Body System: Musculoskeletal		
Session Topic: Assistive Mobility Devices		
Educational Format		**Faculty Expertise Required**
REQUIRED	Interactive Lecture	Expertise in the field of study. Experience teaching in the field of study is desired. Preferred experience with audience response systems (ARS). Utilizing polling questions and engaging the learners in Q&A during the final 15 minutes of the session are required.
OPTIONAL	Problem-Based Learning (PBL)	Expertise teaching highly interactive, small group learning environments. Case-based, with experience developing and teaching case scenarios for simulation labs preferred. Other workshop-oriented designs may be accommodated. A typical PBL room is set for 50-100 participants, with 7-8 each per round table. Please describe your interest and plan for teaching a PBL on your proposal form.

Professional Practice Gap	**Learning Objective(s) that will close the gap and meet the need**	**Outcome Being Measured**
• Knowledge gaps with regard to management for assistive mobility devices such as crutches, walkers, canes, and wheelchairs; as well as knowledge gaps with regard to physical therapy prescriptions. • Knowledge gaps with regard to performing disability and impairment evaluations. • Knowledge gaps with regard to with regard to completing appropriate Medicare documentation for obtaining durable medical equipment (DME); utilizing practice staff to help train patients to use prescribed mobility devices; using pre-visit questionnaires to make the office visit more efficient; counseling patients regarding	1. Establish processes to routinely evaluate of patients' proper fit and use of assistive mobility devices. 2. Determine appropriate assistive devices to improve balance, reduce pain, and increase mobility and confidence. 3. Coordinate referral to a physical therapist for patients who have gait or balance disorders, a new disability, or difficulty using their assistive device. 4. Prepare documentation to be in accordance with prescriptions for Medicare DME and appropriate reimbursement.	Learners will submit written commitment to change statements on the session evaluation, indicating how they plan to implement presented practice recommendations.

direct-to-consumer advertising for DME; appropriate coding/billing for proper reimbursement; and identifying the most appropriate DME for the specific needs of the patient. • Patients who may benefit from using mobility aids do not, or are not willing to use them. • There is a lack of national, empirically derived decision support tools to assist in making post-acute referral decisions regarding assistive devices or services		

ACGME Core Competencies Addressed (select all that apply)

X	Medical Knowledge		Patient Care
X	Interpersonal and Communication Skills		Practice-Based Learning and Improvement
	Professionalism		Systems-Based Practice

Faculty Instructional Goals

Faculty play a vital role in assisting the AAFP to achieve its mission by providing high-quality, innovative education for physicians, residents and medical students that will encompass the art, science, evidence and socio-economics of family medicine and to support the pursuit of lifelong learning. By achieving the instructional goals provided, faculty will facilitate the application of new knowledge and skills gained by learners to practice, so that they may optimize care provided to their patients.

- Provide up to 3 evidence-based recommended practice changes that can be immediately implemented, at the conclusion of the session; including SORT taxonomy & reference citations
- Facilitate learner engagement during the session
- Address related practice barriers to foster optimal patient management
- Provide recommended journal resources and tools, during the session, from the American Family Physician (AFP), Family Practice Management (FPM), and Familydoctor.org patient resources; those listed in the References section below are a good place to start
  - Visit http://www.aafp.org/journals for additional resources
  - Visit http://familydoctor.org for patient education and resources
- Provide recommendations for establishing processes to routinely evaluate of patients' proper fit and use of assistive mobility devices.
- Provide recommendations for determining appropriate assistive devices to improve

balance, reduce pain, and increase mobility and confidence.
- Provide strategies and resources for coordinating referral to a physical therapist for patients who have gait or balance disorders, a new disability, or difficulty using their assistive device.
- Provide recommendations and examples for preparing documentation to be in accordance with prescriptions for Medicare DME and appropriate reimbursement.

Needs Assessment

The U.S. Census Bureau estimates that about 10.7 million people aged 6 and older needed personal assistance with one or more activities of daily living (ADLs) or instrumental activities of daily living (IADLs). Among the population 15 and older, 2.7 million used a wheelchair and 9.1 million used an ambulatory aid such as a cane, crutches, or a walker.[1] Additionally, an estimated 6.1 million community-dwelling adults use mobility devices, including canes, walkers, and crutches, and two-thirds of those persons are older than 65 years.[2]

Data from a recent American Academy of Family Physicians (AAFP) CME Needs Assessment survey indicate that family physicians have statistically significant and meaningful gaps in the medical skill necessary to provide optimal patient management for assistive mobility devices such as crutches, walkers, canes, and wheelchairs; as well as knowledge gaps with regard to physical therapy prescriptions.[3] More specifically, CME outcomes data from 2012 AAFP Assembly: *Assistive Walking Devices* sessions indicate that physicians have practice gaps with regard to completing appropriate Medicare documentation for obtaining durable medical equipment (DME); utilizing practice staff to help train patients to use prescribed mobility devices; using pre-visit questionnaires to make the office visit more efficient; counseling patients regarding direct-to-consumer advertising for DME; appropriate coding/billing for proper reimbursement; and identifying the most appropriate DME for the specific needs of the patient.[4]

A review of the literature suggests that physicians need continuing medical education to help them overcome the following practice gaps:

- Patients often challenged to use assistive devices appropriately in challenging home environments.[5]
- Use of the Medicare durable medical equipment (DME) benefit is frequently under-utilized.[6,7]
- There is a lack of national, empirically derived decision support tools to assist in making post-acute referral decisions regarding assistive devices or services.[8]
- Patients who may benefit from using mobility aids do not, or are not willing to use them.[9]
- Direct-to-consumer marketing of durable medical equipment often prompt patients to request equipment during an office visit, even though the DME may not be medically necessary.[10]
- Physicians often find it difficult to determine in what manner the patient is disabled, and often underestimate or fail to recognize functional disabilities that are reported by their patients.[11]

Family physicians may receive unsolicited requests to prescribe durable medical equipment (DME) or supplies on behalf of their patients. These requests are often initiated from direct to consumer marketing to patients and may not be medically necessary. It is the policy of the

American Academy of Family Physicians that when a family physician receives such unsolicited requests for DME or supplies from vendors, the physician may disregard the request without need to respond to the vendor or notify the patient. However, the physician is encouraged to discuss and educate their patient at the next appropriate clinic visit regarding the appropriate indication of the DME or supply.[12]

Physicians may improve their management of patients in need of assistive mobility devices by engaging in continuing medical education that provides practical integration of current evidence-based guidelines and recommendations into their standards of care, including, but not limited to the following:[2,10,13]

- Assistive devices can be prescribed to improve balance, reduce pain, and increase mobility and confidence.
- Because most patients obtain their assistive device without recommendations or instructions from a medical professional, assistive devices should be evaluated routinely for proper fit and use.
- When only one upper extremity is needed for balance or weight bearing, a cane is preferred. If both upper extremities are needed, crutches or a walker is more appropriate.
- The correct height of a cane or walker is at the level of the patient's wrist crease, as measured with the patient standing upright with arms relaxed at his or her sides. When holding the device at this height, the patient's elbow is naturally flexed at a 15- to 30-degree angle.
- When performing an impairment evaluation: establish the diagnosis, determine the severity of the condition, assess impairment impact, and assess functional ability.
- When writing the physician's report, use clear language and remember that it is intended for nonmedical personnel.
- Power wheelchairs. A power wheelchair is covered by Medicare when all of the following criteria are met:
    - The patient's condition is such that without the use of a wheelchair the patient would be confined to a bed or chair,
    - A wheelchair is medically necessary, and the patient is unable to operate a wheelchair manually,
    - The patient is capable of safely operating the controls for the power wheelchair,
    - A POV would not meet the patient's need, or the patient could not safely operate it,
    - The patient needs a power wheelchair for at least six months.
- Power operated vehicles (motorized scooters). Medicare covers a power operated vehicle (POV) when all of the following criteria are met:
    - The patient has a mobility limitation that significantly impairs his or her ability to participate in one or more mobility-related activities of daily living (MRADLs) such as toileting, feeding, dressing, grooming, and bathing in customary locations in the home,
    - The patient's mobility limitation cannot be resolved sufficiently and safely by the use of an appropriately fitted cane or walker,
    - The patient does not have enough upper extremity function to propel an optimally-configured manual wheelchair in the home to perform MRADLs during a typical day,

- The patient has the mental and physical ability to transfer safely to and from the POV and maintain safety while using the vehicle,
- The patient's home can accommodate use of the vehicle.

Physicians can improve patient satisfaction with the referral process by using readily available strategies and tools such as, improving internal office communication, engaging patients in scheduling, facilitating the appointment, tracking referral results, analyzing data for improvement opportunities, and gathering patient feedback.[14,15]

These recommendations are provided only as assistance for physicians making clinical decisions regarding the care of their patients. As such, they cannot substitute for the individual judgment brought to each clinical situation by the patient's family physician. As with all clinical reference resources, they reflect the best understanding of the science of medicine at the time of publication, but they should be used with the clear understanding that continued research may result in new knowledge and recommendations. These recommendations are only one element in the complex process of improving the health of America. To be effective, the recommendations must be implemented. As such, physicians require continuing medical education to assist them with making decisions about specific clinical considerations.

Resources: Evidence-Based Practice Recommendations/Guidelines/Performance Measures

- Geriatric assistive devices[2]
- Direct-to-consumer marketing of durable medical equipment[10]
- Impairment and disability evaluation: the role of the family physician[13]
- Adding health education specialists to your practice[16]
- Envisioning new roles for medical assistants: strategies from patient-centered medical homes[17]
- The benefits of using care coordinators in primary care: a case study[18]
- Engaging Patients in Collaborative Care Plans[19]
- Health Coaching: Teaching Patients to Fish[20]
- Encouraging patients to change unhealthy behaviors with motivational interviewing[21]
- Integrating a behavioral health specialist into your practice[22]
- Simple tools to increase patient satisfaction with the referral process[14]

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