

# Physical Therapy Section

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During the past year and a half I have been working to develop the population based ASAM Model. I just returned from a cold, wet, but quite enjoyable visit to Germany and have requested one additional change to the model. I think it is important that everyone understand the basis of the model so that when you are surveyed you know where the numbers are coming from. First I strongly believe that while we are excellent Primary Musculoskeletal Evaluators, we are not Primarily Musculoskeletal Evaluators. The demand for physical therapists is not because we are the best at patient evaluation, it is because once we have evaluated the patient we are able to effectively treat the patient. It is our treatment skills that make us invaluable to the organization. It is also our ability to work with the units to identify and correct risk factors and decrease injuries that places us in high demand. So, the model is based upon the role of the therapist evaluating, providing direct, hands-on treatment, and doing injury prevention activities.

I was recently asked by a hospital commander - "I have always been able to meet access standards with one therapist – your model identifies the requirement for 2.5 therapists – why do I need more than one?" I was able to point out that the therapist was Primarily a musculoskeletal evaluator, did very little hands-on patient care or injury prevention activity, and the majority of patients were treated by the PTAs, with only weekly follow-up by the PT. I discussed the importance of the therapist seeing the patient each day and by doing so being able to adjust treatment plans instantaneously based upon the patients responses and decrease the lost duty time.

I developed a population model that varied with the age of the patient and status of the patient (the time required to evaluate and treat an 18 yr old AD is much different than a 60 yr old dependent retired). The folks at ASAM wanted to work initially with one population number so we settled on 1 PT per 7,500 population. We then addressed the support staff. Initially they wanted a fixed 1.7 support per PT. Over time we agreed on a sliding scale that for a single therapist you would begin with 1 receptionist and 2 assistants. This was followed by an addition of therapist to tech at 1:1 with an additional technician added in when there was a need for an NCOIC. Additional receptionists were added at total therapists levels of 6 and 12. These numbers may have changed a little as they have gone through the ASAM process, but the concept is still in place. Now, back to my trip to Germany. While there we identified that, similar to the Rangers, there are a number of locations with troop populations below 7,500 that still require a physical therapist. Here is where our treatment skills become crucial, because it is easy to justify one independent PT doing the evaluation, treatment and injury prevention, but supporting additional staffing is difficult. I have asked that the model now include independent physical therapists for troop populations between 2,500 and 5,500. We identified a number of these positions in Europe and we are currently working on obtaining authorizations to increase the number of therapists in Europe.

I will continue to emphasize the patient treatment role of our therapists and our skills as primary musculoskeletal evaluators, but will also emphasize that we are not, and should not be, **primarily** musculoskeletal evaluators.