctor of physical therapy program approved by the Commission on Accreditation of Physical Therapy Education or who has not obtained a certificate of authorization pursuant to § 54.1-3482.1 may conduct a one-time evaluation that does not include treatment of a patient without the referral and direction of a licensed doctor of medicine, osteopathy, chiropractic, podiatry, or dental surgery, a licensed advanced practice registered nurse practicing in accordance with the provisions of § 54.1-2957, or a licensed physician assistant acting under the supervision of a licensed physician; if appropriate, the physical therapist shall immediately refer such patient to the appropriate practitioner.

D. Invasive procedures within the scope of practice of physical therapy, except for the practice of

dry needling, shall at all times be performed only under the referral and direction of a licensed doctor of medicine, osteopathy, chiropractic, podiatry, or dental surgery, a licensed advanced practice registered nurse practicing in accordance with the provisions of § 54.1-2957, or a licensed physician assistant acting under the supervision of a licensed physician. Nothing in this section shall be construed to authorize a physical therapist in the practice of dry needling to fail to comply with the provisions of § 54.1-2956.9.

E. It shall be unlawful for any licensed physical therapist to fail to immediately refer any patient to a licensed doctor of medicine, osteopathy, chiropractic, podiatry, or dental surgery, or a licensed advanced practice registered nurse practicing in accordance with the provisions of § 54.1-2957 when such patient's medical condition is determined, at the time of evaluation or treatment, to be beyond the physical therapist's scope of practice. Upon determining that the patient's medical condition is beyond the scope of practice of a physical therapist, a physical therapist shall immediately refer such patient to an appropriate practitioner.

F. Any person licensed as a physical therapist assistant shall perform his duties only under the direction and control of a licensed physical therapist.

G. However, a licensed physical therapist may provide, without referral or supervision, physical therapy services to (i) a student athlete participating in a school-sponsored athletic activity while such student is at such activity in a public, private, or religious elementary, middle or high school, or public or private institution of higher education when such services are rendered by a licensed physical therapist who is certified as an athletic trainer by the National Athletic Trainers' Association Board of Certification or as a sports certified specialist by the American Board of Physical Therapy Specialties; (ii) employees solely for the purpose of evaluation and consultation related to workplace ergonomics; (iii) infants and toddlers, from birth to age three, who require physical therapy services to fulfill the provisions of their individualized services plan under Part C of the Individuals with Disabilities Education Act (20 U.S.C. § 1431 et seq.) and students with disabilities who require physical therapy services to fulfill the provisions of their individualized education plan or physical therapy services provided under § 504 of the federal Rehabilitation Act of 1973 (29 U.S.C. § 794 et seq.); (iv) the public for the purpose of wellness, fitness, and health screenings; (v) the public for the purpose of health promotion and education; and (vi) the public for the purpose of prevention of impairments, functional limitations, and disabilities.

2000, c. 688;2001, c. 858;2002, cc. 434, 471;2003, c. 496;2005, c. 928;2007, cc. 9, 18;2015, cc. 724, 746;2018, c. 776;2021, Sp. Sess. I, c. 481;2023, cc. 136, 137, 183.

The chapters of the acts of assembly referenced in the historical citation at the end of this section(s) may not constitute a comprehensive list of such chapters and may exclude chapters whose provisions have expired.

Agenda Item: Adoption of revised policy on meetings held with electronic participation pursuant to statutory changes

Included in your agenda package:

- Proposed revised electronic participation policy;
- Virginia Code § 2.2-3708.3

Action needed:

- Motion to revise policy on meetings held with electronic participation as presented.

Virginia Department of Health Professions

Meetings Held with Electronic Participation

Purpose:

To establish a written policy for allowing electronic participation of board or committee members for meetings of the health regulatory boards of the Department of Health Professions or their committees.

Policy:

Electronic participation by members of the health regulatory boards of the Department of Health Professions or their committees shall be in accordance with the procedures outlined in this policy.

Authority:

This policy for conducting a meeting with electronic participation shall be in accordance with Virginia Code § 2.2-3708.3.

Procedures:

1. One or more members of the Board or a committee may participate electronically if, on or before the day of a meeting, the member notifies the chair and the executive director that he/she is unable to attend the meeting due to:

    a. a temporary or permanent disability or other medical condition that prevents the member's physical attendance;

    b. a medical condition of a member of the member's family requires the member to provide care that prevents the member's physical attendance;

    c. the member's principal residence is more than 60 miles from the meeting location identified in the required notice for such meeting; or

    d. the member is unable to attend to the meeting due to a personal matter and identifies with specificity the nature of the personal matter.

    No member, however, may use remote participation due to personal matters more than two meetings per calendar year or 25% of the meetings held per calendar year rounded up to the next whole number, whichever is greater.

2. Participation by a member through electronic communication means must be approved by the board chair or president. The reason for the member's electronic participation shall

be stated in the minutes in accordance with Virginia Code § 2.2-3708.3(A)(4). If a member's participation from a remote location is disapproved because it would violate this policy, it must be recorded in the minutes with specificity.

3. The board or committee holding the meeting shall record in its minutes the remote location from which the member participated; the remote location, however, does not need to be open to the public and may be identified by a general description.

§ 2.2-3708.3. (Effective September 1, 2022) Meetings held through electronic communication means; situations other than declared states of emergency

A. Public bodies are encouraged to (i) provide public access, both in person and through electronic communication means, to public meetings and (ii) provide avenues for public comment at public meetings when public comment is customarily received, which may include public comments made in person or by electronic communication means or other methods.

B. Individual members of a public body may use remote participation instead of attending a public meeting in person if, in advance of the public meeting, the public body has adopted a policy as described in subsection D and the member notifies the public body chair that:

1. The member has a temporary or permanent disability or other medical condition that prevents the member's physical attendance;

2. A medical condition of a member of the member's family requires the member to provide care that prevents the member's physical attendance;

3. The member's principal residence is more than 60 miles from the meeting location identified in the required notice for such meeting; or

4. The member is unable to attend the meeting due to a personal matter and identifies with specificity the nature of the personal matter. However, the member may not use remote participation due to personal matters more than two meetings per calendar year or 25 percent of the meetings held per calendar year rounded up to the next whole number, whichever is greater.

If participation by a member through electronic communication means is approved pursuant to this subsection, the public body holding the meeting shall record in its minutes the remote location from which the member participated; however, the remote location need not be open to the public and may be identified in the minutes by a general description. If participation is approved pursuant to subdivision 1 or 2, the public body shall also include in its minutes the fact that the member participated through electronic communication means due to a (i) temporary or permanent disability or other medical condition that prevented the member's physical attendance or (ii) family member's medical condition that required the member to provide care for such family member, thereby preventing the member's physical attendance. If participation is approved pursuant to subdivision 3, the public body shall also include in its minutes the fact that the member participated through electronic communication means due to the distance between the member's principal residence and the meeting location. If participation is approved pursuant to subdivision 4, the public body shall also include in its minutes the specific nature of the personal matter cited by the member.

If a member's participation from a remote location pursuant to this subsection is disapproved because such participation would violate the policy adopted pursuant to subsection D, such

disapproval shall be recorded in the minutes with specificity.

C. With the exception of local governing bodies, local school boards, planning commissions, architectural review boards, zoning appeals boards, and boards with the authority to deny, revoke, or suspend a professional or occupational license, any public body may hold all-virtual public meetings, provided that the public body follows the other requirements in this chapter for meetings, the public body has adopted a policy as described in subsection D, and:

1. An indication of whether the meeting will be an in-person or all-virtual public meeting is included in the required meeting notice along with a statement notifying the public that the method by which a public body chooses to meet shall not be changed unless the public body provides a new meeting notice in accordance with the provisions of § 2.2-3707;

2. Public access to the all-virtual public meeting is provided via electronic communication means;

3. The electronic communication means used allows the public to hear all members of the public body participating in the all-virtual public meeting and, when audio-visual technology is available, to see the members of the public body as well;

4. A phone number or other live contact information is provided to alert the public body if the audio or video transmission of the meeting provided by the public body fails, the public body monitors such designated means of communication during the meeting, and the public body takes a recess until public access is restored if the transmission fails for the public;

5. A copy of the proposed agenda and all agenda packets and, unless exempt, all materials furnished to members of a public body for a meeting is made available to the public in electronic format at the same time that such materials are provided to members of the public body;

6. The public is afforded the opportunity to comment through electronic means, including by way of written comments, at those public meetings when public comment is customarily received;

7. No more than two members of the public body are together in any one remote location unless that remote location is open to the public to physically access it;

8. If a closed session is held during an all-virtual public meeting, transmission of the meeting to the public resumes before the public body votes to certify the closed meeting as required by subsection D of § 2.2-3712;

9. The public body does not convene an all-virtual public meeting (i) more than two times per calendar year or 25 percent of the meetings held per calendar year rounded up to the next whole number, whichever is greater, or (ii) consecutively with another all-virtual public meeting; and

10. Minutes of all-virtual public meetings held by electronic communication means are taken as required by § 2.2-3707 and include the fact that the meeting was held by electronic communication means and the type of electronic communication means by which the meeting was held. If a member's participation from a remote location pursuant to this subsection is disapproved because such participation would violate the policy adopted pursuant to subsection D, such disapproval shall be recorded in the minutes with specificity.

D. Before a public body uses all-virtual public meetings as described in subsection C or allows members to use remote participation as described in subsection B, the public body shall first

adopt a policy, by recorded vote at a public meeting, that shall be applied strictly and uniformly, without exception, to the entire membership and without regard to the identity of the member requesting remote participation or the matters that will be considered or voted on at the meeting. The policy shall:

1. Describe the circumstances under which an all-virtual public meeting and remote participation will be allowed and the process the public body will use for making requests to use remote participation, approving or denying such requests, and creating a record of such requests; and

2. Fix the number of times remote participation for personal matters or all-virtual public meetings can be used per calendar year, not to exceed the limitations set forth in subdivisions B 4 and C 9.

Any public body that creates a committee, subcommittee, or other entity however designated of the public body to perform delegated functions of the public body or to advise the public body may also adopt a policy on behalf of its committee, subcommittee, or other entity that shall apply to the committee, subcommittee, or other entity's use of individual remote participation and all-virtual public meetings.

2022, c. 597.

The chapters of the acts of assembly referenced in the historical citation at the end of this section(s) may not constitute a comprehensive list of such chapters and may exclude chapters whose provisions have expired.

Agenda Item: Consideration of Petition for Rulemaking

Included in your agenda package:

- Petition for rulemaking, which requests that the Board amend its regulations to define "invasive procedure," specifically excluding the practice of pelvic floor therapy; and

- Comments received via Town Hall in response to the petition.

Staff Note: 91 comments were received on Town Hall in response to this petition. 43 are redacted entirely because they are not in response to the petition, but instead improperly comment on disciplinary matters before the Board, appeals of disciplinary decisions of the Board, refer to specific practitioners, or contain ad hominem attacks on Board members.

47 of the remaining comments were in support of the petition, some of which contain redacted portions for the reasons stated above. None of the remaining comments were in opposition to the petition.

Action needed:

- Motion to either:
    - Deny the petition for rulemaking, specifying the reason(s) why; or
    - Accept the petition for rulemaking and initiating a Notice of Intended Regulatory Action.

Delivered by Hand 4/6/2023

PT

APR 06 2023

JOSEPH G. GIANFORTONI, MD, FACOG

April 6, 2023

Virginia Department of Health Professions
Board of Physical Therapy
9960 Mayland Drive, Suite 300
Henrico, Virginia 23233

RE: Va. Code §2.2-4007 - Petition for Rule Making

Dear Sir or Madam,

Enclosed, please find my Petition for Rule Making and attached exhibits, pursuant to Va. Code §2.2-4007. I look forward to receiving a notice from the Board of Physical Therapy within fourteen (14) days regarding this petition.

If you have any questions, please don't hesitate to contact me directly.

Sincerely,

J Gianfortoni

Joseph G. Gianfortoni, MD, FACOG

Enclosure

113 BRANCHVIEW CIRCLE, HENRICO, VA 23229
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Virginia Department of
Health Professions
Board of Physical Therapy

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ptboard@dhp.virginia.gov

Petition for Rulemaking

The Code of Virginia § 2.2-4007) and the Public Participation Guidelines of this board require a person who wishes to petition the board to develop a new regulation or amend an existing regulation to provide certain information. Within 14 days of receiving a valid petition, the board will notify the petitioner and send a notice to the Register of Regulations identifying the petitioner, the nature of the request and the plan for responding to the petition. Following publication of the petition in the Register, a 21-day comment period will begin to allow written comment on the petition. Within 90 days after the comment period, the board will issue a written decision on the petition. If the board has not met within that 90-day period, the decision will be issued no later than 14 days after it next meets.

Petitioner's full name (Last, First, Middle initial, Suffix,) Gianfortoni, Joseph, G., MD, FACOG	**Street Address:** 113 Branchview Circle **City:** Henrico **State:** VA **Zip Code:** 23229
Area Code and Telephone Number: 804-240-9581 mobile	**Email Address (optional):** jggianfortoni@gmail.com

Respond to the following questions:

1.What regulation are you petitioning the board to amend? Please state the title of the regulation and the section/sections you want the board to consider amending.

To amend the Regulations Governing the Practice of Physical Therapy, 18 VAC 112-20 by 1) adding a definition for "invasive procedure" in 18VAC112-20-10 and 2) adding section 18VAC112-20-122 titled **"Practice of pelvic floor therapy" where said therapy is noted to be non-invasive.**

2. Please summarize the substance of the change you are requesting and state the rationale or purpose for the new or amended rule.

1. On November 1, 2022, The Board of Physical Therapy issued Guidance Document:112-14 - "Guidance on Electromyography ("EMG"), Sharp Debridement, and Removal of Sutures, Staples, or Surgical Drains and the Practice of Physical Therapy," that holds in relevant part:

Electromyography ("EMG") EMG *is an invasive procedure and requires referral and direction from a licensed practitioner, in accordance with Virginia Code § 54.1-3482.*

Sharp Debridement *Sharp debridement is an invasive procedure and requires referral and direction from a licensed practitioner, in accordance with Virginia Code § 54.1-3482.*

Sutures, Staples, or Surgical Drains T*he removal of sutures or staples is an invasive procedure and requires referral and direction from a licensed practitioner, in accordance with Virginia Code § 54.1-3482.*

2. On March 21, 2023 the Governor of Virginia approved unlimited direct access, to include ***dry needling***, removing the requirement for physical therapists to obtain a prescription. Therefore, ***dry needling is no longer considered an "invasive procedure"*** within the practice of Physical Therapy

3. Va. Code §54.1-3482. Practice of physical therapy; certain experience and referrals required; physical therapist assistants states in relevant part:

D. ***Invasive procedures*** within the scope of practice of physical therapy shall at all times be performed only under the referral and direction of a licensed doctor of medicine, osteopathy, chiropractic, podiatry, or dental surgery, a licensed nurse practitioner practicing in accordance with the provisions of § 54.1-2957, or a licensed physician assistant acting under the supervision of a licensed physician.

4. 18 VAC l 12-20-170(B)(3) Confidentiality and practitioner-patient communication provides in relevant part: **B. Communication with patients**

3. ***Before any invasive procedure is performed***, informed consent shall be obtained from the patient and documented in accordance with the policies of the health care entity. Practitioners shall inform patients of the risks, benefits, and alternatives of the recommended invasive procedure that a reasonably prudent practitioner in similar practice in Virginia would tell a patient. In the instance of a minor or a patient who is incapable of making an informed decision on his own behalf or is incapable of communicating such a decision due to a physical or mental disorder, the legally authorized person available to give consent shall be informed and the consent documented.

5. **As of the date if this filing,** the Virginia Board of Physical Therapy has ***promulgated no amendments to the administrative code to define "invasive procedure"*** other than its November 2022 Guidance Document 112-14, supra. See for example: Virginia Emergency Medical Services Regulations' definition of an "invasive procedure" is at 12VAC5-31-10 and the Virginia Board of Medicine's definition of "invasive procedure" is at 18VAC85-140-150(A)(3)(c).

6. Is **Pelvic Floor Therapy an invasive procedure in the practice of Physical Therapy?** The APTA and the VPTA's pelvic health documentation gives guidance on how the Commonwealth of Virginia's Administrative Process Act should be outlined, including but not limited to, is pelvic floor therapy within the scope of practice for physical therapy, and if a student PT or PTA can perform pelvic floor therapy without pelvic floor certification or without the appropriate entry level degrees required for graduation and licensure.

7. **Does the practice of Pelvic Floor Therapy require certification, licensure or a minimum number of hours of training in the practice of Physical Therapy?**

8. What is the standard of care for **Pelvic Floor Therapy in the practice of Physical Therapy?**

CONTINUED ON ATTACHED ADDENDUM FOR ALL SUPPORTING EXHIBITS FOR AN ADDITIONAL 48 PAGES.

3. State the legal authority of the board to take the action requested. In general, the legal authority for the adoption of regulations by he board is found in § 54.1-2400 of the Code of Virginia. If there is other legal authority for promulgation of a regulation, please provide that Code reference.

Code of Virginia § 54.1-201 A 5 states in part that powers and duties of the board shall be to "promulgate regulations in accordance with the Administrative Process Act (§ 2.2-4000 et seq.) necessary to assure continued competency" and "to prevent deceptive or misleading practices by practitioners." Code of Virginia § 54.1-3474 B states in part the **"Board shall promulgate regulations establishing requirements to ensure continuing competency of physical therapists and physical therapist assistants."**

Signature: Gianfortoni

Date: 4/6/2023

ADDENDUM TO PETITION FOR RULEMAKING

Exhibit 1: APTA Pelvic Health. (2021). *Position Statement on Internal Physical Therapy Pelvic Examinations and Interventions*. Retrieved from https://aptapelvichealth.org/wp-content/uploads/2021/01 Position-Statement-on-Internal-Physical-Therapy-Pelvic-Examinations-and-Interventions-Updated-1-11-2021-1.pdf

[NOTE: "A separate written consent is NOT recommended"]

Exhibit 2: Herman & Wallace. (2019). *Pelvic Floor Function, Dysfunction and Treatment (Level 1).* Virginia: Herman & Wallace.

[NOTE: View page 23 "What is in your Practice Act? … state-specific guidelines… physical therapist, occupational therapist…" and "Internal vaginal and rectal assessment… within the scope of practice of the licensed physical therapist" but "oppose teaching internal pelvic muscle treatment to PTAs." View page 24 "Is this covered in your state practice act?"]

Exhibit 3: APTA Pelvic Health. (2023). *Position Statement on Use of Chaperones*. Retrieved from https://aptapelvichealth.org/wp-content/uploads/2023/01/Academy-of-Pelvic-Health-Position-Statement-on- Use-of-Chaperones.pdf.

[NOTE: The last statement from APTA Pelvic Health only refers to pelvic floor therapy as "sensitive" (23 times) with NO mention of pelvic floor treatment as medically invasive.]

Exhibit 4: VCU Health. (n.d). *Understanding Pelvic Floor Conditions*. Retrieved from https://go.vcuhealth.org/media/file/UrogynGuide-UnderstandingPelvicFloorConditions-Sept2019.pdf

[NOTE: Under "Non-invasive Solutions" ... "You may also receive treatment in the form of physical therapy, which may involve biofeedback or nerve stimulation to teach you how to activate your muscles."]

Exhibit 5: Bon Secours. (n.d). *Women's Health.* Retrieved from http://www.bonsecoursinmotion.com/physical-therapy/physical-therapy-programs/womens-health/.

[NOTE: Under "Pelvic Pain" specifically states "There are non-invasive physical therapy solutions to address pelvic pain. A customized program may include biofeedback, manual therapy, massage, and a home exercise program."]

Exhibit 6: Bon Secours. (n.d). Pelvic Pain. Retrieved from http://www.bonsecoursphysicaltherapy.com/pelvic-pain/.

[NOTE: "There are non-invasive physical therapy solutions to address pelvic pain. The program your therapist customizes for you may include some of the following therapies: ... Manual therapy for pelvis/coccyx realignment... Internal massage to pelvic floor trigger points." Bon Secours additionally states using devices including but not limited: biofeedback, "Gentle electrical stimulation to relax muscles or retrain muscular contraction... Dilator training" advertised as "non-invasive therapy solutions."]

Exhibit 7: The Urology Group. (n.d). *Pelvic Floor Rehabilitation and Stimulation: A Non-Invasive Treatment.* Retrieved from https://www.urologygroupvirginia.com/urologic-care/incontinence/pelvic-floor-rehabilitation.

[NOTE: The entire document is regarding Pelvic Floor Rehabilitation and Stimulation: A Non-Invasive Treatment, including but not limited to pelvic floor stimulation with internal sensors which stimulates the pelvic floor sensors as well as manual examination to check pelvic muscles for spasms and tenderness.]

Exhibit 8: Herman & Wallace. (2021). *Pelvic Floor Function Level 2B.* Virginia: Herman & Wallace.

[NOTE: Page 81 "Use the index and middle fingers from the other hand to pull down on the posterior fourchette." Also on page 81: "Place two fingers into the vagina 2-6 cm (to the level of the PIP-MCP), spread the fingers laterally and press down on the posterior wall. Ask the patient to bear down and observe for the bulging of the posterior wall tissue up between your fingers." Page 61 "When to address the pelvic floor versus pelvis?" Page 85 "cross fiber strum"]

Exhibit 9: Herman & Wallace. (2021). *Pelvic Floor Function Level 2A.* Virginia: Herman & Wallace.

[NOTE: Page 51 "supine, lithotomy, lateral, and standing" and "Inspection of the vulva, perineum, and anus in women and of perineum and anus in men is performed to look for skin pathology and anatomical abnormalities. Testing for pelvic organ prolapse is an integral part of the physical examination of every patient with pelvic floor muscle complaints. A vaginal and rectal exam is part of this investigation." Page 132 "Nerve Flossing Client is supine, hip flexed to 90° with knee bent … Clinician is: (a) sitting on a chair with the client foot on shoulder of clinician"]

Exhibit 10: Herman & Wallace. (2022). *Pelvic Floor Function, Dysfunction and Treatment Level 1.* Virginia: Herman & Wallace.

[NOTE: Page 15 "No Tenting Please!" and "Menses no contraindicated, you can use menstrual cup". Page 149 "Pessaries are used by 86% of gynaecologists, 98% urogynaecologists" and "Pessaries are considered minimally-invasive". Page 152 "Manual therapy… Joint mobilization, Trigger point and soft tissue massage, Myofascial release, Muscle energy techniques, Connective Tissues Massage… Optimal Musculoskeletal alignment, Connective Tissue mobility" As the PFT documentation shows, orthopedic manual therapy modalities should not be confused with pelvic floor therapy treatment as it depends on the intent and the purpose of the treatment; if you're assessing the pubic symphysis, it may be pelvic floor-related, but it could be used for other orthopedic conditions. There should be a delineation.]

Exhibit 11: Herman & Wallace. (2021). *Pelvic Floor Capstone.* Virginia: Herman & Wallace.

[NOTE: Page 127 "This technique allows you to do both internal and external endopelvic fascia at the same, increasing fascial release… combine the internal and external hand."]

Exhibit 12: Various documents from resources provided by teachings from University of St. Augustine from 2008 and 2009.

[NOTE: Page 120, Figure 33 shows palpation of "the anterior surface of both pubic bodies with both thumbs to assess anterior/posterior relations" and Page 108 "Coccyx examination and manipulation" entry-level techniques taught in physical therapy school and reiterated in multiple CEU courses.]

Furthermore, a quick search online and evidence-based journals will show many of these topics easily accessible for one to self-study.

Position Statement on Internal Physical Therapy Pelvic Examinations and Interventions

APTA Pelvic Health, an academy of the American Physical Therapy Association Academy of Pelvic Health Physical Therapy (APTA Pelvic Health) of APTA supports examination and intervention by licensed physical therapists in the management of individuals with pelvic dysfunctions.

Internal vaginal and rectal examination and intervention of pelvic dysfunction, to include external and internal examination of pelvic floor muscles and/or examination of external genitalia specific to diagnoses when those apply, is within the scope of practice of the licensed physical therapist (PT).

In addition, physical therapy assistants (PTAs) may provide internal pelvic floor muscle intervention after the physical therapist performs an internal pelvic floor evaluation examination. PTAs may provide pelvic floor physical therapy interventions 1) under general supervision of the PT 2) under the established PT management plan and plan of care 3) with documented training and competency and 4) within their state Practice Act. Interventions available for PTA use in the treatment of pelvic floor disorders are listed in APTA Pelvic Health's Position Statement on PTA education, revised in January 2021. Physical therapy students may provide internal pelvic floor physical therapy after they have completed documented training and while working under the supervision of a physical therapist.

Licensed physical therapists, student physical therapists and physical therapy assistants (PTAs) should, at all times know, understand, and adhere to their individual State Practice Acts and any rules/regulations that govern PT and PTA professional licenses as they relate to internal pelvic floor muscle examination and interventions.

APTA Pelvic Health advises that physical therapy examination of and interventions to the internal pelvic muscles be taught to physical therapists, supervised physical therapist students and PTAs. PTAs may be instructed in examination and interventions of the internal pelvic muscles under the provision that this education is intended for foundational knowledge and that examination of the pelvic dysfunction should remain within the scope of the licensed physical therapist.

APTA Pelvic Health also recommends the following:

I. The supervising PT must have didactic and psychomotor training and experience in pelvic health before mentoring a PTA or PT student.
II. Interventions for pelvic dysfunction including, but not limited to, therapeutic exercise, neuromuscular re-education, manual therapy and behavioral retraining may require immediate and continuous examination and evaluation throughout the intervention while at other times may be relatively routine. In routine circumstances, those interventions may be delegated to PTAs and student physical therapists under direct supervision. When immediate and continuous examination and evaluation is necessary, those interventions should be performed only by a licensed physical therapist.
III. APTA Pelvic Health recommends that patient/guardian informed consent be well documented when performing external and internal pelvic muscle examination and intervention. A separate written consent is **not** recommended since external and internal pelvic muscle examination is within the scope of practice of the physical therapist.
IV. All clinicians should thoroughly review intake forms and be alert to previous or current sexual abuse

that may affect the patient/client's ability to proceed with internal exam. Many patients with a history of trauma will not divulge this information on intake forms but instead verbally share this information with the clinician during the course of treatment.

V. APTA Pelvic Health offers the following recommendations for the examination and intervention of special populations:

A. **Antenatal, peripartum and postpartum:**

1. APTA Pelvic Health supports internal pelvic muscle examination and intervention in the management of antepartum, peripartum and postpartum women with pelvic dysfunctions.
2. APTA Pelvic Health recommends internal pelvic muscle examination and intervention be considered for the comprehensive standard musculoskeletal assessment of pelvic dysfunction in antepartum, peripartum and postpartum women.
3. The standard assessment in the antepartum and peripartum population should include external pelvic muscle examination.
4. Caution should be advised when performing internal examination and intervention during the first trimester of pregnancy, during any high-risk antepartum diagnosis, and immediately postpartum prior to medical clearance post delivery. If the licensed physical therapist has concerns regarding such circumstances the Academy recommends documenting medical clearance before proceeding with internal pelvic physical therapy.

B. **Pediatric:**

1. The Academy of Pediatrics' definition of pediatric age ranges are as follows –
    a) Infancy – birth-2 years
    b) Childhood – 2-12 years
    c) Adolescence – 12-21 years (Hardin AP, 2017)
2. Patient and parent/guardian's informed consent must be clearly documented.
3. The parent/guardian must be in the room during examination and intervention with a provision for appropriate privacy if requested by the patient.
4. Standard first line examination for a pediatric pelvic patient includes visualization and external surface electrode biofeedback of the external genitalia of the patient.
5. However, APTA Pelvic Health advises that no internal pelvic examination, either vaginal or rectal, be performed by a physical therapist on a minor or a patient who has not previously had an internal pelvic exam unless there is a written referral from the physician and clear documented consent by the parent/guardian and patient.
6. The physical therapist should be aware of and in compliance with state law in reference to age of consent.
7. In regard to Direct Access, a pelvic exam is dependent on the state PT Practice Act, a signed written consent and verbal consent from the parent/guardian and patient, and any facility regulations in place.
8. APTA Pelvic Health recommends that the referring physician be contacted with a request for verbal/written referral for a pediatric patient under the age of 16 years or under the legal consent age of 18 years of age.
9. The referring physician should be contacted with any questions, need for clarification of diagnosis, or to be made aware of any questions/concerns regarding the pelvic floor practice by the parent, child, or family member.
10. Pelvic floor therapy in the pediatric population should be performed only by qualified physical therapists with documented competency and training in pediatric pelvic dysfunction.

C. **Cognitively impaired**

1. APTA Pelvic Health advises internal pelvic muscle examination and interventions only be

performed to individuals who can express clear understanding of the nature of the examination and can provide their informed consent and/or the consent of a guardian.

EXHIBIT

Pelvic Floor Function, Dysfunction and Treatment (Level 1)

July 12-14, 2019 – Fairfax, VA

Developed and Sponsored by

www.hermanwallace.com

Presented by

Pany Nazari, PT, DPT, BCB-PMD
and
Susannah Haarmann, PT, WCS, CLT

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Is pelvic muscle evaluation in my scope of practice?

What is in your Practice Act ?

- The practitioner (regardless of discipline) must take responsibility for knowing his or her own practice act with the accompanying state-specific guidelines. If you are a physical therapist, occupational therapist, nurse, physician's assistant, you must know what your license (and potentially your liability insurance) includes

Statement from the American Physical Therapy Association (APTA) Section on Women's Health (SOWH)

- "Internal vaginal and rectal assessment and treatment of pelvic floor dysfunction is within the scope of practice of the licensed physical therapist." (Position Statement, 2014)
- The SOWH guidelines do oppose teaching internal pelvic muscle treatment to physical therapy assistants

Reference

Position Statement in Internal Assessment and Treatment: Section on. Women's Health, APTA. (2014) Retrieved June 25, 2014 from http://www.womenshealthapta.org/wp-content/uploads/2014/06/SoWH_Position_Statement-Internal_Pelvic_Floor_Assessmen-final.pdf

Second Person in the Room for PFM Rehabilitation

First, complete some research about the following:

- What are your facility or clinic guidelines?
- Is this covered in your state practice act?
- What does your company's legal counsel or liability carrier recommend?
- What is the practice standard in your region?

Second, cover your assets:

- Offer patients the option to have a second person in the room
- If you are in a solo practice, give the patient the option to bring someone in
- Consider how gender may affect a patient's response to having a second person in the room: would a patient prefer opposite or same gender?
- Add to your existing paper or electronic record a note stating that the patient was offered a chaperone, what his or her response was to the question, and then document if there was a second person in the room
- Despite giving consent, if the patient does not seem comfortable with the examination or if you feel uncomfortable based on the patient's behavior, defer the examination

Opinion 8.21 on Use of Chaperones from the American Medical Association (AMA)

- Having chaperones available is recommended
- Communicate availability of chaperones via notice or conversation
- Authorized healthcare person should serve as chaperone when possible
- Sensitive conversations should be limited during chaperoned examination

ACOG has similar recommendations to AMA and also suggests that family members should not be used as chaperones unless requested by the patient. (Sexual Misconduct, 2007)

References

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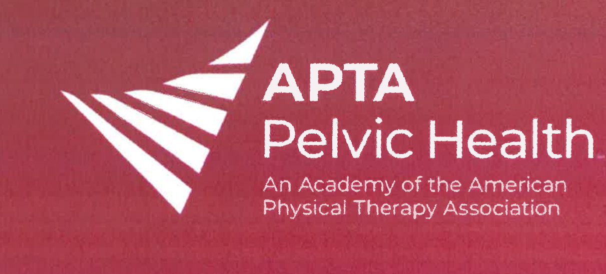
Use of Chaperones. (1998). Retrieved June 26, 2014 from http://www.ama-assn.org//ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion821.page

EXHIBIT



Academy of Pelvic Health Physical Therapy

Position Statement on Use of Chaperones

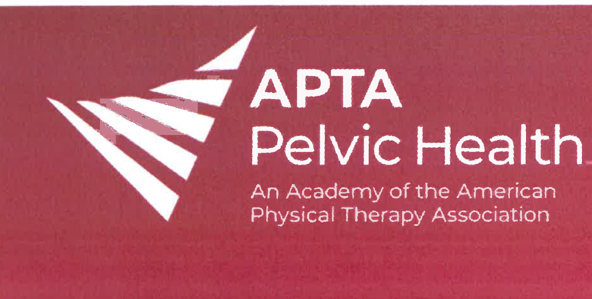
The Academy of Pelvic Health Physical Therapy (APHPT) of the American Physical Therapy Association supports the right of a patient to both request and have a chaperone present during sensitive pelvic floor physical therapy examinations, procedures, or treatments. The APHPT recognizes the patient's decision to have a chaperone present as an integral part of the patient's treatment and individualized plan of care. A chaperone is a member of the health care team who upholds the professional standards of ethical practice, privacy, and confidentiality. Family members or friends are encouraged to be present at the patient's request in appropriate circumstances but are not considered substitutes for a chaperone.

Background

A physical therapy examination and evaluation is an essential part of assessing the patient and establishing a diagnosis, prognosis, list of treatment goals, and/or outcomes. The scope of the examination is dependent on the reason for visit, diagnostic needs, and specialization of the physical therapist. Careful communication about the purpose and scope of the examination should be provided in a way that is easily understood by the patient. The provider-patient relationship is compromised when there is misunderstanding and confusion regarding therapist roles and behaviors, especially when the evaluation or treatment involves a sensitive area. This can lead to complaints as well as allegations of sexual misconduct or abuse. (American Society for Health Care Risk Management 2019)

The American Medical Association (AMA), the American College of Obstetricians and Gynecologists (ACOG), the American Academy of Pediatrics (AAP), the Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN), and the General Medical Council (GMC) in the United Kingdom all have recommendations regarding the use of chaperones for sensitive examinations.

Chaperones protect patients and the practitioner by serving as observers and potential witnesses during sensitive examinations and treatments. When sensitive examinations are performed, the tenets of trauma-informed care created by the Substance Abuse and Mental Health Services Administration (SAMHSA) are recommended to be utilized by both chaperone and the physical therapist. Trauma-informed care honors patient voice, agency, control, and choice. It is important to note that physical therapists are often unaware of a patient's prior experiences; therefore, adopting the tenets of trauma-informed care are crucial to avoid potential re-traumatization. (American College Health Association's Guidelines 2019)



Definitions

A sensitive exam or procedure includes, but is not limited to, an exam, evaluation, palpation, placement of instruments in genitalia, or exposure of: genitalia; rectum; breast.

A patient's personal and cultural experiences may broaden their own definition of a sensitive exam or procedure. Some patients may include in their definition of a sensitive exam an examination or procedure that involves partial exposure or palpation of body parts near sensitive areas (e.g., exposure of undergarments, palpation of the groin or buttocks, or auscultation near the breast), and a chaperone should be offered. (American College Health Association's Guidelines 2019)

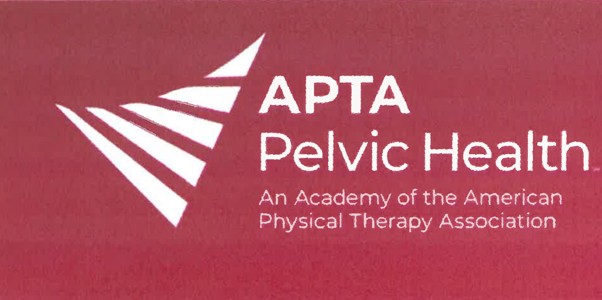
Patients who identify as lesbian, gay, bisexual, transgender, and nonbinary may have increased sensitivity to pelvic examination and may prefer a 2nd person (chaperone) in the room. (Tillman, 2020)

A chaperone is a trained person who acts as a support and witness for a patient and a provider during a sensitive exam or procedure. A chaperone is utilized to help protect and enhance the patient's comfort, safety, security, and dignity during a sensitive exam or procedure, and should be provided at the patient's request. (American College Health Association's Guidelines 2019)

The following factors may influence the decision to have a chaperone present and the choice of the best person to function as the chaperone: patient's request, urgency and type of examination or treatment, gender of the health care provider, and facility protocol. The patient's request may include having a family member or friend present. Additional considerations that may influence the request for a chaperone include age, cultural and/or religious beliefs, mental health status, cognitive ability, and history of sexual assault or dysfunction. A chaperone or health care provider of the same gender may be needed to support the patient's cultural and religious beliefs. (Guimond and Salman, 2013)

Consent

To help protect the therapist from any potential misunderstandings or accusation of sexual misconduct by the patient during a sensitive physical therapy examination or treatment, obtaining informed consent and offering a chaperone to the patient is essential. The therapist should thoroughly explain the examination/treatment including the rationale and reason. Once the patient has been properly educated, the therapist should then explicitly ask for permission to perform the examination/treatment and wait for verbal consent before proceeding. One should not assume that a patient consents to a sensitive examination or treatment because they made a therapy appointment. (Keller, 2019) Consent for sensitive pelvic floor physical therapy procedures should be documented in the medical record for each visit or treatment session. Patients should be informed of the institution's policy on the use of chaperones before the initial encounter.



The patient's preference regarding use of a chaperone should be documented in the medical record for reference in future visits (Pimienta and Giblon, 2018). Since the patient's preference may change, it is recommended at each visit to ask the patient about their wish to have a chaperone present and to document the patient's response and the name of the chaperone who will be present.

Not every patient will disclose a history of sexual trauma; therefore, trauma-informed care should be incorporated into all sensitive examinations (Tillman, 2020) It is essential to empower all patients by ensuring their control over the examination/treatment process and by offering a chaperone for support. (Barbieri, 2020)

Organizational Policies

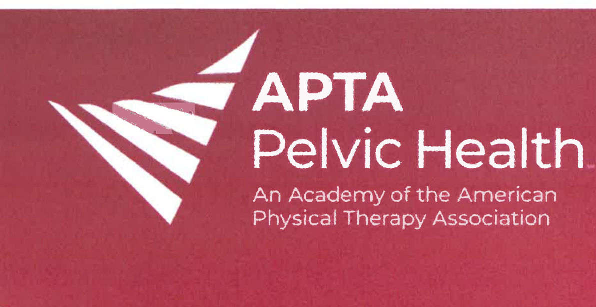
There are three recognized options for a chaperone policy—opt-out, opt-in, and mandatory (American College Health Association's Guidelines 2019). The APHPT recommends that members consult their state practice act and organizational risk management department first in determining which policy is best for their clinic.

- Opt-out policy is one in which a chaperone is planned and provided for at every sensitive exam or procedure and available for any exam upon patient or provider request. A patient has a right to decline a chaperone after being provided adequate education that explains the nature of the sensitive exam and the role of the chaperone. The patient's declination should be documented at each visit.

- Opt-in policy is one in which a chaperone is offered and available upon the request of the patient. Institutions should provide patient education regarding the option of a chaperone and the nature of the sensitive examination. Signage alone as patient education is insufficient.

- Mandatory policy is one in which a chaperone must be present during a sensitive exam or the exam will not be performed. Institutions that adopt a mandatory policy should not allow their policy to impede emergency care.

There are circumstances that necessitate a mandatory chaperone. For example, any patient who is defined by state law as a minor requiring parental consent or who lacks the capacity to provide informed consent at the time of care requires a chaperone and cannot decline.



Chaperone Policy Support Statements

The American College of Obstetricians and Gynecologists, 2020 and the American College Health Association, 2019 advise that chaperones should be used for all breast, genital, and/or rectal examinations. The American College of Physicians, 2021 and the American Medical Association, 2021 support joint decision-making between the provider and the patient regarding the presence of a chaperone. All health care settings should have policies in place to ensure patient safety and minimize risk during sensitive examinations (American College Health Association, 2019)

While the Academy of Pelvic Health Physical Therapy (APHPT) understands these recommendations may require a change in practice, the information shared in this document is based on best-practices of other healthcare organizations treating patients similar to those treated by pelvic floor physical therapists in their practices.

The APHPT recommends the following regarding the use of chaperones while performing pelvic health physical therapy:

- Consent for sensitive pelvic floor physical therapy procedures be documented in the medical record for each visit or treatment session.
- Chaperones are offered to every patient regardless of the gender or role of the clinician or health care provider.
- Patient response to having a chaperone present, i.e. consent or decline, be documented at each visit since the patient's preference may change. Also, documentation of the chaperone's name should be noted if a family member or friend.
- Physical therapists develop policies to include provisions for patient education and training of chaperones and physical therapy clinicians.
- Processes are in place for reporting questionable practices.
- Providers are accountable to receive training on how to communicate with patients and chaperones about examinations and procedures.
- For pediatric patients, pelvic floor physical therapists will follow the American Academy of Pediatrics (AAP) Guidelines regarding consent. Pelvic floor PTs will never be the first practitioner to perform an internal vaginal examination and never be the first to perform a rectal exam despite consent from the patient and/or the parent.

ACADEMY OF PELVIC HEALTH PHYSICAL THERAPY
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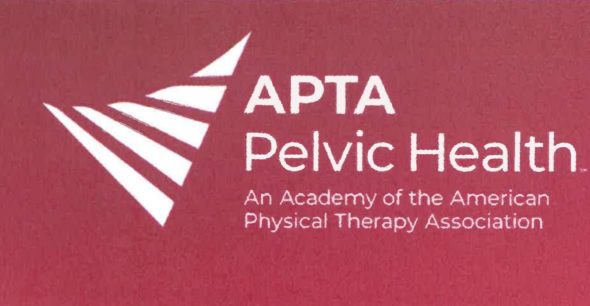

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Last updated: January 19, 2023

For Inquiries: practice@aptapelvichealth.org

EXHIBIT

Understanding Pelvic Floor Conditions

In this Guide:

- Common Questions
- Treatment Options
- Our Mission
- Get to Know Our Specialists

What is the "pelvic floor"?

The pelvic floor supports the weight of internal structures (e.g. bladder, uterus, vagina, bowels and rectum) and may involve the muscles, ligaments and connective tissue between them.[1] At VCU Health, our experts specialize in treating the entire pelvic floor with a multidisciplinary team that includes specialists in urogynecology, urology, colorectal surgery, physical therapy, gastroenterology and nursing.

What are considered pelvic floor conditions, and what are the symptoms?

If you experience a bit of bladder leakage when you sneeze or laugh at a joke, you may have a pelvic floor condition known as incontinence. It's common to think this is a result of the aging process.
However, symptoms like this can occur at any age and often require a more holistic care approach from a pelvic floor specialist. Another common condition is pelvic organ prolapse, which is when an organ (e.g. bladder, uterus, vagina or rectum) shifts or falls from its normal position.

You should consider seeing a pelvic floor specialist if you're experiencing one or more of these symptoms:

- Leaking or dribbling of either urine or stool during normal activities
- Feeling the frequent need to go to the bathroom
- Experiencing constant pressure in the vagina
- Sensing a protrusion or bulge from the vagina, like a part of your inside body is hanging out
- Repeated urinary tract infections
- Blood in the urine (hematuria)
- Problems after placement of pelvic mesh
- Pain in the pelvic area during intercourse, urination or bowel movements

Does my primary care doctor need to diagnose me before I come to VCU Health?

You can make an appointment directly with a pelvic floor specialist without having to first go to your primary care physician or gynecologist. Many insurance companies don't even require a referral, but we encourage everyone to check with their individual insurance provider and plan coverage to make sure. To provide an accurate diagnosis, your pelvic floor specialist will perform a comprehensive exam and do a series of targeted tests. We use the latest technology and innovations to focus on diagnosing and treating patients, one at a time.

Are pelvic floor conditions common?

More than one-third of U.S. women have a pelvic floor condition, and almost one-quarter of U.S. women experience symptoms caused by one or more related issues.[2] If left untreated, these conditions may lead to other medical problems, so it's important to address them early and avoid the possibility of further impairment.

Who is at risk for developing pelvic floor conditions?

Although anyone can develop pelvic floor conditions, they're more likely to occur in women over the age of 20. Risk factors include:

- Aging
- Genetics, race and ethnicity
- Obesity, diet and smoking
- Menopause
- Excessive strain on the pelvis due to childbirth
- Repeated strenuous activity or heavy lifting
- Chronic disease or health conditions that affect the nerves, such as diabetes, stroke or Parkinson's disease
- Pelvic injury and/or surgery
- Constipation and chronic straining
- Sexual dysfunction, such as reduced sexual arousal or painful intercourse
- Emotional stress [3]

Treatment options

Noninvasive solutions: In addition to lifestyle changes, your doctor may recommend exercises to retrain your bladder and strengthen your pelvic muscles. You may also receive treatment in the form of physical therapy, which may involve biofeedback or nerve stimulation to teach you how to activate your muscles.

Another important strategy to help with urinary urgency, frequency and incontinence is medication. Also, Botox injections or urethral bulking agents and acupuncture type nerve therapy may be done in our clinic for urine leakage.

To improve or correct your prolapse symptoms, removable devices, such as vaginal pessaries, may also be used for support.

Surgery: Depending on the diagnosis and severity of your symptoms, you may require surgery. The medical experts at VCU Health are committed to using minimally invasive procedures like vaginal reconstruction, laparoscopic surgery and robotic surgery to help reduce pain and speed recovery.

Our Mission

Each member of our team — from doctors to nurse practitioners to administrative staff — is dedicated to giving you the individual attention you deserve. Our mission is to improve your quality of life, which starts by helping you establish your personal health care goals.

Our commitment extends beyond the VCU Health community, as we share our research across the country and the globe to advance care for all women suffering from pelvic floor conditions. For example, one of our doctors developed a unique training model for teaching surgery and led a course on using this model at an international meeting for female pelvic surgeons. We've been repeatedly recognized for clinical excellence and compassion, having received honors for resident education and training the next generation of practitioners.

We continuously invest in researching and developing new ways to treat pelvic floor conditions, from nonsurgical methods to advanced surgery. Since we believe in providing holistic care, we often collaborate with experts in related fields, such as gastroenterology, colorectal surgery and physical therapy, to develop a tailored treatment plan just for you.

Get to know our specialists

Ashley W. Carroll, MD

Dr. Ashley Carroll became fascinated with pregnancy and women's bodies during high school biology — a class that set her life's course in obstetrics and gynecology. During her medical residency at VCU Medical Center, she discovered an even greater passion for helping women with pelvic floor conditions restore their function and quality of life.

Dr. Carroll treats women living with symptoms related to weak muscles or tissues that support the pelvic floor, which causes organs to drop and creates a bulge in the vagina or rectum, resulting in poor bladder or bowel control.

An associate professor of obstetrics and gynecology at the VCU School of Medicine, Dr. Carroll has done extensive research in surgical outcomes of prolapse repair via robotic surgery; the role of physical therapy in sexual pain; and urodynamic evaluation of overactive bladder. She also enjoys her role as a teacher, mentoring and graduating six resident surgeons each year.

Dr. Carroll's own quality of life involves spending time with her family, hiking in the mountains and exploring the James River.

Lauren Siff, MD

Dr. Lauren Siff is a urogynecologist with training in both women's medical specialties. She treats everyone from women with straightforward issues to those living with complex, chronic urologic or gynecologic issues and those who have tried almost everything — medications, devices, surgeries — to no avail. For that, Dr. Siff and the Women's Health team offer an array of therapies to treat sensitive female conditions, including physical therapy, exercises, medicines, devices and minimally invasive surgeries. She works with a multi-disciplinary team of OB/GYNs, urologists, gastroenterologists, colorectal surgeons and physical therapists who come together daily and meet monthly to review the most challenging cases.

Our team's goal is to treat every individual woman while, as part of an academic medical center, advancing the science of women's health. Dr. Siff's own research, on both a local and national level, focuses on improving surgical success for prolapse surgery; sexual function and depression in urinary incontinence; and diagnosing and managing intraoperative complications. She is also researching the use of technology in surgical education.

Dr. Siff and her husband have two young children and can always find a way, as she says, "to make a celebration out of anything."

Schedule your consultation with Dr. Carroll or Dr. Siff by calling (804) 628-0691

Sources

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EXHIBIT 5

EXPLORE OUR NETWORK

Physical Therapy in Hampton Roads

Main Navigation

Home › Physical Therapy Programs › Physical Therapy Programs › Women's Health

WOMEN'S HEALTH

It's a fact that women's health needs are different from those of men, and not just during childbearing years. Today, women are benefiting from healthcare advances in the way that women's health information is shared, and in the way that providers connect and coordinate women's health solutions and resources

In Motion Physical Therapy has created a women's health program that meets women's needs head on with innovative physical therapy programs. Each program is customized to a woman's special needs. Therapy is provided by physical therapists guided by special training and a strong commitment to women's health.

- **Incontinence and Pelvic Floor Disorders**
  Our experts use biofeedback, manual therapy and pain management strategies to help patients retrain and strengthen their pelvic muscles so they can regain control of their life.
- **Osteoporosis**
  Osteoporosis is a common ailment facing women today. Our experts work with patients to help them manage their pain and return to a normal, healthy lifestyle.
- **Arthritis Program**
  This program promotes increased mobility and strength in addition to reduced pain, stiffness and discomfort.
- **Breast Cancer Rehabilitation**
  Persistent pain, limited mobility and weakness can limit a woman's function after a breast cancer surgery. The lymphedema program and manual lymph drainage techniques can help decrease pain and increase a patient's range of motion.

Privacy - Terms

- **Fibromyalgia**
  Myofascial release is a therapeutic massage that gently manipulates the fascia to decrease pain, headaches, postural changes and increase range of motion
- **Pelvic Pain**
  There are non-invasive physical therapy solutions to address pelvic pain. A customized program may include biofeedback, manual therapy, massage, and a home exercise program.
- **Pre- and Post-Partum Pregnancy Therapy**
  Pregnancy places great demands on a woman's body and can lead to back, hip and knee pain in addition to issues like urinary incontinence and carpel tunnel syndrome. Physical Therapy can help women stabilize their abdominal core, learn proper body mechanics, and strengthen their muscles following cesarean or vaginal delivery.

Our Locations

In Motion at Mary Immaculate

Bon Secours Mary Immaculate Hospital
Health Resource Center
2 Bernardine Drive
Newport News, VA 23602
Phone: (757) 886-6480
View map and get directions

In Motion at Portsmouth YMCA

4900 High St W
Portsmouth, VA 23703
Phone: (757) 483-4518
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In Motion at Portsmouth Boulevard

5553 Portsmouth Blvd
Portsmouth, VA 23701
(757) 465-7906
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In Motion at Hilltop

1817 Laskin Rd., Suite 100
Virginia Beach, VA 23454
Phone: (757) 437-0471
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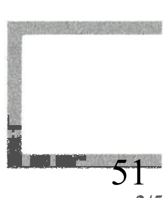

In Motion at Hanbury Crossing

Hanbury Village Shopping Center

235 Hanbury Road East

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In Motion at Mary Immaculate

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Fax: (757) 886-6077

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CONTACT US TODAY

Name

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Phone Number

Zip

Do you need assistance? If asking about medical records or appointment information, please include full name and date of birth.

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Occupational Therapy for National Bath Safety Month

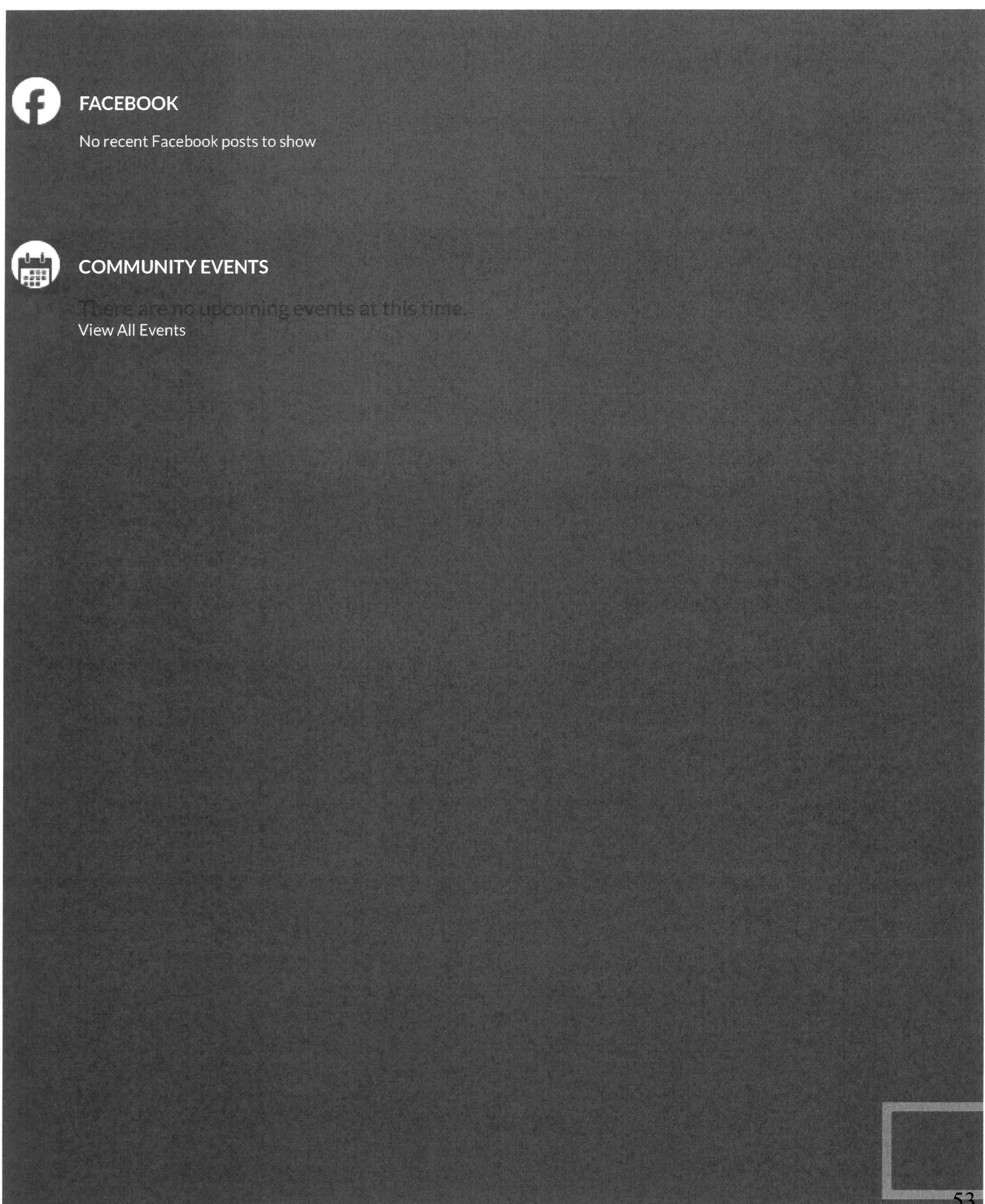
Posted on January 17, 2023

Exercising the Brain After a Stroke

Posted on December 12, 2022

Do You Need the Graston Technique?

Posted on November 8, 2022



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ASK A SPECIALIST

Have one of our staff contact you confidentially about our program options.

Full Name

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Phone Number

What sort of problem do you need assistance with?

SEND QUESTION

KEEP TABS ON THE LATEST TRENDS IN WELLNESS AND UPCOMING EVENTS. SIGN UP FOR THE BON SECOURS GOOD HEALTH E-NEWSLETTER!

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Main Navigation

Home › Pelvic Pain

PELVIC PAIN

A women's health issue, pelvic pain is discomfort that is experienced on the pelvic bone, tailbone, pubis region, buttocks, rectum, or vagina, and even into the upper legs.

Data demonstrates that nearly 1 in 3 woman over 55 will suffer from a moderate to severe pelvic condition and more than half will have some experience with pelvic dysfunction. The numbers of women who need early diagnosis and treatment of pelvic conditions are staggering.

Talk to your gynecologist or urologist if you're experiencing new or abnormal pelvic discomfort. Some of the medical diagnoses associated with pelvic pain are Dyspareunia, Vulvitis/vulvar vestibulitis, Vaginismus, and Interstitial cystitis.

Common causes of pelvic pain include:

- Trauma in or around the pelvis
- Pelvic, abdominal, or low back surgery
- Fractured coccyx
- Irritable bowel syndrome
- Chronic constipation
- Pelvic inflammatory disease
- Frequent urinary tract infections
- Endometriosis
- Pregnancy and childbirth

There are non-invasive physical therapy solutions to address pelvic pain. The program your therapist customizes for you may include some of the following therapies:

- Biofeedback for relaxation/downtraining of pelvic floor muscles
- Biofeedback for uptraining and neuromuscular reeducation
- Manual therapy for pelvis/coccyx realignment
- Internal massage to pelvic floor trigger points
- External massage for lower abdominal or lower lumbar tightness/adhesions
- Gentle electrical stimulation to relax muscles or retrain muscular contraction
- Pain management strategies (visual imagery, TENS, breathing techniques)
- Dilator training
- Home exercise programs

Our Location

Physical Therapy at Westchester

a part of Bon Secours St. Francis Medical Center

611 Watkins Centre Parkway, Suite 300

Midlothian, VA 23113

Phone: 804-325-8822

Fax: 804-794-3986

Bon Secours Richmond Community Hospital Physical Therapy

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Phone: 804-225-1732

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- National Bath Safety Month: How Occupational Therapy Helps
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- Do You Need Physical or Occupational Therapy?

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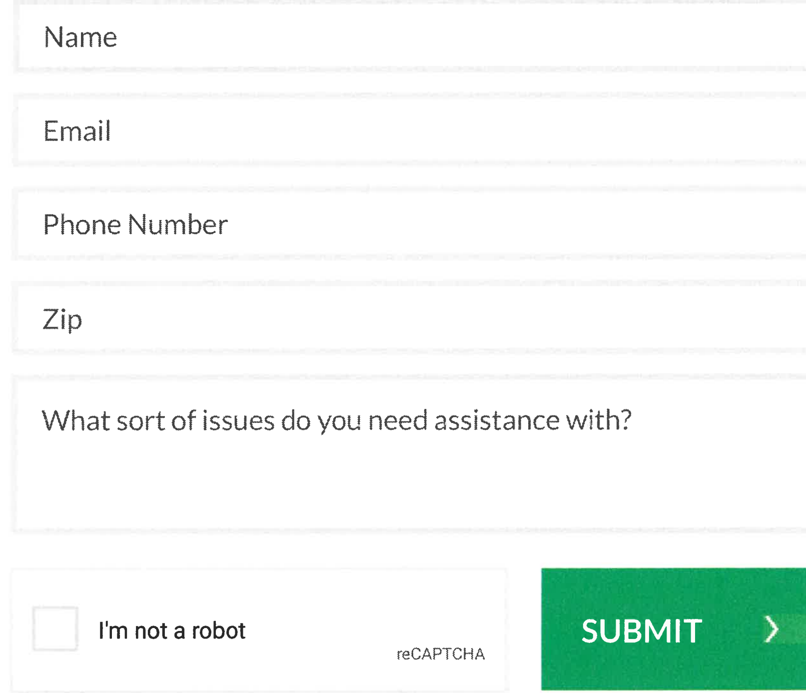
WE LOOK FORWARD TO HEARING FROM YOU!



FACEBOOK

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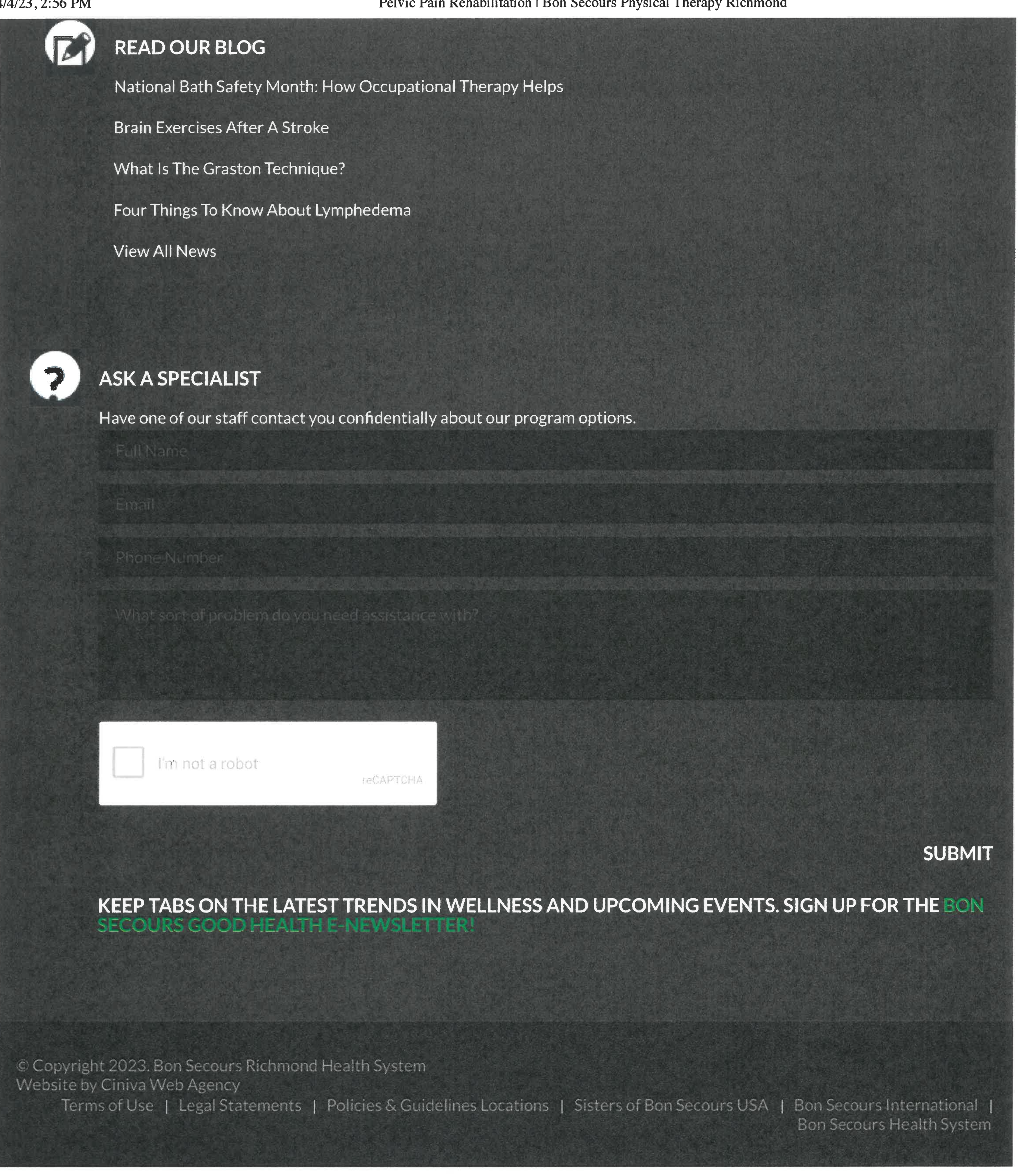
There are no upcoming events at this time.

View All Events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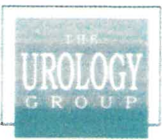

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Pelvic Floor Rehabilitation and Stimulation: A Non-Invasive Treatment

What is Pelvic Floor Dysfunction?

For good bladder control, all parts of your system must work together. The muscles of the pelvic floor control the flow of urine and support the organs found within the pelvis like a "hammock." The pelvic floor muscles hold up the organs, the sphincter muscles control the flow of urine, and the nerves activate these muscles to function. When one or more of these components becomes weak, the system is unable to provide the needed support to keep the urethra closed tightly. The result is a pelvic floor disorder.

Individualized Plan of Care

Your treatment is based on the information obtained from your health history and the pelvic floor muscle measurements taken during the initial consultation. Your therapy may include:

- **Pelvic Floor Rehabilitation**
  It will be determined whether or not you are contracting the correct muscle, and when the muscle begins to fatigue. Using this information, a customized muscle strengthening routine will be prescribed.
- **Pelvic Floor Stimulation**
  This is done with an internal sensor, which stimulates the pelvic floor muscles, causing a comfortable, timed contraction of the pelvic floor. Low frequency, low intensity stimulation, along with muscle strengthening, calms the contractions and symptoms of an overactive bladder.
- **Bladder Retraining**
  Once strength is improved to the pelvic floor, the bladder can be
  "retrained" to hold a larger volume so bathroom stops are not so frequent and sense of urgency can be controlled.
- **Dietary Changes**
  Some people can help alleviate symptoms with simple dietary modifications, which will be discussed during therapy.

What to Expect

Pelvic muscle rehabilitation, bladder retraining and diet modification has shown to be significantly effective in 8 out of 10 people. It is often tried before having surgery for pelvic floor disorders. This is a treatment program that can help you live more confidently. Pelvic floor therapy is an individualized treatment to increase the strength and control of your pelvic floor muscles. The first appointment is 60 minutes, and every appointment after that is 30 minutes. It is important that you arrive on time to each appointment, and remember to bring your probe. Unfortunately if you forget your probe, you will have to be rescheduled. Below is a description of what to expect during your visits.

1. **Manual Examination**

   First we must assess the strength of your pelvic muscle. You will be asked to "squeeze" (do a Kegel) on the therapist's gloved finger. Your strength will be measured on a scale of 0-5. The pelvic muscles are then checked for spasms and tenderness. This procedure insures that you are performing the Kegel correctly.

2. **Electromyography (EMG)**

   A sensor is placed in the vagina (or rectum in males) and you will do a pelvic floor contraction (Kegel) for 10 seconds and then rest for 10 seconds for a total of 10- 20 repetitions. This procedure is particularly helpful in letting the therapist know if the pelvic floor muscles are adequately resting. If the muscles do not rest, they are kept in a weakened and fatigued state.

3. **Anal Manometry**

   As the vaginal sensor is measuring the resting state, we are able to measure when the pelvic muscles fatigue. This measurement is done with a small sensor placed in the rectum. This procedure is very important because it tells the therapist how many Kegels can actually be performed and how long each Kegel can be held by the patient.

4. **Muscle Assessment**

   Your abdominal muscle is checked for its strength and also its coordination with exhalation. It is important to be able to do a Kegel without holding your breath and bearing down. The abdominal muscle's activity is also monitored during the vaginal EMG and rectal manometry with an adhesive electrode placed on the abdominal muscle (like an EKG patch).

With all the information received by doing these important assessments, you will begin a customized home exercise program, and be instructed in bladder retraining and diet modification (if necessary). After the initial session, you will be scheduled for 5 more sessions, each 30 minutes. At these sessions your pelvic floor muscles will be reassessed with the EMG and anal manometry to monitor gains in strength and endurance and to assess tone changes. Your home program will be upgraded as you improve. Additional information is given as needed for bladder retraining and behavior modification.

You will receive an additional part of treatment between your 2nd – 6th session that will help strengthen and normalize the tone of your pelvic floor muscles. You will also get electrical stimulation to your pelvic floor muscles through the vaginal sensor. This is done at a comfortable level and helps strengthen the pelvic floor muscles.

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Pelvic Floor Level 2B

Manual for In-person Coursework

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MMT interpretations by Herman & Wallace Pelvic Rehabilitation Institute
(This combines Laycock and Brink definitions)

Score (Power)	MMT	Descriptions
0	Zero	No palpable contraction/ squeeze
1	Trace	Flicker of squeeze or contraction
2	Poor	Squeeze pressure asymmetrical or felt at various points- no lift or displacement
3	Fair	Squeeze pressure (contraction) and lift or displacement
4	Good	Squeeze pressure (contraction) and lift or displacement from anterior, posterior and side walls
5	Strong	Full circumference of finger compressed, displaced with an inward pull

PELVIC RELAXATION – ANTERIOR AND POSTERIOR WALL EXAMINATION

Observation/palpation techniques without speculum for suspected cystocele, rectocele or uterine prolapse.

To visualize the relaxations, viewing of the anterior (superior) wall of the vagina occurs by placing one finger into vagina 4-6 cm (to the level of the PIP-MCP) and pressing down on the posterior wall. Ask the patient to bear down and observe for the bulging of tissue. Bring your view in line with the canal.

Anterior wall- Cystocele 0, 1, 2, 3, 4

Grade 0 – no prolapse demonstrated
Grade 1 – the most distal point is > 1 cm above the hymen
Grade 2 – the most distal point is 1 cm above or 1cm below the hymen
Grade 3 – the most distal point is > 1 cm below the hymen up to 2 cm below protruding ¾ of the length of the vagina
Grade 4 – Complete eversion of the total vaginal length

Depending on the amount of anterior relaxation the posterior wall (rectocele) may be difficult to visualize. Try one of these three ways:

1. Replace the examining digit with the index finger of the hand that held the labia apart and block the anterior wall from a 45° angle. Use the index and middle fingers from the other hand to pull down on the posterior fourchette. Ask the patient to bear down and the bulge will be apparent below the top hand index digit coming from the posterior wall.
2. Place two fingers into the vagina 2-6 cm (to the level of the PIP-MCP), spread the fingers laterally and press down on the posterior wall. Ask the patient to bear down and observe for the bulging of the posterior wall tissue up between your fingers.
3. Place one examining finger 2-4 cm in the vagina on the posterior wall and ask the patient to bear down and feel for the bulge displacing your examining finger inside the vagina rather than trying to observe it.

Scale of severity the same as for an anterior wall

Posterior Wall -Rectocele 0, 1, 2, 3, 4

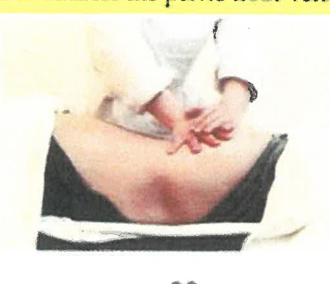
Grade 0 – no prolapse demonstrated
Grade 1 – the most distal point is > 1 cm above the hymen
Grade 2 – the most distal point is 1 cm above or 1cm below the hymen
Grade 3 – the most distal point is > 1 cm below the hymen up to 2 cm below protruding ¾ of the length of the vagina
Grade 4 – Complete eversion of the total vaginal length

Manual Therapy

- Myofascial release
- Trigger point releases
- Visceral mobilization
- Strain-counterstrain, positional release
- Joint mobilization
- Muscle energy techniques
- Connective tissue manipulation

Manual Therapy

- When to address the pelvic floor versus pelvis?



Orthopedic Manual Therapy (Skills Learned in 2B)

- Abdominal wall releases, fascial mobilization
- Scar tissue mobilization
- Connective tissue mobilization
- Trigger point releases
- Pelvic girdle bony landmark identification aids in muscle/tissue mapping and releases

Pelvic Floor Muscle/Perineal Manual Therapy

- Can treat fascia and connective tissue superficially
- Scar tissue mobilization
- Internal techniques
  - Superficial tender point releases
  - Deep tender point releases in pelvic floor and walls
  - Can use your muscle mapping skills

Pelvic Floor Manual Technique Indicators

- Pain with pelvic floor contraction
- Trigger points on examination
- Muscles feel taut and rigid versus supple
- sEMG: Elevated resting baseline, inability to return to baseline or rebound from baseline
- Muscular findings plus urinary urgency, dyspareunia, constipation

"Understanding and measurement of muscle tone as related to clinical muscle pain." (Simons & Mense, 1998)

- Muscle tension based on viscoelastic properties of soft tissue (tone) and resistance to displacement
- Resting muscle **tone** is the elastic and/or viscoelastic stiffness in the absence of contractile activity
  - *Short* muscle
  - Taut bands of myofascial trigger points
  - Spasm is EMG activity not under voluntary control

LAB 4: Perineal and Internal Techniques for Pelvic Pain

Student Name____

Activity	Specifics
Explain purpose of techniques	Treat vulvar and vaginal internal painful areas , review anatomy with patient
Ischiorectal fossa release	Identify location of ischiorectal fossa by finding bony landmarks (pubic rami, ischial tuberosity, coccyx). Use thumb and fingers to grasp tissue and glide/roll tissue superiorly to inferiorly
Clitoral prepuce mobilization	Use both thumbs or index fingers to rectract the clitoral prepuce and mobilize into restriction. Alternatively, use one thumb to anchor side of prepuce and opposite thumb/finger to glide opposite side into restriction
Perineal Body Assessment Skin Roll	Check positioning to allow viewing Skin roll with finger, scar mobility to 1st or 2nd muscle layer sweep each side
Labial grasp	Gently pinch tissue of labia majora, gently roll the tissue along the labia. Try using opposite hand to slacken the labial tissue towards palpating fingers
Bimanual treatment of 1st layer	Palpating STP to insertion, tensioning or slackening the tissue with thumb or opposite hand.
Introitus Stretch	Practice teaching anatomy and manual self stretching of 1st or 2nd muscle layer with thumbs
Periurethral release	At 2nd layer, identify periurethral muscles located at 1 and 11 o'clock. Can perform contract-relax (25%), prolonged stretch, TA contraction, "shhhhhh"
Internal Levator ani muscle sweep/ tone check 3rd layer Pubo/iliococcygeus	Identify the Iliococcygeus and Pubococcygeus for length and tenderness. Can perform prolonged stretch to lengthen, contract-relax (25%), cross fiber strum, deep breathing, bulging, visualization and autogenics
Obturator internus	Assess for tenderness throughout muscle. Can perform sweep across muscle, cross fiber strum, isolate muscle contraction (lateral rotation) and perform contract/relax. Gentle hip ER/IR.
Coccygeus muscle	Sweep from ischial spine to coccyx is firm due to sacrospinous ligament parallel Cross fiber strum
Pubic attachments of PF muscles (2nd and 3rd layer)for urgency and frequency	Pubic portion of PC muscle 11 and 1 o'clock followed by stretch posteriorly (Weiss technique) Palpate medial to assess pelvic floor muscle attachments
Reciprocal inhibition with PNF activation	Position legs and contract into flexion/ abduction and internal rotation Recheck tone of muscles after contraction
Educate in dilator use	Purpose, positioning, lubrication
Describe techniques	Circumference, angle, lateral stretches, sweep and in/out motions
Describe the innervation(s) of different portions of perineum • Ilioinguinal- L1 • Iliohypogastric- T12-L1 • Genitofemoral- L1-2 • Lateral femoral cutaneous- L2-3 • Pudendal- S2-4	Mons pubis = Ilioinguinal/genitofemoral/ Clitoris= Pudendal, Dorsal nerve of clitoris Medial thigh= Ilioinguinal Nerve Labia= Ilioinguinal Nerve Vagina= Pudendal, perineal branch Perineal body= Pudendal perineal branch Anus= Pudendal, Inferior hemorrhoidal or inferior rectal nerve

Pelvic Floor Level 2A

Live Content Manual

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Digital Palpation

- Assesses pelvic floor muscles at rest and with contraction
- Assesses pain – palpation of the PF may reproduce or increase pain symptoms
- Voluntary Contraction – contraction of PF muscles on demand
- Voluntary Relaxation – relaxation of PF muscles on demand

Voluntary Contraction

- Contraction will have palpable tightening, lifting, or squeezing

Voluntary Relaxation

- Palpation will reveal relaxation at the end of the contraction

Vaginal Palpation

- Document any asymmetries in pelvic floor muscle function
- Posterior and anterior
- Left and right

ICS VISUAL INSPECTION[1] OF THE PELVIC FLOOR

- Investigators reporting pelvic floor muscle studies should state the position of the patient (supine, lithotomy, lateral, and standing) and the time of the day. When appropriate the verbal instructions given to the patient should be literally written down. Also, additional instruments used should be described.
- Inspection of the vulva,[2] perineum and anus in women and of perineum and anus in men is performed to look for skin pathology and anatomical abnormalities. Testing for pelvic organ prolapse[3] is an integral part of the physical examination of every patient with pelvic floor muscle complaints. A vaginal and rectal exam is part of this investigation.
- During inspection, the patient is asked to perform a pelvic floor muscle contraction. Good instruction is mandatory; ask the patient to prevent the escape of gas or urine. In the normal situation, a pelvic floor muscle contraction will lead to ventral and cranial movement of the perineum.
- When the patient is asked to cough, the perineum should show no downward movement; ventral movement may occur because of the guarding action of the pelvic floor muscles.
- Anal/rectal prolapse can be evaluated by asking the patient to strain, as if defecating, while seated on a commode chair.
- Perineal elevation is the inward (cephalad) movement of the vulva, perineum, and anus.
- Perineal descent is the outward (caudal) movement of the vulva, perineum, and anus. The position of the anus and the perineum should be noted at rest and during straining. If perineal descent is seen, when the patient has been asked to contract the pelvic floor muscles, this indicates that the patient is straining instead of contracting the pelvic floor muscles.
- Extra pelvic muscle activity is the contraction of muscles other than those that comprise the pelvic floor, for example the abdominal, gluteal and adductor muscles. Extra pelvis muscle activity is needed for maximal pelvic floor muscle effort.[4]

---

[1] It is mandatory to give the patients a full explanation as to what to expect during the physical examination, before starting it. An assessment must be discontinued if the patient exhibits any symptoms of distress during the examination. Patient dignity must be considered and maintained at all times (w.w.w.gmc.uk.org/standards/intimate.htm).

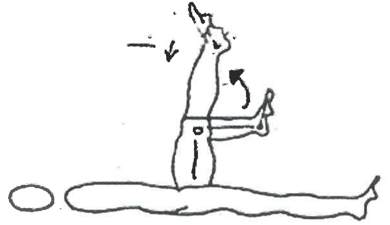
[2] The condition of the vulva and vagina (atrophy, inflammation) should be noted. A touch test is advised. In this test, the introitus is touched lightly with a cotton swab at different points. Normally this does not hurt but in patients with a vulvar pain syndrome it will be classified as painful.

[3] In female patients, the ICS POPQ system is advised [Bump et al., 1996). In female and male patients attention should also be focused on the anus, looking for rectal or anal prolapse.

[4] The two muscle groups, pelvic floor, and transverses abdominis are now understood to be part of the local muscle system of lumbo-pelvic stability. The other components are the diaphragm and the deep

Pudendal Nerve External Techniques

Adverse Neural Tension Assessment –
Obturator or Sciatic Bias to provoke- burning, tingling, lightning bolt

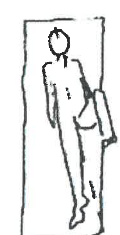


Abducted: obturator bias
Adducted: sciatic bias

Nerve Flossing

Client is supine, hip flexed to 90° with knee bent

* Clinical suggestion *
Have client lie angled on the table so hip rotation can be in neutral (not IR) during treatment. Make sure that you as the clinician have good postural alignment



Clinician is:
(a) sitting on a chair with client foot on shoulder of clinician
(b) sitting on edge of table with lateral hand on knee/controlling flexed leg + medial hand assessing sacrotuberons ligament
(c) anchor sacrotuberous ligament and "floss" pudendal nerve underneath
    - flexion oscillation
    - IR/ER
    - add abduction
(d) clinician rocks forward and back to "drive" and "steer" hip while anchoring sacrotuberous ligament
(e) clinician may sit on edge of table as well

EXHIBIT 10

Pelvic Floor Function, Dysfunction and Treatment Level 1

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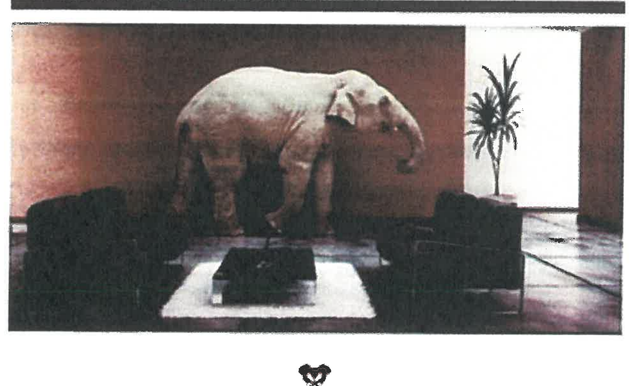
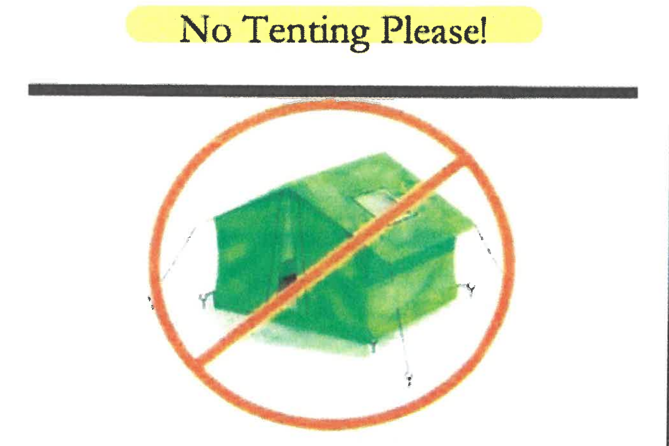
Lab 1 Preparation



No Tenting Please!



Don't Fake It!

- We want you to feel confident and successful
- Grab any instructor or lab assistant if you have a question!
- If you can't find urethra, it's probably tough to spot…

Sensitivity

- Be aware of ***every word you say, all feedback you provide to the PERSON on the table***
- Avoid commenting on their body in ways that are harsh, not relevant to the task at hand, or that are judgemental in nature
- Avoid making diagnoses/prognoses, provide positive feedback, be curious
- Remember this is not a private space
- "Read the room" including facial response

Sensitivity

- Check in with your partner before calling an instructor over ("I'm noticing some redness in the vestibule, would it be ok if I asked an instructor for some feedback?")
- Do not allow other participants in the space without explicit and obvious consent from person on table
- Be aware of your facial expressions, vocalizations, and where your hands are placed

Lab Preparation

- Complete "patient" history
  - Menses not contraindicated, you can use menstrual cup
  - Gloves- observe first, then prepare before you place the gloves on!
- Patient education: Describe exam
- Lab space
- Enter and exit doors: Privacy

Summary of Pessary Treatment

General

- A pessary is a removable device placed into the vagina to aid in supporting pelvic organs
- Pessaries are used by 86% of gynaecologists, 98% urogynaecologists
- Most pessaries are made of silicone, many are ring-shaped
- Pessaries may be an option for women who are not surgical candidates
- Pessaries are considered minimally-invasive

Patient preference

- Some patients cannot retain a pessary (keeps falling out) or find the device painful or uncomfortable
- Short vaginal length, large genital hiatus, prior hysterectomy or surgical repairs of prolapse may lead to unsuccessful fitting of pessary
- The patient, if she cannot remove/clean/reinsert pessary, may need to schedule monthly with her physician for pessary care
- 50-80% of women "successfully-fitted" continue to use a pessary after one year

Evidence

- Pessary use may be as effective as surgery in improving health-related quality of life
- There may be a decrease in urogenital hiatus size after continuous use of pessary
- Side effects may include bleeding, vaginal discharge, pain, constipation, odor
- While severe complications are rare, a long period of use or neglect can lead to infection or impaction
- Pessary use appears to not inhibit sexual function, and in fact, enhances it
- Potential benefits include improved symptoms of bulging, decreased bladder irritation, improved body self-image

Reference

Lamers, B. H., Broekman, B. M., & Milani, A. L. (2011). Pessary treatment for pelvic organ prolapse and health-related quality of life: a review. *International urogynecology journal*, *22*(6), 637-644.

PELVIC PAIN TREATMENT
PELVIC FLOOR TREATMENT PLANNING

Treatment	Specific interventions	Outcome
Therapeutic Exercise	•Pelvic floor strengthening or Pelvic floor lengthening •Stretching or strengthening of pelvic girdle and trunk muscles • Aerobic exercises	•Optimal function of trunk and pelvic muscles •Improved fitness
Biofeedback	•EMG assisted pelvic floor exercises •Pelvic floor identification and awareness •Strengthening – uptraining •Relaxation – downtraining •Coordination training	•Pelvic floor muscle identification and isolation and determination of muscle over activity, relaxation techniques
Relaxation Exercises	• Jacobson techniques • Imagery • Autogenic Relaxation Techniques • Muscle discrimination techniques	•Increased awareness of muscle tension •Coordination of pelvic floor with breathing and lifting Autonomic Nervous System quieting
Postural Education Functional Training	•With ADL's •With positions that create pain	•Improved alignment of trunk and pelvis to enhance sitting and standing tolerance
Electrotherapy	• TENS • High volt pulsed current (HVPC) • Interferential/NMES	•Pain management •Muscle stimulation for fatigue or general tonus reduction
Thermal agents	•Ultrasound •Heat and ice packs •Diathermy- Historic	•Improve soft tissue extensibility •General relaxation and pain relief
Manual therapy	•Joint mobilization •Trigger point and soft tissue massage •Myofascial release •Muscle energy techniques Connective Tissue Massage	•Optimal musculoskeletal alignment Connective Tissue mobility
Other	•Craniosacral therapy •Visceral manipulation •Strain/ Counterstrain •Vaginal dilators •Chronic pain management program	•Specific to the treatment

Pelvic Floor Capstone

Manual for Live Zoom Content

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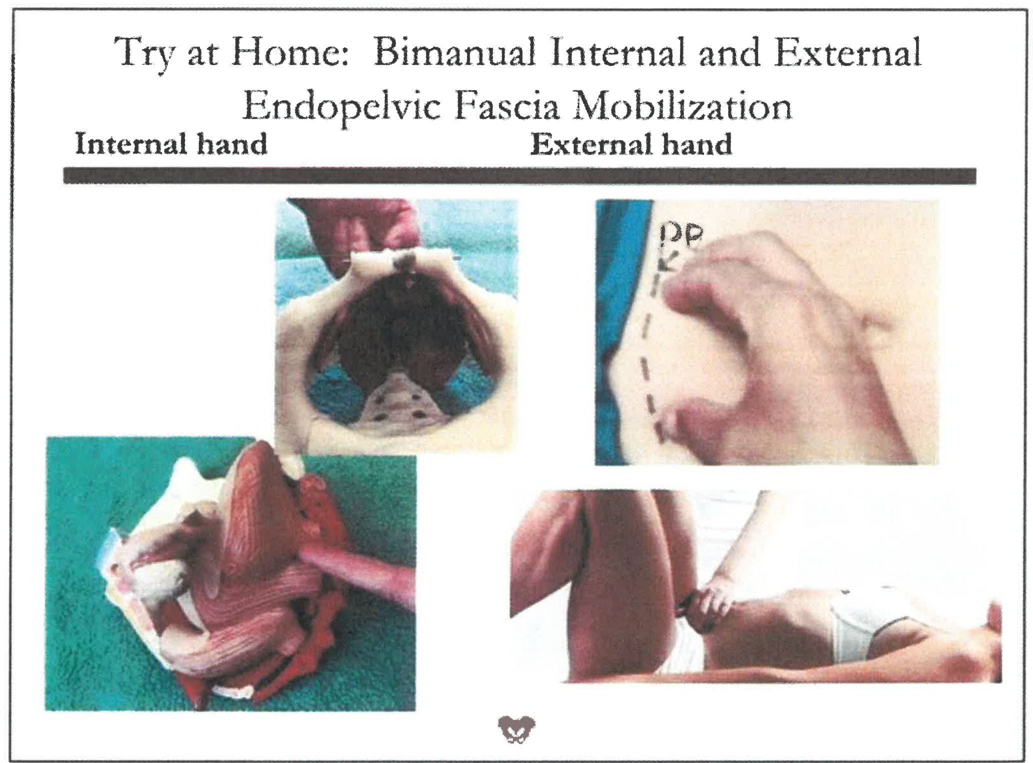


ONCE YOU GET BACK TO THE CLINIC:

This technique allows you to do both internal and external endopelvic fascia at the same, increasing fascial release and dialogue throughout the endopelvic fascia and cortex.

Use the instructions from the prior two techniques and combine the internal and external hand.

If you can use props, blocks, etc to prop the patient's legs, you can the prior two techniques. This would be best performed once you have done the prior techniques about a dozen times each. This takes a bit of coordination and an accurate palpation for location and tension lines of the tissues

Keeping it gentle, create a line of ease between the two structures. You can add or eliminate lines of tension by stacking the external hand toward or away from the internal hand as you sink, also using breath, extremities, pelvic tilting, UE position, and the amount of hip or cervico/thoracic flexion.

EXHIBIT 12

Pelvic Girdle Evaluation

- Sitting Tests
- Sacral Side Bending/Rotation
  - Spinal side bending is utilized to assess ipsilateral sacral side bend and contralateral sacral rotation
  - To evaluate side bending, palpate the ILA's, the ipsilateral ILA displaces inferior and the contralateral ILA displaces superior.
  - To analyze sacral rotation, palpate the sacral sulci. The ipsilateral sulci should deepen (moves anterior) and the contralateral sulci becomes shallow (moves posterior) (Fig. 26)
  - For example: A spinal RSB test should elicit sacral RSB and LR. Therefore, the right ILA moves inferior while the left moves superior. The right sacral sulci should move anterior while the left sacral sulci moves posterior.

Sacrum follows the spine (if spine has motion)

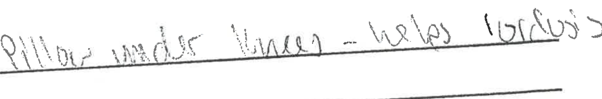
ILA post only

Can check Rot c SB (E...)

But: To check Rot we need to be on sacral sulci or ILA post

Pelvic Girdle Evaluation

- Supine Tests
- Palpation for Pelvic Position
- ILIAC CRESTS - Contact the ilias to assess height as well as rotation in the sagittal and/or frontal planes by placing the space between the thenar and hypothenar eminences on the asis's and molding the hands to the ilia. (Fig. 27).



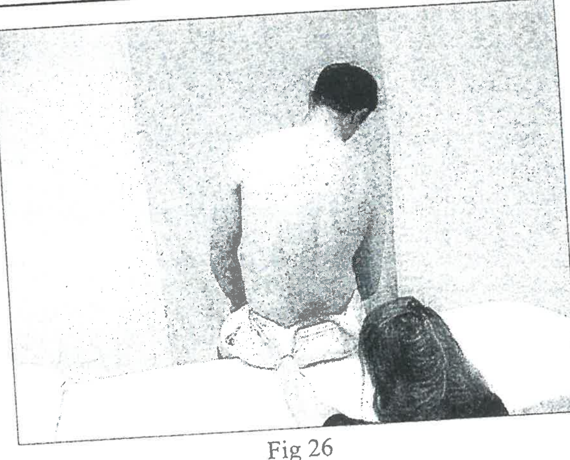


Fig 26

Fig 27

Pelvic Girdle Evaluation

- Supine Tests
  - Palpation for Pelvic Position
  - Asis's - Assess superior/inferior, anterior/posterior and medial/lateral position by palpating with thumbs on the inferior medial aspects of the ASIS (Fig. 28). The umbilicus can be used as a point of reference if it is centrally positioned.

Fig 28

Pelvic Girdle Evaluation

- Supine Tests
- Pubic Tubercles
  - Palpate both tubercles with the first two digits of both hands to assess height (Figs. 29, 30). A discrepancy may indicate a superior/inferior translation of the pube or ilium or a posterior/anterior ilial rotation. If difficulty is encountered in palpating the pubic tubercles, have the patient flex the hips and knees to lessen abdominal tone. If you stand at the head of the table use thumb palpation on the pubic tubercles to assess height (Fig. 31).

heel of hand -> better feel ē two fingers

across inf/sup

Fig 30

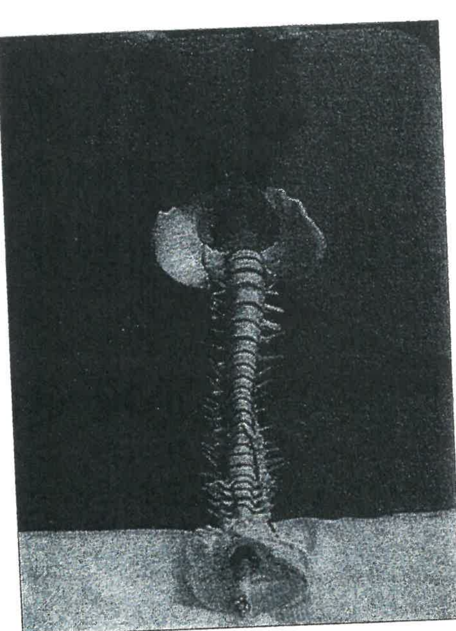


Fig 29

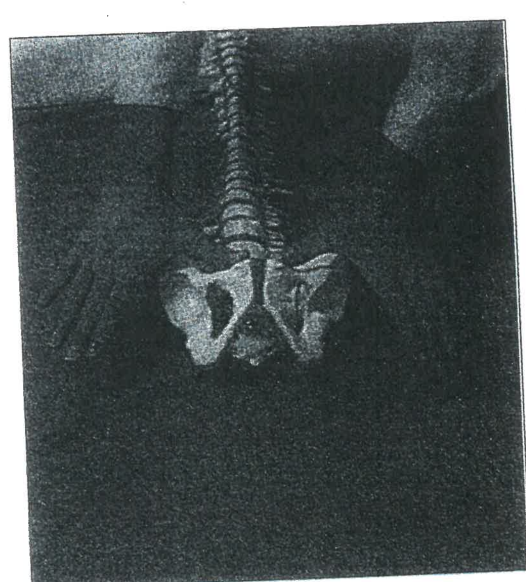


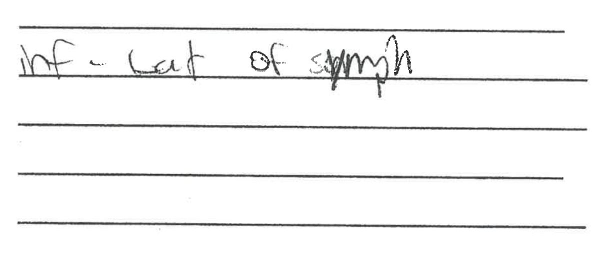
Fig 31

Pelvic Girdle Evaluation

- Supine Tests
- Pubic Bodies

  - (PUBIC BODIES) - Palpate the anterior surface of both pubic bodies with both thumbs to assess anterior/posterior relations (Figs. 32, 33). Anterior or posterior translations may accompany an anterior or posterior rotation of the pube or ilium.

access Ant/Post



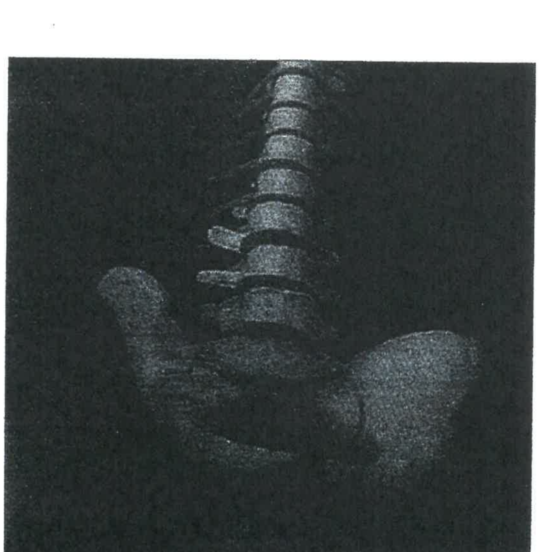


Fig 32

Fig 33

Causes of Coccygeal Dysfunction

- Sprain's from direct trauma from a fall
- Fracture
  - childbirth
  - direct trauma
- Indirect stress
  - Hypermobile sacroiliac via sacrospinous ligament
  - Disc pressure on dura mater causing pull on fium terminale to 2nd piece of coccyx

Examination

History
- Trauma, sitting, defecation
- Localized pain & tenderness

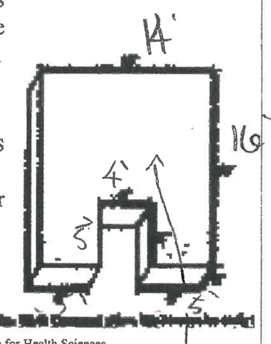
Palpation
- Tenderness to direct pressure
- Tenderness to passive motion
- Restricted mobility
- Indirect Stressing - tenderness to resisted glut. max.

Radiology
- Fracture
- Displacement

Standard Treatment

Stress reduction
- Coccygeal pillow or pads
  - Rings is not of much value
  - Rolled up newspapers will do in an emergency
- Avoid climbing stairs
- Avoid "sling type" chairs

Airline seats are often the worst - consider a pad under each ischial tuberosity



1.5 - 2 in foam

Acute Synovitis/Hemarthrosis

- Leave for 10 days post injury
  - Unlikely you would see the patient on initial injury

Chronic Discomfort
- Cause most probably due either:
  - to adhesions that keep being aggravated - manipulate
  - Periostitis - reduce stress as described
- Manipulative treatment is to stretch/rupture the adhesions
  - Long axis distraction
  - Long axis plus correction
  - Three to four sessions maximum

Prognosis

Excellent with proper instruction in care over time

Technique Coccyx Manipulation

- Use gloves & lubricant
- Be escorted by a colleauge of the same sex as patient
- Place index finger of one hand into rectum
- Use thumb of other hand over external coccyx to give counter pressure
- Pull in long axis of coccyx - repeat 3 to 5 times
- Conclude with ultrasound

2nd and 3rd Sessions:
- Repeat the long axis traction & ultrasound

If above ineffective:
- Consider performing a long axis thrust.

Must IR hips/femurs

Coccyx Examination and Manipulation

MANIPULATION

Inferior Pube Glide (Left Side)

Patient position

- supine (opposite hip and knee may be flexed)

Therapist position

- standing on involved side at head end of patient

Hand placement

- left thumb contacts left superior pubic rami and the base of the right hand contacts over the left thumb (Figs. 116, 117). You may use the hypothenar aspect of the right hand without left thumb contact (Fig. 118).

Force application/direction

- use the base of right hand (left thumb, if used, is inactive) to prevent superior pube movement and encourage inferior pube glide. Do not use force or pressure to push the pube inferior, but instead take up the slack after the pube is felt to slide inferior. The patient's respiratory mechanism will influence pube movement with inhalation elevating the pube and exhalation facilitating inferior movement. Resist superior movement during inhalation and enhance inferior movement on exhalation.

Fig. 116

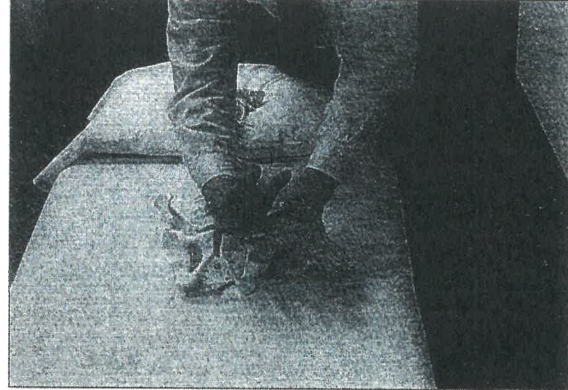
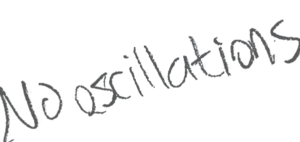


Fig. 117



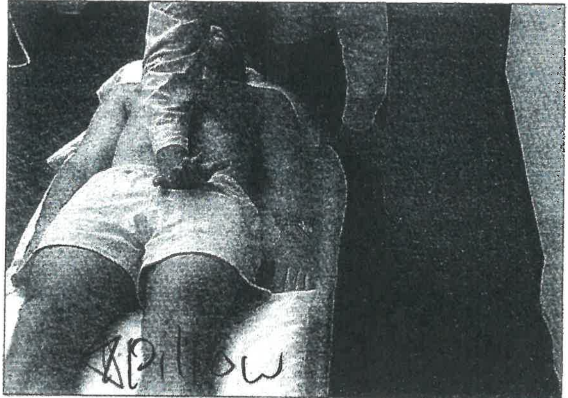


Fig. 118

Posterior Pube Glide (Left sided problem)

Patient position

- supine with the feet shoulder width apart.

Therapist position

- standing on involved side at the feet end facing the patient. Same side only

Hand Placement

- hypothenar aspect of left hand contacts anterior surface of left pube while keeping arm at right angles to the symphysis (Figs. 119, 120).

Force application/direction

On inhalation superior-posterior directed force to the left pubic body using a respiratory assist or continuous mobilization method. A patient with a more posterior pelvic position will require more of a posterior directed mobilization force whereas a patient who has a greater anterior pelvic position will require more of a superior directed force.

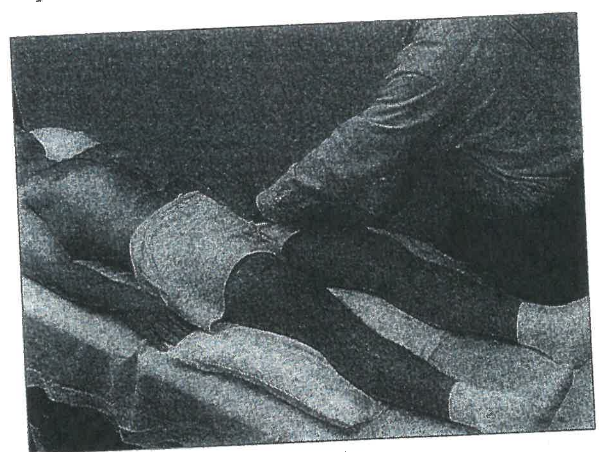


Fig. 119

dummy thumb is an option

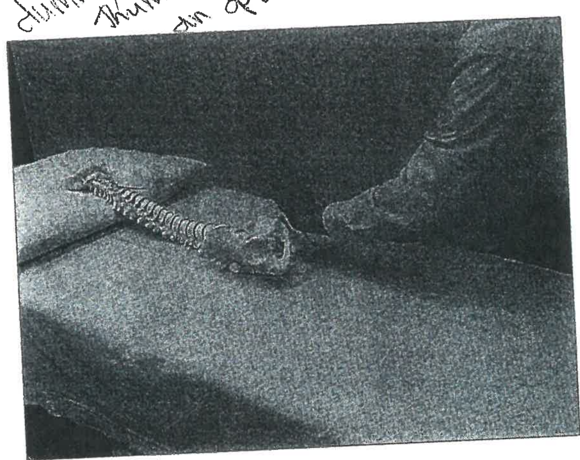


Fig. 120

Virginia.gov Agencies | Governor

Export to PDF Export to Excel

Agency **Department of Health Professions**

Board **Board of Physical Therapy**

Chapter **Regulations Governing the Practice of Physical Therapy [18 VAC 112 - 20]**

91 comments

All good comments for this forum Show Only Flagged

Back to List of Comments

Commenter: Dr. Joseph Gianfortoni, MD, FACOG 5/8/23 8:18 am

Support Defining Invasive Procedure and Define Pelvic Floor Therapy as Non-Invasive Procedure

1. On November 1, 2022, The Board of Physical Therapy issued Guidance Document:112-14 - "Guidance on Electromyography ("EMG"), Sharp Debridement, and Removal of Sutures, Staples, or Surgical Drains and the Practice of Physical Therapy," that holds in relevant part:

Electromyography ("EMG") EMG *is an invasive procedure and requires referral and direction from a licensed practitioner, in accordance with Virginia Code § 54.1-3482.*

Sharp Debridement *Sharp debridement is an invasive procedure and requires referral and direction from a licensed practitioner, in accordance with Virginia Code § 54.1-3482.*

Sutures, Staples, or Surgical Drains *The removal of sutures or staples is an invasive procedure and requires referral and direction from a licensed practitioner, in accordance with Virginia Code § 54.1-3482.*

2. On March 21, 2023, the Governor of Virginia approved unlimited direct access, to include ***dry needling***, removing the requirement for physical therapists to obtain a prescription. Therefore, ***dry needling is no longer considered an "invasive procedure"*** within the practice of Physical Therapy

3. Va. Code §54.1-3482. Practice of physical therapy; certain experience and referrals required; physical therapist assistants states in relevant part:

> D. ***Invasive procedures*** within the scope of practice of physical therapy shall at all times be performed only under the referral and direction of a licensed Doctor of Medicine, osteopathy, chiropractic, podiatry, or dental surgery, a licensed nurse practitioner practicing in accordance with the provisions of § 54.1-2957, or a licensed physician assistant acting under the supervision of a licensed physician.

4. 18 VAC l 12-20-170(B)(3) Confidentiality and practitioner-patient communication provides in relevant part: **B. Communication with patients**

> 3. ***Before any invasive procedure is performed***, informed consent shall be obtained from the patient and documented in accordance with the policies of the health care entity. Practitioners shall inform patients of the risks, benefits, and alternatives of the recommended invasive procedure that a reasonably prudent practitioner in similar practice in Virginia would tell a patient. In the instance of a minor or a patient who is incapable of making an informed decision on his own behalf or is incapable of communicating such a decision due to a physical or mental disorder, the legally authorized person available to give consent shall be informed and the consent documented.

5. **As of the date if this filing**, the Virginia Board of Physical Therapy has ***promulgated no amendments to the administrative code to define "invasive procedure"*** other than its November 2022 Guidance Document 112-14, supra. See for example: Virginia Emergency Medical Services Regulations' definition of an "invasive procedure" is at 12VAC5-31-10 and the Virginia Board of Medicine's definition of "invasive procedure" is at 18VAC85-140-150(A)(3)(c).

6. **Is Pelvic Floor Therapy an invasive procedure in the practice of Physical Therapy?** The APTA and the VPTA's pelvic health documentation gives guidance on how the Commonwealth of Virginia's Administrative Process Act should be outlined, including but not limited to, is pelvic floor therapy within the scope of practice for physical therapy, and if a student PT or PTA can perform pelvic floor therapy without pelvic floor certification or without the appropriate entry level degrees required for graduation and licensure.

7. **Does the practice of Pelvic Floor Therapy require certification, licensure or a minimum number of hours of training in the practice of Physical Therapy?**

8. What is the **standard of care** for **Pelvic Floor Therapy in the practice of Physical Therapy?**
CommentID: **216875**

Commenter: Anonymous 5/8/23 8:36 am

CommentID: **216876**

Commenter: Joanne Biddix BSN RN CWCN 5/8/23 11:12 am

CommentID: **216878**

Commenter: Dr. Christine Ressler 5/8/23 12:21 pm

CommentID: **216879**

Commenter: Linda M Hogan 5/8/23 1:38 pm

CommentID: **216880**

Commenter: Pat Kropac 5/8/23 1:44 pm

Support Pelvic floor pt noninvasive

The field of PT is so specialized now with certifications available for very unique treatments the PCP's and other Doctors can't keep up with it. A patient has to be proactive to find solutions for ailments Doctors tend to treat with medication rather then trying to get to the root cause. Pelvic floor PT and needling are great examples. Neither treatment would require outpatient protocol or inpatient. That is how I define an invasive treatment. You don't have a team of medical professionals participating in the treatment either.

CommentID: **216881**

Commenter: Karen McDonald 5/8/23 1:44 pm

CommentID: **216882**

Commenter: Lois DuRant 5/8/23 2:11 pm

CommentID: **216883**

Commenter: Kara Topping 5/8/23 2:25 pm

CommentID: **216884**

Commenter: Anne Carr Regan 5/8/23 2:33 pm

CommentID: **216886**

Commenter: Jim tait 5/8/23 3:10 pm

Support

I am in support of pelvic floor therapy being non invasive.

CommentID: **216888**

Commenter: Catherine Bredrup

5/8/23 3:17 pm

CommentID: **216889**

Commenter: Anonymous

5/8/23 4:01 pm

DO YOU KNOW…facilities the BoPT members either teach or practice list PFT as NON-INVASIVE!!

How is it possible that the BoPT member(s) were able to promulgate a **"new regulation,"** stating for the first time **"pelvic floor therapy was an INVASIVE procedure,"** without having **ANY certified** experts in pelvic floor therapy present and **NOT knowing their own facilities websites**, where they teach or practice, ***which still to date***, list pelvic floor therapy as **NON-INVASIVE**?

http://www.bonsecoursphysicaltherapy.com/pelvic-pain/

There are non-invasive physical therapy solutions to address pelvic pain. The program your therapist customizes for you may include some of the following therapies:

- Biofeedback for relaxation/downtraining of pelvic floor muscles
- Biofeedback for uptraining and neuromuscular reeducation
- Manual therapy for pelvis/coccyx realignment
- Internal massage to pelvic floor trigger points
- External massage for lower abdominal or lower lumbar tightness/adhesions
- Gentle electrical stimulation to relax muscles or retrain muscular contraction
- Pain management strategies (visual imagery, TENS, breathing techniques)
- Dilator training
- Home exercise programs

https://go.vcuhealth.org/media/file/UrogynGuide-UnderstandingPelvicFloorConditions-Sept2019.pdf

Treatment options

Noninvasive solutions: In addition to lifestyle changes, your doctor may recommend exercises to retrain your bladder and strengthen your pelvic muscles. You may also receive treatment in the form of physical therapy, which may involve biofeedback or nerve stimulation to teach you how to activate your muscles.

CommentID: **216890**

Commenter: ALVIN S. PEYTON

5/8/23 5:13 pm

CommentID: **216892**

Commenter: Wanda Lee Jiggetts

5/8/23 7:23 pm

Pelvic Floor Therapy

I am in support of the board listing pelvic floor therapy as non-invasive.

CommentID: **216895**

Commenter: Anonymous

5/8/23 7:28 pm

CommentID: **216896**

Commenter: India Gail Peters

5/8/23 7:59 pm

Pelvic Floor Therapy

I am in support of the Physical Therapy Medical board in listing pelvic floor therapy as non-invasive.

CommentID: **216897**

Commenter: Anonymous

5/8/23 8:21 pm

CommentID: **216898**

Commenter: Sandra Rutherford

5/8/23 8:58 pm

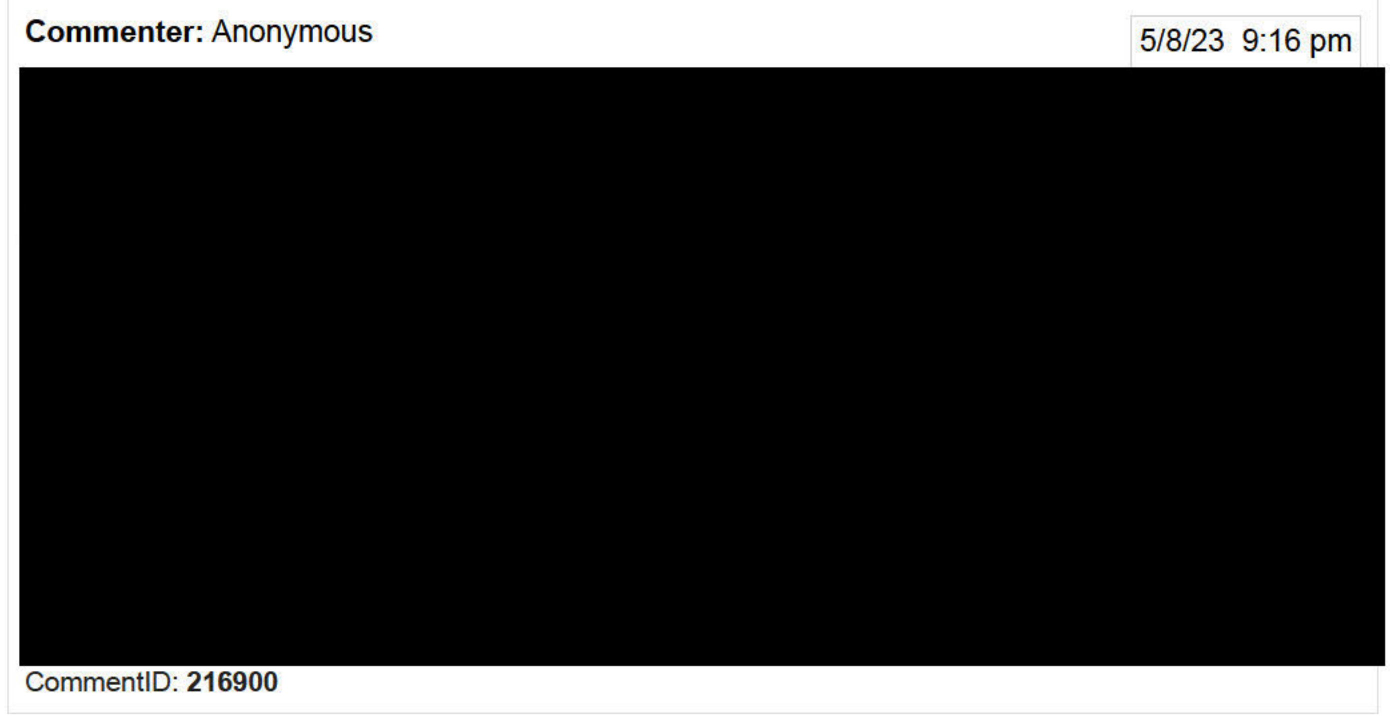
Support as non-invasive

Support as non-invasive

CommentID: **216899**

Commenter: Anonymous

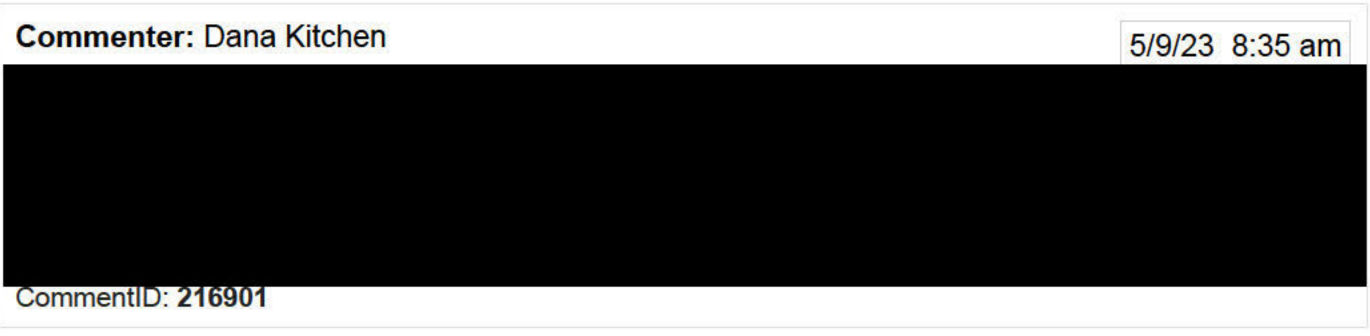
5/8/23 9:16 pm



CommentID: **216900**

Commenter: Dana Kitchen

5/9/23 8:35 am



CommentID: **216901**

Commenter: John Green

5/9/23 8:44 am

CommentID: **216902**

Commenter: Phil Armas

5/9/23 12:20 pm

CommentID: **216917**

Commenter: Anonymous

5/9/23 12:35 pm

CommentID: **216920**

Commenter: Anonymous

5/9/23 1:53 pm

Pelvic floor

Non invasive PT technique

CommentID: **216928**

Commenter: Maureen Roberts

5/9/23 3:40 pm

Pelvic Floor Therapy

I have received pelvic floor therapy previously and it helped tremendously. It needs to be done with full consent and understanding of the patient but it is non-invasive.

CommentID: **216935**

Commenter: Daniel Arkin, Ph.D.

5/9/23 5:38 pm

CommentID: **216938**

Commenter: Keith Roberts

5/9/23 9:26 pm

CommentID: **216940**

Commenter: Vinh Tong

5/10/23 9:28 am

CommentID: **216942**

Commenter: Anonymous

5/10/23 9:34 am

Commenter: Anonymous

5/10/23 9:42 am

Commenter: Anonymous

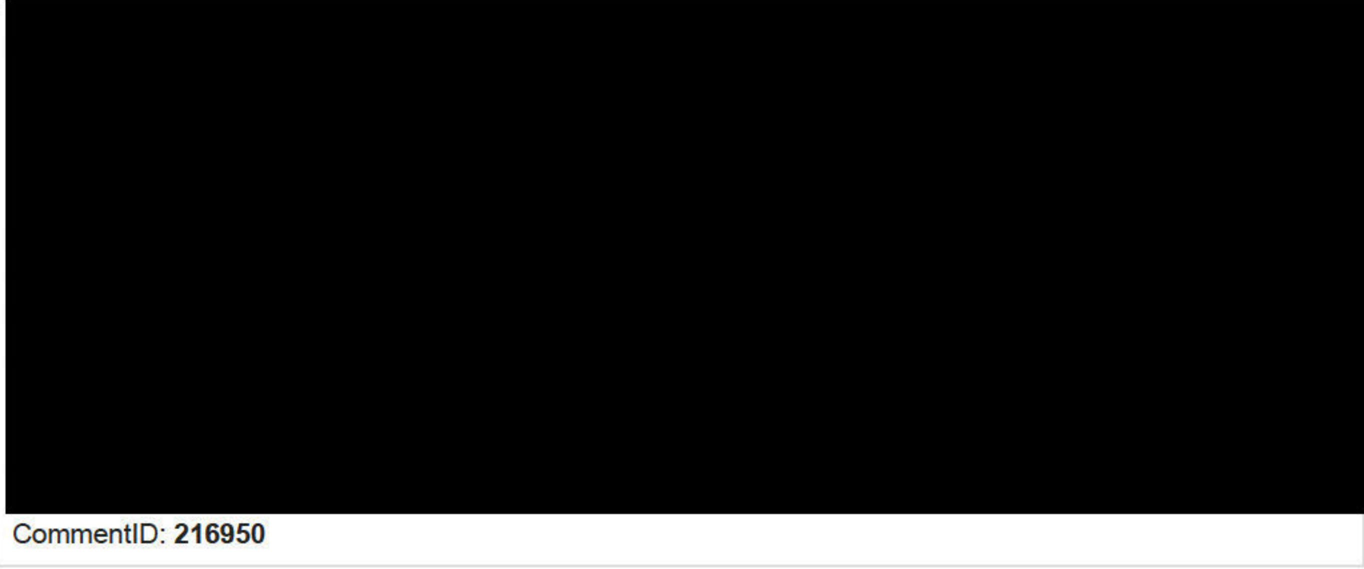
5/10/23 11:20 am

Commenter: Anonymous

5/10/23 11:26 am

Commenter: Anonymous

5/10/23 11:42 am



CommentID: **216950**

Commenter: Anonymous 5/10/23 12:13 pm

CommentID: **216951**

Commenter: Anonymous 5/10/23 12:28 pm

Make pelvic floor therapy non-invasive

As a person who has benefited greatly from pelvic floor work through physical therapy, please vote to have this therapy classified as non-invasive as it has always been.

CommentID: **216952**

Commenter: Shelby Latney 5/10/23 12:31 pm

Support for the petition for making Pelvic Floor Therapy Non-invasive

I am in support of the board listing pelvic floor therapy as non-invasive.

CommentID: **216953**

Commenter: Darleen Eldet 5/10/23 12:59 pm

CommentID: **216955**

Commenter: Anonymous

5/10/23 1:11 pm

Pelvic Floor Therapy

BoPT and VDHP - In reviewing this matter I want you to know that I am in support of listing Pelvic Floor Therapy treatment as non-invasive. Thank you for your consideration.

CommentID: **216956**

Commenter: Richard A. Stauffer MD

5/10/23 1:15 pm

CommentID: **216957**

Commenter: Ann Dutton

5/10/23 1:18 pm

PFT

Support petition to make PFT NON-invasive.

CommentID: **216958**

Commenter: MIchele Riedel

5/10/23 1:19 pm

Keep pelvic floor PT non-invasive.

I am in favor of keeping Pelvic floor physical therapy non-invasive.

CommentID: **216959**

Commenter: Erin Poston, PA-C

5/10/23 1:59 pm

Support for "non-invasive"

CommentID: **216960**

Commenter: Frances Duty 5/10/23 3:04 pm

Pelvic floor therapy

I am in support of the board listing pelvic floor therapy as non-invasive, as it always has been. I have benefited from pelvic floor therapy a number of times and it does not need to be made a complicated mode of therapy nor put in a situation where the increased cost is prohibitive to women who may need the therapy but might not be able to afford it. Thank you.

CommentID: **216962**

Commenter: Steve Fey 5/10/23 3:40 pm

CommentID: **216963**

Commenter: Panteha Nazari, PT, DPT, BCB-PMD, PRPC, IF 5/10/23 3:54 pm

Pelvic rehab in non-invasive and necessary part of physical and sexual health

All the therapists, who have the proper training, are taught to assess the anatomy and function of the pelvic floor musculoskeletal and neurological systems through an internal assessment, when necessary. This examination provides valuable information which will decide the course of treatment and interventions. Internal assessment and treatment of the pelvic floor is NEVER forced and only provided with patient's consent. Otherwise, the physical or occupational therapist who is providing care would assess externally, with limitations.

CommentID: **216964**

Commenter: Anonymous 5/10/23 4:21 pm

PFT

In support of pelvic floor therapy remaining non invasive.

CommentID: **216968**

Commenter: Robert Cantermen 5/10/23 7:43 pm

CommentID: **216972**

Commenter: Anonymous 5/10/23 10:34 pm

CommentID: **216976**

Commenter: Anonymous 5/10/23 10:37 pm

In Full Support to Keep Non-Invasive

If this were to become invasive, it would open the door for anyone not in adherence to potentially have their license revoked, lawsuits, re-imbursement to insurance companies, etc.? I am in support to keep in non-invasive.

CommentID: **216977**

Commenter: Anonymous

5/11/23 12:48 pm

Keep Pelvic Floor Therapy Non-Invasive

I am in full support of keeping pelvic floor therapy listed as non-invasive. As a therapist practicing now for over 10 years, this has always been the way pelvic floor therapy has been classified and is an appropriate therapy to provide to patients in need, by skilled therapists with adequate training.

CommentID: **216985**

Commenter: Lester Roark

5/11/23 7:25 pm

CommentID: **216986**

Commenter: Anonymous

5/11/23 9:30 pm

CommentID: **216987**

Commenter: Rachel

5/11/23 9:51 pm

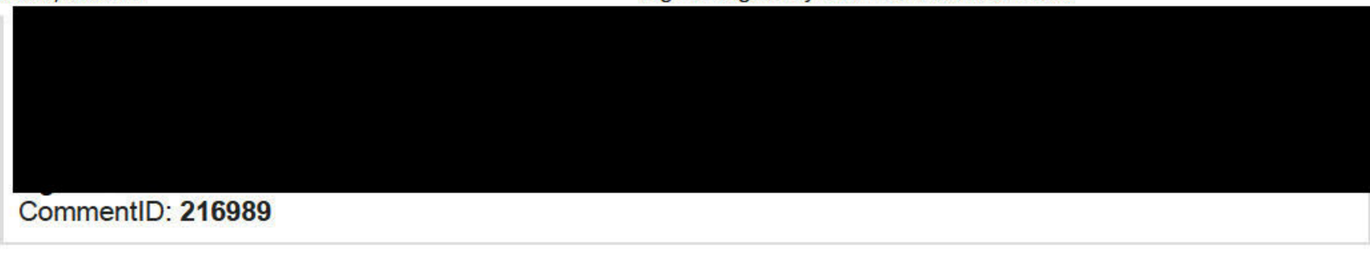
I support pelvic floor therapy remaining noninvasive as it always has been.

I support pelvic floor therapy remaining noninvasive as it always has been. This therapy was the only way I found relief from a 2 year old injury that no one was able to fix. Three pelvic floor treatments later and I have never dealt with the pain from that injury again, and 6 years have past. Thanks to pelvic floor treatment by my trained and licensed PT.

CommentID: **216988**

Commenter: Anonymous

5/11/23 10:17 pm



CommentID: **216989**

Commenter: Anonymous 5/12/23 1:31 pm

Pelvic Floor Therapy - NON INVASIVE

I am in support of the board in labeling pelvic floor therapy as non invasive.

CommentID: **216990**

Commenter: Dr. Jan Evans 5/12/23 1:46 pm

CommentID: **216991**

Commenter: Anonymous 5/12/23 6:44 pm

Keep non invasive

Keep pelvic floor treatment non invasive

CommentID: **216992**

Commenter: Keith Roberts 5/12/23 6:45 pm

Keep non invasive

Keep pelvic floor therapy non invasive

CommentID: **216993**

Commenter: Keith 5/12/23 7:09 pm

CommentID: **216994**

Commenter: Jesse L B Thurlow, PT

5/13/23 4:18 am

Pelvic Floor Examination/Treatment

Dear Sir/Madam:

As a practicing physical therapist for 47 years, I support keeping pelvic floor therapy a noninvasive treatment regimen.

Jesse Thurlow, PT

CommentID: **216995**

Commenter: Anonymous

5/13/23 12:20 pm

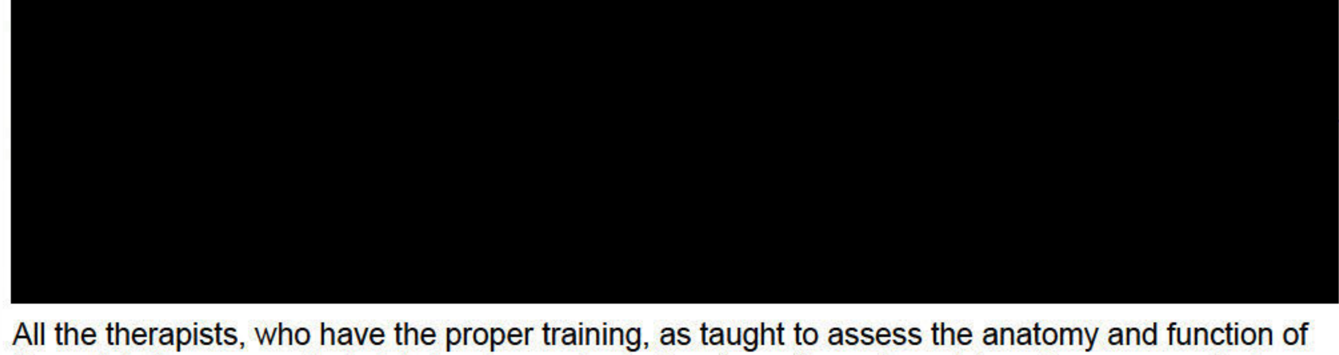
Pelvic Floor Therapy

Keep pelvic floor therapy as non-invasive…as it always has been.

CommentID: **216996**

Commenter: Panteha Nazari

5/14/23 11:46 am



All the therapists, who have the proper training, as taught to assess the anatomy and function of the pelvic floor musculoskeletal and neurological systems through an internal assessment when necessary.

This examination provides valuable information which will decide the course of treatment and interventions. Internal assessment and treatment of the pelvic floor is NEVER forced and only provided with patient's consent. Otherwise, the physical and occupational therapist who is providing care would assess externally, with limitations.

Please focus on understanding the required training and if you are enthusiastic about doing something useful, put your efforts on making requirements for proper amount of training on each specialty vs. making un-educated assumptions and decisions.

CommentID: **216997**

Commenter: G. K Barber 5/14/23 1:50 pm

CommentID: **216998**

Commenter: Anonymous 5/14/23 2:50 pm

keep pelvic floor non evasive

I believe they should keep pelvic floor non evasive as it has been.

CommentID: **216999**

Commenter: Anonymous 5/14/23 2:54 pm

Pelvic Floor

I believe they should keep Pelvic Floor non invasive as it has been.

CommentID: **217000**

Commenter: Anonymous 5/14/23 7:59 pm

Pelvic Floor

Keep pelvic floor non invasive.

CommentID: **217001**

Commenter: anonymous 5/15/23 11:54 am

CommentID: **217002**

Commenter: Chris Melton 5/16/23 4:19 pm

Support the petition

I am in support of the board listing pelvic floor therapy as non-invasive!!!

CommentID: **217005**

Commenter: Richard A. Stauffer MD

5/16/23 4:25 pm

Keep PFT Noninvasive

I can foresee no benefit to either patients or clinicians to change the designation of pelvic floor therapy to being invasive.

CommentID: **217006**

Commenter: Christine Kivett

5/16/23 8:52 pm

Keep Pelvic Floor Therapy Non-Invasive

Keep Pelvic Floor Therapy non-invasive, as it has always been.

CommentID: **217008**

Commenter: Nancy Lech

5/17/23 1:52 pm

Pelvic floor therapy /non invasive

I am in support of Pelvic Floor therapy being considered non invasive. It is therapy that has helped me tremendously in the past.

CommentID: **217010**

Commenter: Anonymous

5/17/23 3:29 pm

Support

I support keeping pelvic floor therapy as noninvasive as it has always been!

CommentID: **217012**

Commenter: Maureen J

5/19/23 1:12 pm

Pelvic floor therapy as non- invasive

I am in favor of keeping pelvic floor therapy as non invasive.

CommentID: **217016**

Commenter: Dianne Rife

5/22/23 11:32 am

Pelvic Floor Therapy

The National Library of Medicine lists pelvic floor therapy as non-invasive. It has been considered this for years. I support pelvic floor therapy as non-invasive

CommentID: **217017**

Commenter: Jan Dommerholt 5/22/23 1:05 pm

Pelvic Physical Therapy is a non-invasive therapy

Defining non-invasive pelvic physical therapy as invasive would be a mistake with far-reaching consequences. Would palpating mandibular condylar movement for pain by inserting a finger into the patient's ear constitute an invasive therapy? How about performing a long-axis distraction mobilization of the TMJ? Each of these procedures involves the insertion of the therapist's finger into a patient's body cavity, and throughout medicine and physical therapy, these standard procedures have not been considered "invasive" procedures. Please keep the definition of pelvic physical therapy as "non-invasive."

CommentID: **217019**

Commenter: Anonymous 5/22/23 2:43 pm

CommentID: **217020**

Commenter: barbara Orton

5/24/23 7:21 am

pelvic floor therapy

I feel that this procedure should remain non-evasive. It is up to the client and their individual therapist to make the decision to use this therapy with the classification remaining the same as they are and have always been.

CommentID: **217022**

Commenter: Krystal Johnson

6/7/23 6:21 pm

Pelvic Floor Therapy Must STAY Non-Invasive

Pelvic floor therapy needs to be an easily accessible therapy because it works. It must be labeled non-invasive. This is a therapy that makes sense physiologically and it has lasting results; I know it works because I am a patient who sought treatment for long term headaches. The procedure provided relief with the first session!

Labeling it Invasive only stigmatizes it and creates a barrier of time, office visits AND money that is unnecessary. The fact that a patient would need to have an MD referral to perform this procedure requires more out of pocket expense, which is huge disadvantage to low income individuals and families seeking pain relief. Professional physical therapists should be able to perform this procedure as it has always been performed.

CommentID: **217072**

Commenter: Scott J.

6/7/23 6:36 pm

CommentID: **217073**

Commenter: Nancy Boykin

6/7/23 7:34 pm

Pelvic floor therapy

I am leaving this comment because I am support of the board listing pelvic floor therapy as a non-invasive procedure. As a healthcare provider for over 25 years and as a former patient who has received pelvic floor therapy this needs to be labeled as noninvasive receiving this therapy has provided a great deal of relief for my pain. labeling this particular therapy as invasive is not factual

as there's nothing invasive about this additionally, as patients are seeking to achieve pain relief, stating that it is invasive, create additional fear to the possible client. Additionally, with the high use of opiates, this form of therapy avoids the need of this medication as it works to relieve pain. As with all healthcare procedures, a therapist can provide the client with specific information that will allow the client the opportunity to have informed consent prior to receiving this therapy.

CommentID: **217074**

Commenter: Melissa Wyatt

6/7/23 8:25 pm

Support both requests

I support the petitioner's requests that regulations be amended to 1) define invasive procedure and 2) further define the practice of pelvic floor therapy (PFT) as a noninvasive procedure. Current regulations state solely that dry needling is an invasive procedure but does not indicate what actually constitutes an invasive procedure. The proposal seeks not only to demonstrate how a procedure is determined to be invasive but also explicitly categorizes PFT as noninvasive (as is implied under current regulations).

CommentID: **217075**

Commenter: Anonymous

6/7/23 9:28 pm

Pelvic floor therapy

I am in support of the board listing pelvic floor therapy as non-invasive…as it always has been

CommentID: **217076**

Commenter: Alex

6/7/23 9:43 pm

Pelvic floor is non-invasive

Pelvic floor is a non-invasive therapy that has helped many find relief from a multitude of problems.

CommentID: **217077**

Commenter: Ann Hutch

6/7/23 10:16 pm

CommentID: **217078**

Commenter: Helen D. Simpson

6/7/23 10:19 pm

Commenter: Traci McFalls

6/7/23 10:26 pm

Keep pelvic floor therapy noninvasive

Keep pelvic floor therapy noninvasive

CommentID: **217080**

Commenter: RBDJ

6/7/23 11:07 pm

Pelvic Floor Therapy

I am support of Pelvic Floor Therapy remaining "non-invasive". I also request that this decision be coordinated with other governing bodies that oversee other disciplines that practice pelvic floor (OTs, PA's, etc.) so that all PF treatment follow the same professional rules.

CommentID: **217081**

Commenter: Anonymous

6/7/23 11:27 pm

Pelvic Floor

I am in support of the board listing pelvic floor therapy as non-invasive. In my professional experience, I agree with this stance.

CommentID: **217082**

Commenter: David Pong, MD

6/7/23 11:40 pm

I support the BoPT defining Pelvic Floor PT as non-invasive

While I believe that informed consent should be obtained prior to performing pelvic floor PT, as well as other procedures that may cause discomfort, adverse outcomes, or trigger strong emotional responses, I believe pelvic floor PT should continue to be defined as non-invasive by the BoPT. I see pelvic floor PT, when performed by well-trained and skilled professionals, as valuable to address a wide variety of conditions, and believe it should be treated in a fashion similar to dry-needling.

CommentID: **217083**

Commenter: Anonymous

6/7/23 11:59 pm

CommentID: **217084**

Board Discussion and Actions

Review and Affirm Approval of Credentialing Agencies for Graduates of Non-Accredited Schools (18VAC112-20-50)

Part II. Licensure: General Requirements

18VAC112-20-50. Education requirements: graduates of schools not approved by an accrediting agency approved by the board.

A. An applicant for initial licensure as a physical therapist who is a graduate of a school not approved by an accrediting agency approved by the board shall submit the required application and fee and provide documentation of the physical therapist's certification by a report from the FCCPT or of the physical therapist eligibility for licensure as verified by a report from any other credentialing agency approved by the board that substantiates that the physical therapist has been evaluated in accordance with requirements of subsection B of this section.

B. The board shall only approve a credentialing agency that:

1. Utilizes the FSBPT Coursework Evaluation Tool for Foreign Educated Physical Therapists, as required to sit for FSBPT examination, and utilizes original source documents to establish substantial equivalency to an approved physical therapy program;

2. Conducts a review of any license or registration held by the physical therapist in any country or jurisdiction to ensure that the license or registration is current and unrestricted or was unrestricted at the time it expired or was lapsed; and

3. Verifies English language proficiency by passage of the TOEFL and TSE examination or the TOEFL iBT, the Internet-based tests of listening, reading, speaking, and writing or by review of evidence that the applicant's physical therapy program was taught in English or that the native tongue of the applicant's nationality is English.

C. An applicant for licensure as a physical therapist assistant who is a graduate of a school not approved by the board shall submit with the required application and fee the following:

1. Proof of proficiency in the English language by passing TOEFL and TSE or the TOEFL iBT, the Internet-based tests of listening, reading, speaking, and writing by a score determined by the board or an equivalent examination approved by the board. TOEFL iBT or TOEFL and TSE may be waived upon evidence that the applicant's physical therapist assistant program was taught in English or that the native tongue of the applicant's nationality is English.

2. A copy of the original certificate or diploma that has been certified as a true copy of the original by a notary public, verifying the applicant's graduation from a physical therapy curriculum. If the certificate or diploma is not in the English language, submit either:

a. An English translation of such certificate or diploma by a qualified translator other than the applicant; or

b. An official certification in English from the school attesting to the applicant's attendance and graduation date.

3. Verification of the equivalency of the applicant's education to the educational requirements of an approved program for physical therapist assistants from a scholastic credentials service approved by the board and based upon the FSBPT coursework tool for physical therapist assistants.

D. An applicant for initial licensure as a physical therapist or a physical therapist assistant who is not a graduate of an approved program shall also submit verification of having successfully completed a 1,000-hour traineeship within a two-year period under the direct supervision of a licensed physical therapist. The board may grant an extension beyond two years for circumstances beyond the control of the applicant, such as temporary disability, officially declared disasters, or mandatory military service.

1. The traineeship shall be in accordance with requirements in 18VAC112-20-140.

2. The traineeship requirements of this part may be waived if the applicant for a license can verify, in writing, the successful completion of one year of clinical physical therapy practice as a licensed physical therapist or physical therapist assistant in the United States, its territories, the District of Columbia, or Canada, equivalent to the requirements of this chapter.

Statutory Authority

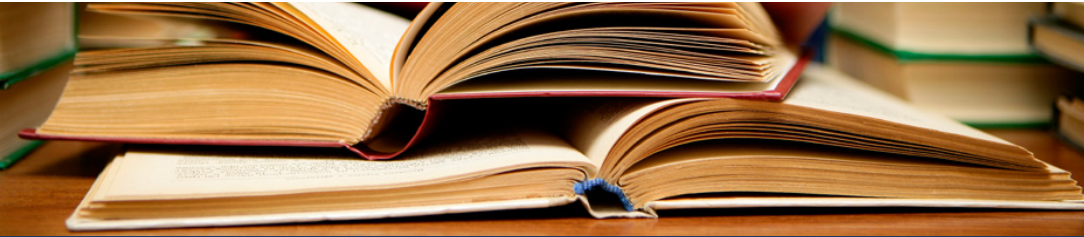
§§54.1-2400 and 54.1-3474 of the Code of Virginia.

Historical Notes

Derived from Virginia Register Volume 16, Issue 25, eff. September 27, 2000; amended, Virginia Register Volume 20, Issue 24, eff. September 8, 2004; Volume 22, Issue 23, eff. August 23, 2006; Volume 25, Issue 26, eff. September 30, 2009; Volume 29, Issue 21, eff. July 17, 2013; Volume 37, Issue 14, eff. April 30, 2021.

Promoting Safety and Competence

Free Resourc



Acronyms A-Z

Continuing Competence

Credentialing Organizations for Non-US Candidates

Ethics Articles

Faculty Newsletter

Foreign Educated PTs and PT Assistants

FSBPT Forum

Credentialing Organizations

Agencies for Non-US Educated Physical Therapists

If you are a non-US educated physical therapist, many states will require you to go through the credentialing process before you are issued a physical therapy license. Credentialing is also required in order to obtain healthcare worker certification.

What is Credentialing?

Credentialing is a comparison of the foreign education curriculum to the current US standards, and when appropriate, to previous standards to match the year of graduation.

Below is a list of credentialing organizations for non-US candidates. These agencies may be licensed to use FSBPT's coursework tools for foreign educated physical therapists.

Organizations Recognized by USCIS to Issue Healthcare Worker Certificates:

Foreign Credentialing Commission on Physical Therapy (FCCPT)

124 West Street South, 3rd Floor

Alexandria, VA 22314, USA

Phone: (703) 684-8406*

Website: www.fccpt.org

*View the FCCPT Call Center Hours.

Commission on Graduates of Foreign Nursing Schools (CGFNS)

3600 Market Street, Suite 400

Philadelphia, PA 19104-2651, USA

Phone: (215) 349-8767*

Website: www.cgfns.org

*CGFNS call center hours of operation are Monday through Friday 8:00am to 12:00pm, U.S. Eastern Time.

Organizations Licensed to use the FSBPT Coursework Tool (CWT):

Foreign Credentialing Commission on Physical Therapy (FCCPT)

124 West Street South, 3rd Floor

Alexandria, VA 22314, USA

Phone: (703) 684-8406*

Website: www.fccpt.org

*View the FCCPT Call Center Hours.

International Consultants of Delaware, Inc. (ICD)

3600 Market Street, Suite 450

Philadelphia, PA 19104, USA

Phone: (215) 222-8454 Ext. 603*

Fax: (215) 349-0026

Website: www.icdeval.com

*ICD Customer Service phone lines are open Monday through Friday from 12:30pm to 3:30pm, U.S. Eastern Time.

International Education Research Foundation, Inc. (IERF)
PO Box 3665
Culver City, CA 90231-3655, USA

Phone: (310) 258-9451
Fax: (310) 342-7086
Website: www.ierf.org

FSBPT®
Federation of State Boards of Physical Therapy
124 West Street South, Third Floor
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Applicant inquiries (215) 222-8454 ext 603
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(310) 258-9451

~~**University of Texas at Austin Graduate & International Admissions Ctr**~~
~~2608 Whitis Avenue~~
~~Austin, TX 78712~~
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Board of Physical Therapy
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