The Team Approach
to Amputee Rehabilitation

Fighting the Fragmentation of Healthcare Services to Better Serve Patients

by Rick Bowers

In recent years, there have been dramatic changes – both positive and negative – in the medical world. One change, however, seems to be causing great and unnecessary harm to many amputees, according to some prominent members of the prosthetic and physical therapy communities. Many amputees aren’t getting the kind of healthcare services they need and deserve, says Bella J. May, EdD, PT, FAPTA, an acclaimed educator, researcher, author and physical therapist (PT).

Kevin Carroll, CP, the vice president of prosthetics for Hanger Orthopedic Group, explains the problem. “Traditionally, after amputation, a patient would be referred to a rehab hospital or an amputee clinic where...”
the doctor in charge would bring together a team consisting of a prosthodontist, a physical therapist, an occupational therapist, and maybe a case manager and a psychologist. The doctor would keep everything together and make sure that the physical therapist and occupational therapist would be involved, and generally you'd have a good outcome."

That’s changed as physicians have become less and less involved, explains Robert Bedotto, CPO, PT. “I think doctors are kind of ‘washing their hands’ of patients because the hospitals just want to get rid of them. I mean, an amputee gets two days, if they get that, in the hospital. The physical therapist can’t even come in and do proper wrapping of the residual limb. I see patients many times that are ready for a temporary prosthosis, but nobody’s ever taught them how to wrap, nobody’s done preprosthetic work. It’s kind of like we’ve slipped backwards. When I was a PT and starting out, we used to keep amputees in the rehab center for six months or more. Now, they’re lucky if they get six sessions.”

As a result of this lack of coordination by physicians and the rush to discharge patients from the hospital, patients’ access to the care they need at the appropriate time has become fragmented, and there is little unified effort to ensure that all of a patient’s rehabilitation needs are met. A revived “team approach” among healthcare providers is, thus, needed to ensure that patients have access to a total rehabilitation experience.

**A Matter of Money**

Part of the problem is managed care, Bedotto argues. Managed care has taken over and caused the business end of the medical profession to surpass the care aspect, and that’s been harmful to patients, he asserts. “I think what the physicians have to do is take their patients back.”

May agrees that it’s often a matter of dollars and cents. “Managed care and the insurance companies have not learned to value the rehabilitation of the chronically disabled, so they may not authorize the most optimum prosthesis or components and the level of care that patients need to return to a productive lifestyle.”

**A Lack of Knowledge**

In general, there are two basic scenarios for patients, and the one the patient experiences may greatly affect his or her rehabilitation outcome.

“If it’s a young individual whose amputation is the result of trauma, the surgeon will usually be an orthopedic surgeon,” May explains. “These surgeons have more education in prosthetic care and prosthetic management than other surgeons and are much more aware of prosthetic rehabilitation, so if there is an amputee clinic in the area, they will make sure that the patient is referred. They will involve physical therapy early, which is when it should be involved.

“Oh the other hand, an older individual who has diabetes is more likely to come to amputation after long-term attempts to save the limb, and if an amputation is done, it is usually done by a vascular surgeon or a general surgeon who is educated in amputation surgery but not in amputation rehabilitation. That individual is less likely to be referred to a rehabilitation center and more likely to fall through the cracks. They’ll be sent home, the physician may well not involve physical therapy early, they’ll sit at home until the residual limb is totally healed, and then at that point, which could be four or five months down the road, the surgeon may say, ‘Oh, well, he’d better go see a prosthodontist.’”

At that point, the patient may already have severe problems as a result of not seeing a physical therapist and being inactive for so long. He or she may end up with contractures, weakness, edema and other problems. In addition, he or she will not have been properly prepared for using a prosthesis, which might require the strengthening of certain muscles.

To avoid these problems, “both the prosthodontist and the PT would like for the patient to get involved in the system before surgery or immediately after surgery,” says May.

**Building Team Relationships**

Educating surgeons on the importance of pre-amputation and immediate post-amputation involvement of physical therapists and prosthetists is perhaps the best method of ensuring that both are involved in the rehabilitation process early. When doctors understand the importance of the team approach to amputee rehabilitation, May says, most are willing to refer the patient to an amputee clinic or other members of the healthcare team in a timely manner and follow up with the patient to ensure that he or she is following the prescribed program. “Most of them want what’s best for their patients,” she says. “Many are just not aware of what’s available.”

Relationships also need to be nurtured between prosthetists and PTs to ensure that patients reach their highest level of independence, May says. “We need to learn how best to work together, how to develop strong communications, and to truly understand each other’s profession.”

May’s goal is to educate prosthetists on the role and education level of the physical therapist, which prosthetists are often unaware of. This is important because the amputating surgeon will at some point need to send the patient to a prosthodontist, and if the team approach is not developed
at the physician level, the prosthetist can refer the patient to the physical therapist, although it will at that time already be quite late in the rehabilitation process. However, although the prosthetist can refer patients for physical therapy, most insurance companies still ultimately require a physician to sign off on the therapy.

Bedotto argues that although some prosthetists might balk at this added expectation of them to make the referral to a PT, they should look at it differently. “If I make a prosthesis, I care about anything that’s going to contribute to the success of it, including physical therapy. It’s just a professional thing.”

May says it has to be a two-way street. “To work effectively with the prosthetist, I need to reach out to the prosthetist and not only educate him or her about what I do, but learn the problems and issues that he or she faces from his or her point of view.”

Carroll feels the same way and says that he’s always found physical therapists to be complementary to his work. “I have much more successful outcomes when I work with physical therapists than when I don’t.”

He paints a picture of the give and take required in this relationship. “The therapist will explain to me that something could be changed with the prosthesis. I will talk about the logistics of the dynamics of the prosthesis, and they’ll talk about physiological aspects of the person that they’re trying to treat, such as muscle imbalances. Both should, therefore, be very knowledgeable of one another’s field.”

Carroll points out another important way that prosthetists can help patients get the full benefit of therapy. Amputees, he says, go to physical therapy because they want to learn how to walk, but the PTs start working their upper-body muscles and other muscles and there doesn’t seem to be an emphasis on walking. Amputees often don’t understand that they have to learn balance and other aspects of walking before they can walk properly, and sometimes they stop going to physical therapy because they consider it too much useless work. Carroll explains, however, that physical therapy is very important, and the patients who build a relationship with a physical therapist and continue to go back for therapy do a lot better with their prosthesis. The prosthetists’ part, he says, is, therefore, to continually encourage patients to go to physical therapy and occupational therapy and to make them understand their importance.

Sometimes, he says, amputees don’t know that they have a problem with their walking, etc., until a couple of years down the road when they get back problems and body pains because they are walking so poorly. To avoid such problems, Carroll recommends that his patients see a physical therapist every year for an evaluation. “The ones who continue to do that are the best walkers, and the ones who don’t follow through are the ones who lose out over the years and start declining.”

Carroll also stresses the involvement of the occupational therapist (OT). “I think it’s important for occupational therapy to be involved, especially in the beginning to teach the person how to put the prosthesis on, how to take it off, how to dress themselves, how to take care of their personal hygiene, and all that stuff that they have to do at home. Bringing that whole team together goes back to the doctor, who should continually follow up with that particular patient.”

The physician, the prosthetist, the physical therapist, the occupational therapist and the patient should all walk hand in hand together, he says. In fact, Hanger offers free seminars around the country to prosthetists and physical and occupational therapists to give them the opportunity to learn about each other’s work and to get to know each other. Prosthetists are also offering to do guest lectures in PT programs and inviting PT students to visit their facilities to foster such relationships.

**Leading the Team**

Perhaps one of the most critical aspects of developing this inclusive team approach to amputee rehabilitation is the patient.

“The patient should lead the rehabilitation team,” says May. She argues that all the other members should be equals with different roles. “We each have our specialties and our areas of expertise, and we each need to contribute those things that we can contribute best. I am the expert in physical therapy; therefore, I know what physical therapy can and cannot offer. The prosthetist similarly is the expert in prosthetics and prosthetic components and is, therefore, the best person to select the most optimum prosthetic components.” He or she also knows funding sources, she says, and which components would work best for someone who is elderly and/or overweight, etc.

Consumers need to recognize that they have a very important voice, she says. “They have the right to demand the appropriate level of rehabilitation, but I think too
often, neither the patient nor the family, either because of timidity or lack of knowledge, will speak up for themselves.”

This is a common problem and is to be expected. After all, most patients have never had an amputation before. They know little or nothing about what they need. In fact, Bedotto, says, they often don’t even ask about warranties, what happens if their prosthesis breaks, or how long it’s going to last. “Unfortunately, a lot of patients feel like second-class citizens and don’t understand that they can change anything. Sadly enough, what they often say is, ‘Well, I have to go wherever my insurance tells me. I may not get the best care, but I can’t afford it.’” He says patients have to take responsibility for their care, speak up to doctors, and say, “This is what I want.”

It’s important to give patients choices, Bedotto says, if they are to be the real leaders of the team. “Getting a prosthesis is a pretty major thing in their life. It’s a pretty major expense for the insurance company; and if there’s a co-pay, it can be a major expense for the patients. And yet, they just go to whomever.”

He finds it surprising that consumers know how to pick other types of vendors, but they don’t know how to pick a physician or healthcare provider. “They look at it like it’s not their money, but somebody’s paying a very good premium today for very little care. If they want to hire a plumber or electrician, they’re going to find out what they need done and what it’s going to cost. They’re going to get at least three estimates. They have to ask the same types of questions about their healthcare.”

If doctors want to do what’s best for their patients, Bedotto says, they should have their patients visit two or three prosthetists and see who they think they can work with. The same is true for physical and occupational therapists.

In the end, it’s really about education, and that’s why unbiased organizations like the ACA are so important to helping amputees become the leaders of their healthcare team, Bedotto says. “Patients are being blitzed with information, but they’re being blitzed by manufacturers who want to sell their products. Unfortunately, this type of education can’t come from manufacturers. It has to come from an unbiased source. It’s education and magazines like the ACA’s inMotion and First Step, physical therapy magazines, O&P magazines and physicians’ magazines that can help.”

**Making It Easy**

Benchmark Medical, Inc., is one company that’s making the team approach easier. By bringing together into a single company 200 outpatient physical therapy centers and O&P facilities in 14 states, the company has made it a seamless effort to ensure that patients get the benefits of the various rehab specialties.

“We are a musculoskeletal company,” says Jim Alaimo, CPO, vice president of clinical services for orthotics and prosthetics, “and the purpose of putting our company together was really to provide better care for the amputee through a combined approach to rehabilitation care. Our goal has been not only to evaluate patients’ prosthetic needs but also to evaluate their physical therapy, their occupational therapy and their other rehabilitation needs.”

The company feels that it is inappropriate to provide amputees with a prosthesis without making sure that they have the gait training and other therapy that go along with it, Alaimo says. “Our model is really based on serving the total rehabilitation needs of the patient.”

Unfortunately, this type of facility, amputee clinics, and other types of coordinated care are not available in many areas, so it’s often up to the fragmented members of the potential healthcare team – the physician, the prosthetist, the PT and OT, and the patient – to step outside of their territory and reach out to the others to develop an adhoc team for the patient’s best interest.

**Discovering What Healthcare Is Really About**

“Healthcare is about caring,” Bedotto says. “Most people go into this profession because they care and they want to make a difference.” The purpose should be service, caring and giving patients the best care possible, not just getting the patient out of the system as quickly and as cheaply as possible.

The key element in healthcare, he says, should be hope. “That’s what rehab used to be. And I think we’ve lost a lot of that.” Bringing some of that hope back is what the “team approach” is all about. It’s about making sure that all aspects of the patient’s problems are dealt with by the right professional at the right time. It’s about total rehabilitation.”