

GERINOTES

SECTION ON GERIATRICS, AMERICAN PHYSICAL THERAPY ASSOCIATION

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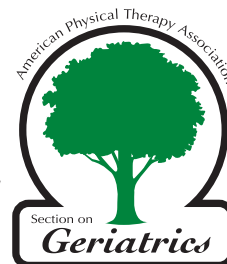
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PRESIDENT'S MESSAGE: RESILIENCE PART 2

William H. Staples, PT, DHS, DPT, GCS, CEEAA



In the last issue I started a discussion about resilience. Now I would like to speak about factors that are associated with resilience and

how to build resilience in our patients. Resilience is the result of a successful adaptation to some adversity. The capacity to make realistic plans and take steps to carry them out, positive view of yourself, and confidence in your strengths and abilities, are vital to this adaptation. Resilience also requires skills in communication and problem solving, with the ability to manage strong feelings and impulses. Resilience is not a trait that people either have or do not have. Resilience involves behaviors, thoughts, and actions that can be learned, nurtured, coached, and developed in anyone. These are factors that people can develop in themselves, or with assistance from others. Physical therapists can fit prominently into this equation. Many of you have probably done just that when working with your patients.

Think about your patients and how many of them could benefit from increased resilience. When you have resilience, you harness inner strength that helps you rebound from a setback or challenge, such as a job loss, an illness, a disaster, or the death of a loved one. For our patients it could be a fractured hip, a stroke, or a diagnosis of a chronic disease. Some of our patients do much better than others. If you lack resilience, you might dwell on problems, feel victimized, become overwhelmed or depressed, or turn to unhealthy coping mechanisms, such as substance abuse. Can we build resilience in our patients? Yes, we can! According the American Psychological Association there are 10 ways to build resilience¹:

1. **Make connections.** Good relationships with close family members, friends, or others are important. Accepting help and support from those who care about you and will listen to you strengthens resilience. Some people find that being active in civic groups, faith-based organizations, or other local groups provides social support and can help with reclaiming hope. Assisting others in their time of need also can benefit the helper.
2. **Avoid seeing crises as insurmountable problems.** You can't change the fact that highly stressful events happen, but you can change how you interpret and respond to these events. Try looking beyond the present to how future circumstances may be a little better. Note any subtle ways in which you might already feel somewhat better as you deal with difficult situations.
3. **Accept that change is a part of living.** Certain goals may no longer be attainable as a result of adverse situations. Accepting circumstances that cannot be changed can help you focus on circumstances that you can alter.
4. **Move toward your goals.** Develop some realistic goals. Do something regularly--even if it seems like a small accomplishment--that enables you to move toward your goals. Instead of focusing on tasks that seem unachievable, ask yourself, "What's one thing I know I can accomplish today that helps me move in the direction I want to go?"
5. **Take decisive actions.** Act on adverse situations as much as you can. Take decisive actions, rather than detaching completely from problems and stresses and wishing they would just go away.
6. **Look for opportunities for self-discovery.** People often learn some-

thing about themselves and may find that they have grown in some respect as a result of their struggle with loss. Many people who have experienced tragedies and hardship have reported better relationships, greater sense of strength even while feeling vulnerable, increased sense of self-worth, a more developed spirituality and heightened appreciation for life.


7. **Nurture a positive view of yourself.** Developing confidence in your ability to solve problems and trusting your instincts helps build resilience.
8. **Keep things in perspective.** Even when facing very painful events, try to consider the stressful situation in a broader context and keep a long-term perspective. Avoid blowing the event out of proportion.
9. **Maintain a hopeful outlook.** An optimistic outlook enables you to expect that good things will happen in your life. Try visualizing what you want, rather than worrying about what you fear.
10. **Take care of yourself.** Pay attention to your own needs and feelings. Engage in activities that you enjoy and find relaxing. Exercise regularly. Taking care of yourself helps to keep your mind and body primed to deal with situations that require resilience.

To summarize, these 10 suggestions can be utilized by physical therapists to assist patients to be more resilient. First, we should try to get or keep them connected with others. This can be accomplished by joining a support group. Have your patients do something that gives them a sense of accomplishment and purpose every day. Set their goals to help them look toward the future with meaning. Let them learn and grow from the experiences. You cannot change what has happened in the past, but you can always look toward the future. Accept-


ing and even anticipating change makes it easier to adapt and view new challenges with less anxiety. Encourage your patients to take care of themselves both physically and emotionally. Have them participate in activities and hobbies that they enjoy. Explain the importance of performing their home exercise program or including other physical activities in their daily routine. Encourage them to get plenty of sleep and eat a healthy diet. To restore an inner sense of peace or calm, instruct them in practicing stress management and relaxation techniques, such as yoga, meditation, guided imagery, deep breathing, or prayer. Although it can take time to recover from a major setback, traumatic event, or loss, teach your patients that their situation can improve if they actively work at it using these suggestions. Here is to providing optimal care and teaching resilience to our patients.

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1. American Psychological Association. <http://www.apa.org/helpcenter/road-resilience.aspx#>. Accessed April 18, 2013.



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EDITOR'S MESSAGE

Melanie Sponholz, MSPT, GCS, CCEP, CHC



Being an editor and being a runner are both great ways of meeting new people. I actually had that thought while running today.

Long Run Sunday often provides the best time to sort out the events of the week and plan for the days ahead, and for a few minutes I found myself thinking about my upcoming transition out of my role as the Editor of *GeriNotes*. I have had the honor of holding the position for almost 3 years, and the most enjoyable part of the job has been meeting the many folks who have contributed to the magazine.

I did my first editing as a summer intern at Random House in 1992. It was a pivotal time in my life, as I forayed into what would be my first career, in publishing, and settled into my first apartment in New York City. My world was alive with new experiences and excitement. I have always loved books, and having a chance to learn from editors at one of the world's major publishing houses was amazing, as was bringing my suburban self to live in one of the world's most dynamic cities. It was the same summer that I fell in love with running, on the streets and trails in Central Park. As much as I loved the workout, I craved the unparalleled people watching and social interactions found in the park. Within a year, I had volunteered to captain the Random House team for the Corporate Challenge 5K series in the park; and for the first of many times in life, running lead to meeting great new friends. There may be those out there who have had other experiences, but for my part, I have never met a real jerk who loves to run. Runners seem to uniformly share a down-to-earth nature and easy comradery. The years at Random House were filled with new friends met through

books and runs, and both groups were filled with diverse and interesting people from all over the map, both literally and figuratively.

Somehow more than 20 years have passed since that summer (although magically I am still only 35)! My time line has had some curves, including graduate school to become a Physical Therapist; moves from NYC to Rhode Island, to Michigan, to Georgia, to Pennsylvania, and New Jersey; and a transition from practicing therapist, to Quality Assurance Director, to Compliance Officer! Most recently my work in the field of compliance has taken me out of rehabilitation and into another area of post-acute care, home infusion, as I serve as the Chief Compliance Officer for Home Solutions. There has been a great deal of change, but some consistent themes. I have edited and logged running miles at every stop along the way; and through those pursuits, I have met wonderful people who I might otherwise never have encountered. And I have learned from all of them, whether through trail run conversations, interviews for articles, or reading the words of the many experts on various topics I have had a chance to review. I certainly consider myself blessed to have encountered everyone I have worked with through *GeriNotes*, and I know I will be lifelong friends with many of them. I wish you all happy trails, and am pleased to introduce the new Editor, Meri Goehring. We will be working together on the focus issue in November, before she takes the reins for the January issue.



Meri Goehring,
PT, PhD, GCS

Meri Goehring was born and raised in Colorado and moved to Kansas while in college. She graduated

from Wichita State University with a Bachelor of Science in Physical Therapy in 1979. While remaining in clinical practice, she continued her education at Wichita State receiving a Master of Health Science degree in 1990 and her PhD from Nova Southeastern University in Ft. Lauderdale, Florida in 2006. She became certified by the American Board of Physical Therapy Specialists as a Geriatric Clinical Specialist in April of 2000 and was re-certified in 2009. She remains clinically active in acute care and adult rehabilitation. Meri began teaching at Wichita State University in 1997 and then taught at Northern Illinois University in DeKalb, Illinois until 2009. She was the Illinois State Advocate for the APTA's Geriatric Section and District Chair for the North Central Illinois PT Association. She served 6 years on the Examination Development Committee for the Federation of State Boards of Physical Therapy (FSBPT) and received the Presidents Award for her service to the FSBPT in 2011. She currently serves as the Vice President of the Western District of the Michigan Physical Therapy Association. She was recently appointed by the Geriatric Section to assist in development of Clinical Practice Guidelines (CPGs) and attended the recent APTA seminar on CPG development. She is studying to become certified as a Wound Care Specialist. Meri's research interests are in geriatrics, acute care, and integument. She is married to a classically trained chef and enjoys travel, food, and wine. She has two college age sons.

CASE REPORT: EFFECTS OF AQUATIC THERAPY ON BALANCE IN EARLY STROKE RECOVERY

Dorin J. Pinkham, PTA, ATRIC, BS Exercise Science
Karen A. Gage, PT, DPT, CEAS, RSPF-NDT

INTRODUCTION

Stroke is the leading cause of long-term disability in adults.¹ This statistic alone should be enough for practitioners of physical therapy to strive to find and employ the best treatment techniques at our disposal to provide evidence-based care to stroke survivors during their rehabilitation.

Every 45 seconds in the US someone has a stroke; that results in a number greater than 700,000 people annually.^{1,2} Of those experiencing stroke only 10% will recover completely, 25% will recover with only minor impairments, and 50% will recover with moderate to severe impairments.³ The recovery process after stroke is long and may take several years. The most recovery occurs in the first 6 months, up to the first 2 to 3 years, and is the most crucial.¹ While some survivors will experience full recovery, at one year post stroke two-thirds of all survivors will have some level of disability.

People older than 85 years of age make up 17% of the 795,000 total stroke survivors; and they are more likely to require longer hospitalization, and are less likely to be discharged back to their prior living setting.⁴ In addition, these people receive less evidence-based care.

The economic cost of stroke is staggering. The cost in the US alone is estimated to be \$43 billion per year, which includes the indirect and direct costs. The direct cost of stroke with regards to medical care and therapy is \$28 billion. As therapists, it is of utmost importance to be using evidence-based, high quality treatment early in stroke recovery to maximize function, decrease burden of care, and increase quality of life in survivors.³

BACKGROUND

Physical therapists and physical therapist assistants use many different treatment techniques and modalities in the rehabilitation of stroke; many

are evidence-based and well researched. One modality less researched and with little evidence-based support in stroke recovery is aquatic therapy, especially when employed early in stroke recovery. Of the few research articles addressing aquatic therapy in stroke rehab, most address aquatic therapy with regards to chronic stroke in community level survivors.⁵ The limited research that has been conducted is promising showing statistical changes in balance in stroke survivors,⁶ but what is the role of aquatic therapy in early stroke recovery as part of a comprehensive physical therapy plan of care? There is no literature or research that addressed this. Using a case study, we hope to show the need for strong studies and research to be conducted that address the role and benefits of aquatics in early stroke recovery to improve functional outcomes using proven tests for evidence of recovery.

"As therapists, it is of utmost importance to be using evidence-based, high quality treatment early in stroke recovery to maximize function, decrease burden of care, and increase quality of life in survivors."

Comprehensive physical therapy plans of care seek to address impairments and improve function. Common impairments experienced after stroke are: hemiparesis, ataxia, difficulty with left-right orientation, pain, and joint contracture.¹ These impairments can lead to decreased ability to perform functional mobility tasks and increased

fall risk. Through physical therapy intervention, the goal is to reduce fall risk, decrease the burden of care, increase access to the environment, decrease pain, and increase quality of life. Reaching these goals will in turn allow for the safest discharge at the highest level of independence.

The aquatic environment affords several benefits and unique qualities that are beneficial in the role of rehabilitation. Several of these qualities are as follows: buoyancy, hydrostatic pressure, viscosity, temperature, and flow patterns or currents.⁸

Buoyancy is defined by Sova as "a force acting in the opposite direction of gravity, felt as an upward thrust."⁶ This "weightlessness" decreases joint compression forces, increases pain free mobility, and challenges postural alignment. In addition buoyancy can help reduce the fear of falling.⁶

Hydrostatic pressure is defined as the "force exerted on immersed body by fluid molecules," with "fairly equal pressure everywhere,"⁷ and it is dependent on two factors: the density of the fluid and the depth of submersion. Hydrostatic pressure is also responsible for stimulating sensory input.⁷ The benefits of this quality of water can result in decreased pain and edema, increased venous return, the evening of tactile input, and the slowing of muscle atrophy.⁷

Viscosity is the drag force of the water, and is what provides resistance and impacts flow patterns and currents. The benefits of application of Bernoulli's Law result in improved muscle tone, decreased edema, and improved postural awareness, and provide an increased reaction time.⁷

Temperature variations in the pool can produce different effects. Some of these are: decrease in joint stiffness, pain relief, decrease in muscle spasm, increase in blood flow, and a sedative effect.⁸

As with most modalities there are some contraindications and precautions that must be considered. The following are contraindications according to Sova: open wounds, skin infections, throat infections, influenza, gastrointestinal infections, urinary tract infection, water-borne infections, and vomiting. Other precautions to consider are: HIV, ostomy, IV site, central line catheter, bowel incontinence, epilepsy, unstable blood pressure, decreased vital capacity, low endurance, fear, severe impulsivity, use of psychotropic drugs, swallowing deficits, vestibular deficits, radiation, kidney disease with tolerance to fluid loss, disease affecting gross thermal regulation, perforated eardrum, non-tunnel catheters, absent cough reflex, cognitive status, and medical history positive for multiple sclerosis.⁷

Effectiveness of treatment in stroke recovery can be measured by functional gains, but using standard testing provides a reliable, valid way to measure progress. Because the impairments common in stroke have such a great impact on balance using tests that measure balance and can assess fall risk are logical. Several such tests are: the Berg Balance Scale, the Timed Up and Go (TUG), and the 10 Meter Walk Test (10MWT).

CASE STUDY

The participant is a 70-year-old male who experienced an intracerebral hemorrhage in the left thalamus region, with resultant right-sided hemiparesis and hemisensory loss. Prior to his CVA he was living in a one-story home with his spouse; he was employed and independent with all community level mobility tasks. He spent 27 days in an acute care setting before admission to a skilled nursing facility. His past medical history includes: posterior circulation stroke secondary to basilar artery occlusion, uncontrolled hypertension, autonomic dysfunction, left vertebral artery obstruction, coronary artery disease, acute systolic congestive heart failure secondary to stress-induced cardiomyopathy, ejection fraction of 40%, chronic obstructive pulmonary disease with a history of nicotine and alcohol abuse, and hyperlipidemia. Upon initial skilled nursing facility physical therapy evaluation, his primary goal was to return home as independently as possible.

ASSESSMENT

The BERG Balance Assessment, TUG, and 10MWT were used to assess and track the participant's progress in therapy with regard to fall risk and independence with mobility. These tests were performed in a pretest, posttest fashion for both his inpatient skilled stay and his outpatient physical therapy.

The Berg Balance Scale measures static and dynamic balance with a focus on maintaining position and postural adjustments to voluntary movement. It is a 56-point scale with 14 tasks. The reliability of this tool is found to be good, with interrater reliability at $r = 0.98$, intrarater at $r = 0.99$, and internal consistency at 0.96. Sensitivity is 64% to 82.5%, and the specificity is 90% to 94%.⁹ The BERG was performed using the standard cues for each portion of the test.

The TUG measures dynamic balance and mobility via timing the performance of a sequence of standing, walking a set distance, and returning to a sitting position. It has been found to be reliable and valid; interrater $r = 0.99$ and intrarater $r = 0.99$, sensitivity at 87% and specificity at 87%.¹⁰ When performing the TUG, a cone was placed 3 meters from the seated participant and the following instructions were given: "When I say go, I want you to stand up and walk to the cone, turn around, and then walk back to the chair and sit down again. Walk at your normal pace." The participant was timed from "go" to completion of sitting.

The 10MWT measures gait speed and velocity, which correlate with function,⁹ by measuring the time it takes for an individual to walk 10 meters. This tool has also been found to be reliable and valid, $r = .749$.¹¹⁻¹³ When performing the 10MWT, a 20-meter measured distance was used, and the participant was given cues to "stand up and walk" towards the end point. Timing started at the 5 meter mark and ended at the 15 meter mark. Three trials were performed, and the scores averaged to obtain a score. Gait velocity was calculated from this data.

During his inpatient stay the 10MWT was administered a total of 3 times, the BERG was administered twice, and the TUG twice.

During outpatient therapy service, the 10MWT was administered 4 times,

the BERG 3 times, and the TUG 3 times.

INTERVENTIONS

The participant received inpatient physical therapy services for a total of 99 days, averaging 6 treatments session per week. After his discharge to home, he returned for outpatient physical therapy for an additional 24 sessions.

Physical therapy consisted of traditional interventions to address the common impairments that result from stroke, as well as aquatic therapy. He received a total of 24 aquatic therapy sessions while an inpatient, with an average session time of 43 minutes. He received 11 aquatic therapy sessions during his outpatient services, with an average session time of 35 minutes. All sessions were conducted one-on-one with a certified aquatic therapist.

A typical session in the pool consisted of dynamic drills that facilitated activation and sustained muscle activity of the right trunk and right hip musculature and also addressed balance impairments to facilitate righting reactions. Prior to each session in the pool, blood pressure and heart rates were obtained and recorded. Verbal cues and manual cues were provided as needed during activities to ensure desired muscle activity, and typical sessions were performed in chest deep water. Examples of activities performed are: ambulation on an underwater treadmill against jet resistance with bilateral upper extremity support, unilateral upper extremity support, and no upper extremity support; side-stepping; backwards ambulation; 180° turns and 360° turns in bilateral directions; and bilateral lower extremity therapeutic exercise in standing to encourage motor planning and control, single leg stance, righting reactions and increased cardiac endurance (left ventricular hypertrophy). Sessions were adjusted to progress participant and increase challenge of activities.

OUTCOMES

The participant improved his scores in all 3 measures over a course of 35 aquatic therapy sessions spanning 162 days. In addition, initial inpatient testing was performed with a hemi-walker, and the final inpatient testing was performed with a small base quad cane. Initial outpatient testing was performed using a small base quad cane, and final

outpatient testing was performed without an assistive device.

The 10MWT was measured 7 times, with a beginning score of 22.71 seconds and an ending score of 14.82 seconds. Based on these times gait velocity was obtained and improved from .44 m/s to

.67 m/s. These improvements represent a change in category from household ambulatory to limited community level ambulatory.¹³ See Figure 1.

The BERG was performed a total of 5 times, with a beginning score of 10/56 and an ending score of 50/56. This end-

ing score correlates with a “moderate” fall risk and “good” balance,⁹ which is a change from initial category of “wheelchair bound” and “high” fall risk. See Figure 2.

The TUG was performed 5 times, with an initial score of 47.7 seconds and a final score of 15.78 seconds. This final score represents “mostly independent with mobility” and “good” balance,¹⁰ which represents a change in category from “requires assist with mobility” and “dependent in mobility skills.” See Figure 3.

DISCUSSION

There are multiple approaches and modalities available to physical therapists and physical therapist assistants in order to provide the most effective rehabilitation after stroke. Aquatic therapy is one such modality that affords a plethora of benefits that positively impact impairments typically experienced after stroke. However, this approach is often overlooked until the stroke is considered a chronic condition. Like other modalities, aquatic therapy is not appropriate for every patient who has experienced stroke as part of the early intervention plan of care, but it should be considered more often.

Addressing impairments as a result of stroke in the aquatic environment offers benefits that cannot be achieved on land. The ability to activate and sustain muscle activity in an environment with decreased effects of gravity is improved. The warmer water temperature helps promote relaxation. The opportunity to decrease pain is increased when in the water. Challenging balance and encouraging righting reactions is facilitated, because the risk of falling is greatly reduced, and the muscles responsible for initiating righting reactions are more easily activated. The qualities of the water environment can stimulate sensory input and proprioception that can positively impact function in survivors of stroke. It stands to reason that the sooner the impairments of stroke are addressed effectively, the quicker the return to the highest level of independence with mobility skills can be obtained.

Aquatic therapy is not risk free, and as with any intervention or modality should be used as indicated and individualized for each patient. When placing a patient in the pool early on in the rehab

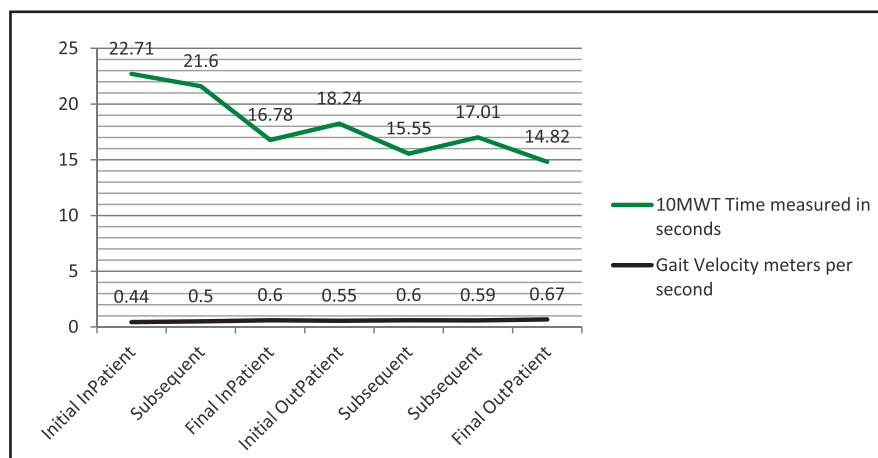


Figure 1. 10 Meter Walk Test & gait velocity.

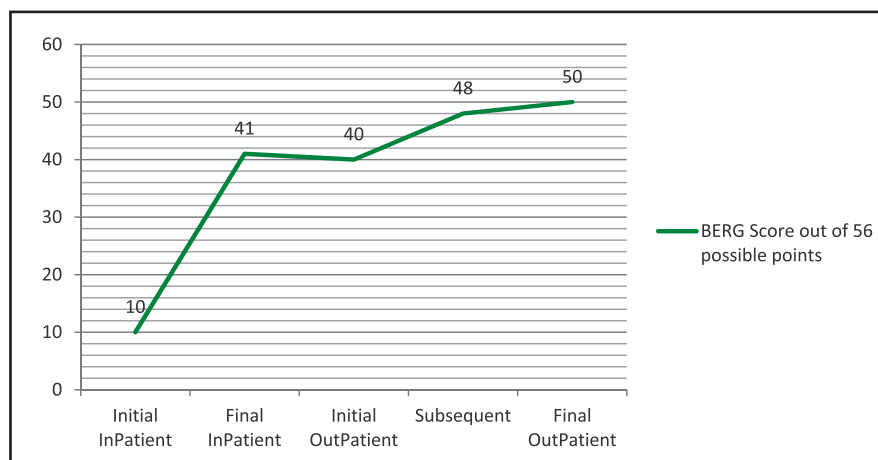


Figure 2. BERG scores.

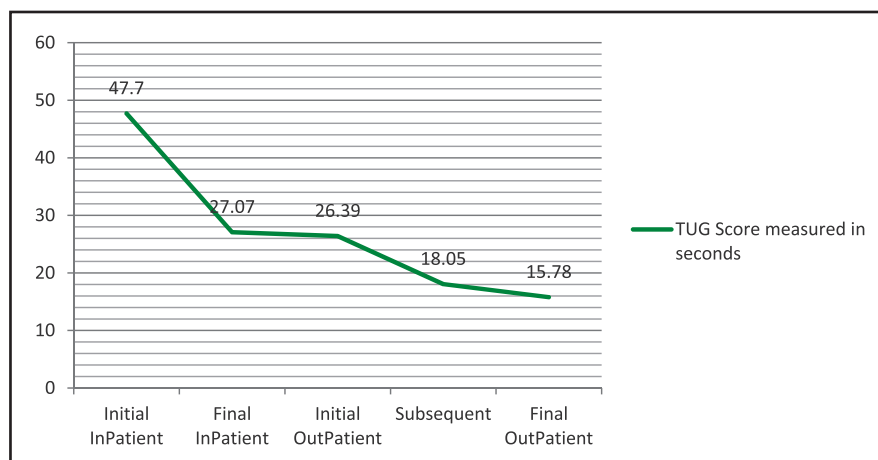


Figure 3. TUG scores.

process, they should be closely monitored; but considering the benefits of being in the aquatic environment, it seems reasonable to employ this treatment as early in stroke recovery as safely as possible rather than waiting until the disease is considered a chronic condition.

The use of aquatic therapy is not without barriers. Unfortunately not every therapist has a pool at their disposal, and public pools are not always a viable option to achieve a therapeutic aquatic environment. Also the medical stability and co-morbidities of individuals may preclude them from use of the pool in early rehabilitation. And there will be some patients who choose not to get in the water based on fear of falling or fear of the water. In a medical community driven by evidence-based practice, there are not enough strong studies that support the use of aquatic therapy in early stroke recovery, and this too may be a barrier to support for use of aquatic therapy early on in stroke recovery.

CONCLUSION

The positive and significant outcomes of this case study support the need for comprehensive research and studies to provide evidence-based research on the role of aquatic therapy in early stroke recovery.

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Dorin Pinkham graduated from the University of Maine in 2007 with a BS in exercise science and graduated from Kennebec Valley Community College in 2010 with his PTA degree. He became ATRIC certified (aquatics certified) in 2012.

Karen A Gage graduated from the University of New England in 1998 and returned to complete her DPT in 2011. She also received certification in the Runyan Problem Solving Framework with NDT focus in 2011. Both Dorin and Karen are currently employed at the Maine Veterans' Home in Bangor.



WHO MOVED MY PIZZA?: A BASIC UNDERSTANDING OF LEADING

Matthew Mesibov, PT, GCS

When asked to write an article about leadership for *GeriNotes*, I took a step back and thought about what I would want to read if I were the reader. As all engaging speakers and writers do, in my opinion, I thought I would write from experience. The hope is that it might serve as a path or example to someone reading this article who has yet to step up and lead, yet knows they would like to lead on some level. For those of us that are already leading, it is always good to reflect back on some of the more basic concepts as a way to ground oneself.

Why call this “Who Moved My Pizza?” Well, first, if you have never read the very quick read, *Who Moved My Cheese*, by Spencer Johnson, you ought to! Coming out of a divorce some years ago, this book was a light bulb moment for me. It teaches one of the most critical lessons, to look objectively at what is not working for you, and change it. This is a great principle of leadership as well. It taught me to be honest with myself, learn from my errors, and adapt. The sole purpose was and is to correct you from the frustration of repeating the same mistake over and adapting a new and winning strategy. So why pizza? Well, as a recent arrival to the beautiful state of Minnesota from New Jersey, I soon learned they do not seem to make pizza the way I am used to. Believe me that if you are from the Northeast or Midatlantic, having to have pizza as if it is flatbread is somewhat disappointing to say the least! Enough said, let’s get on track with leadership.

What is leadership? According to the Webster online dictionary, one definition includes: “*The quality of character and personality giving a person the ability to gain the confidence of and lead others.*” I like this definition as it provides a lot of room to define a person’s character and personality and, therefore, what type of leader you can be.

Let’s look at personality qualities by way of a do-it-yourself exercise. First

think of two different people you have come across in positions of leadership. The first type of person is someone who you found was able to influence others, and the second is someone who had trouble influencing others. Under each type of leader, list 5 adjectives to describe that person. Now put your lists to the side, as we delve into other aspects of leadership, and we will return to this exercise later.

Leaders, both good and bad, have two attributes...influence and power. Failure of leadership happens when the leader is unable to influence others to “own the vision” or influence comes in various forms¹:

- the act or power of producing an effect without apparent exertion of force or direct exercise of command,
- the power or capacity of causing an effect in indirect or intangible ways,
- the power to change or affect someone or something, or
- the power to cause changes without directly forcing them to happen.

Power includes the following¹:

- the ability to influence others to perform, behave, or accomplish tasks; or
- a person or organization that has a lot of influence over other people or organizations.

In a nutshell, I believe successful leadership is not derived from job specific influence (ie, it is not dependent on a job title), rather it is situation specific (ie, when an event occurs, how you handle the situation and what kind of example are you to others).

A natural question is, “how do I attain the power to influence?” My quickest answer is first, you must know yourself. Are you comfortable in your own skin? Know where your power comes from. Of course if I ended with that, it would be only part of an answer and a very short article. Next

we need to understand what forms of power exist and how they impact the people that would follow you. Choosing your sources of power will define your ultimate success. As you read through the following power sources, write down which two types of power produce the most effective leader with long-term, committed followers^{1,2}:

1. Legitimate Power (Position dependant)

- Leader’s position in an organization
- Leader’s level of authority that is inherent in that position
- Being the supervisor, manager, or boss

2. Reward Power

- Leader’s ability to give the staff something of value
Tangibles: salary, benefits, promotion
Intangibles: recognition, respect, special privileges

3. Coercive Power (Punishment)

- Leader’s ability to take something of value away
Tangibles: no raise, loss of job
Intangibles: reprimand, loss of respect, embarrassment, loss of status

4. Expert Power

- Leader’s knowledge, skill, and expertise so that others have confidence in the leader’s ability
- The amount of power is related to the level of expertise

5. Personal Power

- Leader’s personal *charisma* and personal characteristics
- Relates to the *likeability* of the leader
- Relates to the leader’s *emotional intelligence*

When looking at these 5 types of power, we find that the least effective sources of power are Legitimate and Coercive. People are most willing to follow, and commit to following on a

long-term basis, when a leader derives power from the Expert and the Personal power realms. The other realms generally will not create strong, long-term leadership.

Stephen Covey³ surveyed 54,000 people about characteristics of an effective leader and found the top answers to be:

1. Integrity (Personal Power)
2. Communication (Personal Power)
3. People Orientation (Personal Power)
4. Vision (Expert Power)
5. Caring (Personal Power)

Now look back at your adjectives list of two types of leaders. You should be able to start connecting the dots as to why you see one person as a more effective leader than the other.

The grooming and development of a strong leader is a life-long endeavor. One must be willing to be proactive, have the strength to stick with achieving the vision while being cognizant of where one derives power from. In my travels, I once asked a successful restaurant franchisee, who earlier on in his career was on the brink of bankruptcy, what lead to his success. He answered, "No matter what, I never took my eye off the goal." In other words, you can't let yourself become a victim of the road bumps that happen now. Rather, keep working towards the destination that you set for yourself.

Another exercise in self-awareness that has helped me is coming to understand my communication style, and effectively assessing the style of others. The tool that I have used most frequently is the DISC profile (http://en.wikipedia.org/wiki/DISC_assessment). I am aware of one leader who has a DISC profile for all of his direct reports. When having face-to-face meetings, he will quickly refer to the profile to make sure his communication style adapts to his employee's style. He finds this ensures the employee is engaged in the conversation and fully receives the communication.

Now that we have discussed some of the building blocks of being an effective leader, it is time to set your wheels in motion. Knowledge is power, but it means nothing if you do not apply and experience it. How will you step up to leadership roles?

- Will it be clinically, on a day-to-day basis, as you choose to provide evidence-based services and practice with integrity?
- Will you seek out a form of leadership training within the APTA structure?
 - + HPA: The catalyst section has leadership trainings through the **Institute for Leadership in Physical Therapy Leadership** (<http://www.aptahpa.org/>)
- Will you step up and volunteer within the APTA framework?
 - + Volunteer for the APTA Section on Geriatrics (<http://www.geriaticsppt.org/volunteering/index.cfm>)
 - + Volunteer for your APTA chapter
 - + Sign up on the APTA "Volunteer Interest Profile" (<http://www.apta.org/VolunteerGroups/>)

In closing, I would like to share some of myself and my leadership journey. I had to first look within myself during a darker period of my life in order to get comfortable in my skin. It was not an overnight process, and is one that is ongoing. I then chose to step up at an APTA chapter meeting and say, "here are my skill sets and interests; is there a place for me to volunteer and help?" I met people who were willing to give me a chance and mentor me along the way. I mentored others and learned from my mentees as much and more than I gave. Having said that, I offer myself up as someone you can reach out to if you ever want to have a conversation about yourself and leadership. My contact information is available at the APTA member listings page and with this article.

In the meantime, I have not found the pizza of the southern NJ area but that is OK, I enjoyed Walleye fish for the first time.

Wishing you a successful leadership journey!

Matthew Mesibov, PT, GCS

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Save the Date

The
GeriNotes

Editorial Board Meeting

will be held on

Tuesday,

February 4, 2014

during the

Combined Sections Meeting

in Las Vegas, NV

from 12:30 – 1:30 pm.

*Location will be announced
at a later date.*

PHYSICAL THERAPIST ASSISTANTS: TIME FOR INNOVATION

Sherry Teague, MESS, ATC, PTA

What is the landscape for physical therapist assistants (PTAs) in geriatric care? Have PTAs evolved to the place that will make them irreplaceable in the care of the elderly? What needs to happen to ensure PTAs a strong foot hold in an ever changing care paradigm?

As a home health agency owner, I have witnessed first-hand the changes that have occurred in reimbursement throughout the different settings in therapy. I have been present for the change from fee for service to "RUGS" and "home health PPS."

One thing has not changed...patient care, particularly, our relationship and partnership with Physical Therapists in the care of our patients. While we have been measured and timed and counted and tracked and moved from employed positions to per visit to contract and back again, repeatedly, when push comes to shove our primary focus as "patient driven" clinicians has not changed. The PTAs perform the majority of treatment visits in the home health setting.

One of the changes in paradigm considerations I would like to happen is the concept of whether the time has come for the PTA professional to evolve and catch up with other aspects of patient care delivery that surrounds us.

While physicians assistants and ARNPs have taken on a more substantial role in primary care of patients, including the ability to prescribe medication and refer to ancillary care, PTAs in most states are still unable to receive and act on a medical doctor's verbal order without the involvement of the PT. Lastly, but certainly not inclusive of all examples, physicians assistants, ARNPs, and PTs are able to see a patient for a period of time without the input of an MD or DO. The PTAs in comparison are being supervised onsite every 6 visits in some states and being tracked by CMS as a potentially less expensive visit type than PTs.

Take this scenario into consideration:

A PTA with 10 years home health experience has been treating a patient under the supervision of a PT in the home health setting in FL for 10 visits. During visit 11, the patient's doctor calls the patient and tells them to begin TENS to help with their intractable pain. The PTA is not able to begin training the patient for TENS, because they are unable to reach their supervisor and TENS is not on the care plan of treatment in the PT evaluation. The treatment for this patient's 8 of 10 pain has to wait until the PTA reaches her supervisor, or PT does an additional visit.

Does this scenario and the subsequent wait by the patient for needed treatment demonstrate efficacious and appropriate care? Was the patient's need the number one consideration, or was care hindered by regulations? Are these regulations appropriate?

Physical therapist assistants first began practice in 1969. The time has certainly come to enhance the abilities of the PTA through the creation of a mid-level "bachelors" level PT profession. A "Physical Therapist Assistant Practitioner" or an "Advanced Registry Physical Therapy Assistant" level that could improve the chances of patient's needs being met in real time and decrease the likelihood or risk of the traditional PTA being relegated to the level of an educated therapy tech. While PTs have moved from a bachelor's degree to the title of Doctor, PTAs continue with extremely limited access to bridging our education and experience into a PT degree or a mid-level therapy degree. At the time of this writing, there are only two schools that serve to bridge the gap from a PTA to PT.

The following statement on the APTA Web site under "History of the PTA" reflects the thinking that dominates today:

As for PTA education, although the entry-level degree for the PT is moving toward the DPT, the educational program for the PTA has remained a 2-year associate's degree. "Some people think as one degree program progresses, the other needs to progress in proportion. That's not really the case," says Emerick.

The need for degree augmentation should be grounded in a concomitant change in the role and scope of work of the PTA in physical therapy. At this time, evidence does not support an expansion or change in the scope of work of the PTA.

In home health, PTAs have to practice with a high level of autonomy. They are alone in the house with no fellow professionals nearby. Is the current level of PTA education sufficient for this setting?

When did PTAs miss the train? Why have PTAs not evolved and taken more of a role?

I believe it is directly related to PTA's role and participation in our professional organization. Some time ago, PTAs lost a seat at the table in the APTA. Physical therapist assistants lost the ability to vote and be a part of the decision making in their primary professional organization. What did PTAs do in response to this issue? Did they protest? Did they strike? Do they make sure that they are included and have a voice that cannot be ignored? I believe, initially, there was some activity in disagreeing with the stance of the APTA with regards to voting and participation. Some of these activities have led to two nonvoting delegate positions for PTAs. There are also PTA delegates that represent each state in the PTA caucus.

I know that there are many of us who remain active in the APTA and various sections. This participation in no way reflects our numbers working in the field. In fact, at the 2013 Combined Sections Meeting in San Diego, CA where over 5,600 therapists attended,

PTAs compromised 741 total. The current total number of therapists in the Home Health Section of the APTA is 2364, 127 are PTAs.

Take a minute and reflect on that level of participation. This participation is far from an appropriate representation of the number of PTAs working in home health today. Does that appear to be a group that is poised to fill a gap in treating clinicians left by having the DPTs among us?

APTA "History of the PTA" also includes the statement:

"Not everybody can be the chef in the kitchen; you need other people to help prepare the meal," says Emerick. "We're part of a team. [We help] the PT." This statement still holds true; however, it looks like the meal preparers are not even showing up to learn and advance their skill and knowledge at the largest assembly that the APTA holds. Are PTAs poised to become the mid-level provider for Physical Therapy, the way PAs and ARNPs have functioned for medicine?

I, for one, do not think we are. Physical therapist assistants need to show up, and become the voice for their profession. We need uniformity in practice. We can facilitate that with participation. With participation will come inclusion and respect.

I mentioned earlier that I am a home health agency owner, what I failed to mention is that I am also a PTA. We need to make a commitment to education, beyond required continuing education and licensure requirements. How many PTAs have returned to college and received their Bachelor's degree? I would say that is a great place to start.

I think many PTAs are natural leaders. In fact, I know many that are at the director level in their facility. My partner in the home health agency is a PT. She leads the clinical direction of our agency, while I lead the financial. We broke up responsibilities this way not only because of acumen but also practicality. Physical therapists are 'gate-keepers' in home health; therefore, taking her out of patient care related activities is not productive.

In my travels, I have yet to come across a PTA that is the administrator of a Skilled Nursing Facility or Home Health Agency. I am sure there are some out there, but I have not met them. I have met many nurses with the same

level of college (Associated Degree) as PTAs in both of those roles. What role do you play in your facility? Are you stuck on the visit, visit, and visit train? Do you want to get off and explore other areas or aspects of care provision? If yes, what have you done to improve your skills to be considered for a role that does not require a full docket of visits? What can you do? What should you do?

To start asserting a pattern for leadership, become an active member of your professional organization. Join the section of that organization that pertains to your area of practice or practice setting. Plan to be a presenter at the national conferences to highlight the roles and challenges of PTAs in practice.

Volunteer to help with any projects that may be occurring. Also, consider getting involved in the agency and facility level in the role of committee member. Directors of Nursing and Administrators would welcome willing assistance of experienced clinicians to help with regulatory and documentation audits and quality improvement. This will also serve to let your superiors know that you are interested in being considered for management and leadership opportunities.

We have to move toward a higher level of independence. In the home health setting, for example, many agencies are moving toward PT only staff. This is in response to the regulations requiring the reassessment of the patient at visit 13 and 19. I think the patient deserves reassessment every time a therapist enters their home. They should have the opportunity to have their care altered as needed. With the clamor about high visits and cost of care, we need to be innovators and ensure that every visit counts.

The DPTs are trained to innovate. They are poised to change the way therapy is reimbursed and how we are valued in the medical home model that will take the practice of PT into the future. Having a mid-level practitioner to take care of day to day visit and evaluation responsibilities will ensure the DPT's education and abilities will be put to optimal use.

Becoming a PTA can be the first step toward a diverse career in health care. The ever-changing landscape of health care is in need of individuals who embrace life-long learning and aspire to

lead the future of health care. If we, as frontline practitioners evolve into decision making roles, it will ensure that patients continue to receive high quality, individualized care. If we take the reins, the patient's needs are ensured to continue to guide decision making.

Join me as a member of the Home Health and Geriatric Sections of the APTA. Join me at the Combined Sections meeting in Las Vegas next February. Let's change our future!!



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Power Players BNI (Business Networkers International) chapter in Ocala, FL. She received her athletic training degree from Valdosta State University (GA) in 1989, and her Masters in Exercise and Sport Science degree from the University of Florida in 1991. She completed her A.S. degree at St. Pete Jr. College in St. Petersburg, FL, to become a physical therapist assistant in 1998.

POLICY TALK: MedPAC Speaks – Physical Therapy Must Listen

Ellen R. Strunk, PT, MS, GCS, CEEAA

In case you haven't seen, heard, or read about the June 2013 MedPAC report to Congress, it was full of important policy recommendations. MedPAC stands for the Medicare Payment Advisory Committee. They are a Committee that is mandated by Congress to report regularly on the Medicare payment system and the issues affecting the Medicare program, including changes in health care delivery and the market for health care services. In its June 2013 report, they discussed issues such as how to incorporate private plan bidding and fee-for-service in one system, as well as more sector-specific issues.

Of particular interest to physical therapy are the chapters on bundling postacute care (PAC) services and Medicare's payment for outpatient therapy services. This column will provide an overview of the recommendations made by MedPAC. You can find the full report on MedPAC's web site at: http://medpac.gov/documents/Jun13_EntireReport.pdf

APPROACHES TO BUNDLING PAYMENT FOR POST-ACUTE CARE

Physical therapists are acutely aware of how differently Medicare pays each of the 4 PAC settings [skilled nursing facilities (SNF), home health agencies (HHA), inpatient rehabilitation hospitals (IRF), and long-term care hospitals (LTCH)]. After all, we provide services in all these settings and therefore have an obligation to understand the qualifying criteria for each. We are consistently challenged with the different conditions of participation and coverage rules that do not clearly delineate the types of patients who are appropriate for each of these settings.

In recent years, MedPAC has become more and more concerned with the utilization rates for PAC services, and how there are significant geographical

differences in PAC use. Furthermore, these differences in use cannot be explained by differences in beneficiaries' health status.¹ Some of this variance may be more of a result of beneficiary access, eg, some areas of the country do not have any IRFs or LTCHs, so these people may receive care in SNFs or from home health agencies. In fact, recent statistics showed that 99% of all Medicare beneficiaries live in an area served by at least one home health agency, and 98% of all beneficiaries live in an area served by two HHAs.² The result is there is more variation in program spending per beneficiary in PAC than in any other provider setting. Per person, per month use of PAC services differed more than two-fold when comparisons were made between low-use areas and high-use areas.³

MedPAC believes that shifting the payment methodology to a bundled system would incentivize providers to improve care coordination, as well as require providers to accept some of the financial and clinical risks for care beyond their own walls. A bundled payment system, however, would require implementation of a common patient assessment tool across settings, or at the very least, adding common elements to each of the existing tools in use today (MDS 3.0, OASIS-C, and IRF-PAI). Between 2008 and 2011, CMS did embark on a Postacute Payment Demonstration that tested the Continuity Assessment Record and Evaluation tool. Although the tool did show some promise in meeting this need, it continues to be modified to better estimate resource need and measure care results. While MedPAC did state that bundled payments are not the only method to align provider incentives and improve accountability for care, they did acknowledge that the other well-publicized avenue – Accountable Care Organizations – would require PAC

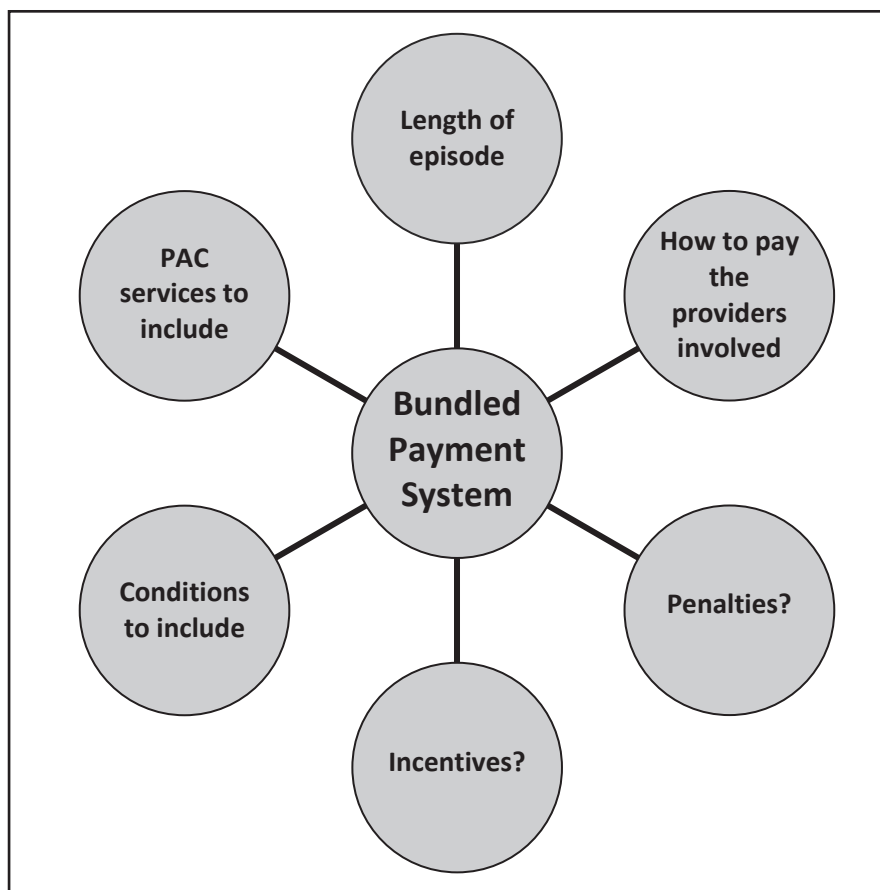
providers manage all services furnished by all providers over the course of year. Unfortunately most PAC providers do not have the infrastructure and capital to assume this responsibility.

So what would a bundled payment system look like? There are several different aspects to any bundled payment system that should be considered.

- Should the payment cover a 30, 60, or 90 day period?
- Should each PAC provider be paid separately? Or should one provider be the all-inclusive provider?
- Should providers be penalized for readmissions or emergency department visits?
- Should providers be rewarded for more cost-effective care? Or outcomes better than a benchmark?
- Should the program begin with just a few select conditions?
- Should all PAC services be included? Or should they be separated?

These are questions Congress, policy makers, CMS, and providers are trying desperately to answer. MedPAC's report discussed a bundle that included the following characteristics:

1. A combined hospital-PAC bundle.
2. A system that would start with 10 selected conditions that make up 23% of all hospital episodes and 15% of all fee-for-serve spending.
3. A model that includes potentially preventable readmissions; eg, extend the current hospital readmission reduction policies to all PAC providers so they share the responsibility for readmissions.
4. Design a bundle that would include longer durations, such as 90 days, which is comparable to Medicare Advantage per capita payment plans.
5. Establish benchmarks for each condition included, and then



compare actual average spending with the benchmark. If providers kept average spending below the benchmark, they would receive a bonus payment at the end of the period. But in order to avoid stinting on care, providers would not be compared on individual cases, but rather on aggregate payments, such as quarterly or even annually.

In June 2013 Congress also jumped into the discussion, when the House Ways and Means Committee sent a letter to all PAC stakeholders seeking their input on how to improve PAC payment accuracy, combat fraud, and address the variation in utilization. The questions appeared to be seeking input in the areas of quality measurement, patient assessment instruments (MDS, OASIS, IRF-PAI, and the CARE tool), how to transition to value-based purchasing, the role of PAC providers in reducing hospital readmissions, and the pros and cons of moving to a bundled payment system. The APTA hosted two audio conferences where members who work in these settings could give input into the response APTA will submit to the Ways and Means Committee.

IMPROVING THE PAYMENT SYSTEM FOR OUTPATIENT THERAPY SERVICES

GeriNotes Policy Talk and this writer have discussed the utilization of Medicare Part B therapy services frequently in past columns. The most recent MedPAC report illustrates that utilization continues to grow. In 2011, about 4.9 million beneficiaries—about 15% of all beneficiaries—received outpatient therapy services.⁴ Determining ‘why’ these patients are seeking outpatient therapy services is more challenging because the diagnosis codes used to bill therapy tend to be nonspecific ICD-9 codes, such as ‘pain in the joint’ or ‘aftercare’ V-codes which are nondescriptive codes that describe only the type of therapy received, not the reason for receiving it. For physical therapy, the most frequency categories are back problems (27%), nontraumatic joint disorders (19%), connective tissue disorder (15%), and osteoarthritis (9%).⁵ However, using a hierarchical condition category system to risk-adjust patient severity, MedPAC found that users of outpatient PT had lower risk scores than either OT or speech-language pathology users.⁶

Medicare spending on outpatient

therapy totaled \$5.7 billion for services to those 4.9 million beneficiaries. Two thirds of that spending was for physical therapy services, which averaged approximately \$942 per beneficiary user.⁷ This number reflects an approximate 10% growth in per user spending since 2008. Even more alarming is that in 2011, Medicare spending on therapy services (across all therapies) averaged \$1,173 per user, but the top-spending counties spent 5 times more per beneficiary than the lower-spending counties.⁸ As a result, there are numerous questions raised about the possible inappropriate use of the Medicare outpatient therapy benefit in some geographic areas. Another trend found that when beneficiaries exceeded the cap, there were more likely to have spending dramatically higher than that of beneficiaries whose total therapy spending stayed below the cap. For example, in 2011 19% of persons receiving PT and ST services exceeded the cap. The average spending per user for these beneficiaries was more than 5 times the average spending for beneficiaries who remained below the cap: \$3,013 per user versus \$542 per user.⁹

The Middle Class Tax Relief and Job Creation Act (MCTRJCA) of 2012 required the MedPAC Commission to study outpatient therapy services provided under the Part B benefit and make recommendations for reforming it. The legislation actually directed MedPAC to study two areas specifically:

1. how to better document patient’s functional limitations and severity of condition in order to better assess patient’s therapy needs; and
2. study private sector initiatives to manage outpatient therapy.

In November 2012, MedPAC actually delivered part of their report to Congress 7 months early. They did this because certain statutory provisions related to outpatient therapy were set to expire on December 31, 2012. The result was some good news, some bad news, and other news that falls somewhere in the middle:

As you can see, physical therapists have a lot to look forward to! Change is quickly becoming the new normal. Of

Good News	? You Decide?	Bad News
<ul style="list-style-type: none"> MedPAC acknowledged that outpatient therapy services can help Medicare beneficiaries improve their level of function and live independently. 	<ul style="list-style-type: none"> MedPAC recommended national guidelines should be developed for therapy services such that payment edits could be implemented to prevent “implausible amounts of therapy”¹⁰ from being paid. 	<ul style="list-style-type: none"> MedPAC acknowledged the therapy benefit is vulnerable to abuse.
<ul style="list-style-type: none"> Therapy Cap Exception process should be extended. <i><u>*Recommendation implemented*</u></i> 	<ul style="list-style-type: none"> MedPAC recommended fraud and abuse efforts be targeted in high-use geographic areas and with aberrant providers. 	<ul style="list-style-type: none"> The Manual Medical Review above the \$3,700 amount was continued. <i><u>*Recommendation implemented*</u></i>
<ul style="list-style-type: none"> MedPAC recommended a streamlined process to review claims that exceed either level of therapy cap. <i><u>*Some recommendations implemented*</u></i> 	<ul style="list-style-type: none"> MedPAC recommended decreasing the maximum certification period from 90 days to 45 days to increase physician oversight of the therapy plan of care. 	<ul style="list-style-type: none"> The MPPR increased to 50% of the practice expense on the 2nd+ CPT code billed in a single visit. <i><u>*Recommendation implemented*</u></i>
	<ul style="list-style-type: none"> Include hospital outpatient departments permanently under the therapy caps to insure no setting has an unfair advantage. <i><u>*Recommendation implemented*</u></i> 	<ul style="list-style-type: none"> MedPAC recommended reducing the therapy cap limits to \$1,270 in 2013.
	<ul style="list-style-type: none"> Tighten diagnosis coding practices; discontinue the use of V-codes as diagnosis codes on therapy claims. 	<ul style="list-style-type: none"> MedPAC recommended combining therapy codes that are commonly performed together into single comprehensive codes with the payment rates reflecting these efficiencies.
	<ul style="list-style-type: none"> Develop and collect measures of functional status for outpatient therapy users. <i><u>*Some recommendations implemented*</u></i> 	

course we must stay engaged and we must continue to look for viable solutions that we can champion to our peers, Medicare policy-makers, and Congress. Change starts from within, however, and there are a lot of things that each one of us can begin to implement within our own practices:

- Are you gathering functional outcomes on each one of your patients?
- Are you making every visit count in order to reduce waste in the system?
- Are you using “smart” documentation to insure the services your patients need are covered by their benefit?
- Do you understand how to choose a treatment ICD-9 code?
- Do you follow CPT coding rules and understand what you are billing?
- Are you talking to your peers in the continuum of care to insure successful hand-offs from one setting to the next? We do have a role in preventing re-hospitalizations.

We all have a role in this change that is coming. Seek yours!

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GERIATRICS... WHO WOULD HAVE THOUGHT?

As Public Relations (PR) Chair I am always looking for stories and information that can be shared with our Section on Geriatrics (SOG) members and those outside our association that focus on work with the older adult population. In recent discussions with two new therapists I have crossed paths with, I wanted to hear what they had to say about why they chose geriatrics as their area of practice. I know that many of you have heard similar stories from new graduates, or have stories like this that may be your own! The PR Committee would love to hear them. The SOG would encourage you to use the power of share through our social media networks of Facebook or Twitter to tell us your story of “*Who would have thought?*”

*Karleen Cordeau, PT, MS
Public Relations Chair*

Samantha's Story

Growing up as an athlete, I experienced many injuries. I had to go to physical therapy, which helped me return to competition. Throughout my undergraduate and graduate courses, I always believed that I would give back to the community by working in an outpatient clinic specializing in orthopedics.

As a graduate student, I made sure that my first clinical experience was in the outpatient field where I was most comfortable. For my second clinical experience I fought to work on a hospital orthopedic floor. Finally, my last internship was subacute care, which I was dreading the most. I tried to keep an open mind walking into the subacute rehabilitation setting, but my wall was up in my first two weeks, until I saw how rewarding older adults are to work with! Here I was thinking that athletes needed my help the most, while I was blinded to those who suffer from even more impairments, functional limitations, and disability leading to a poor quality of life. Older adults are full of wisdom. Their primary goal may be as simple as performing everyday tasks such as getting up from a chair and walking to the bathroom, or as advanced as getting back to running.

One patient in particular will always stick out in my mind. He was a 70-year-old man who suffered a severe CVA, leaving him with multiple impairments and functional limitations, including the inability to transfer, ambulate, speak, or eat. Prior to his CVA, he had 5 therapy dogs that he would bring around to hospitals to help others. Now, he was the one dependent on others. My clinical

instructors stayed positive with me. With hard work, determination, and support from his family, he was able to walk out of the facility.

During the last two weeks of my clinical, I was making sure it was known to the Director that I wanted a job working in subacute rehab. The week after I graduated I got my temporary license and began working with the same company where I performed my clinical affiliation. I had the experience of going to several buildings and treating multiple categories of conditions in areas of orthopedics, neurological, cardiopulmonary, and integumentary. This led me to take on their geriatric residency program to further learn about this wonderful population. After my first year of working, I have taken on even more responsibilities as a Director in a skilled nursing facility, continuing to show my professional and personal dedication to each resident and the clinicians I work with.

By the time I finish my residency, my goal is not only to use my knowledge and experiences to maximize each patient's functional and social capabilities but to encourage students to want to experience the practice of geriatrics with their own eyes.

Samantha Krupa, DPT, received her bachelors in health science at Saint Joseph's College, West Hartford, CT and her Doctorate of Physical Therapy from University of Hartford, West Hartford, CT in 2011. She currently works for AllStar Therapy, LLC as a

Director of Rehabilitation and is in their Geriatric Residency Program.

Michael's Story

I was a two-sport collegiate athlete who, unfortunately, had multiple experiences with physical therapy including Achilles tendon repair, ACL and meniscus repair, and other various strains and sprains. I entered physical therapy school with the hopes of treating injured athletes, like myself, back to their full performance potential.

When I discovered that my PT school required me to select a rotation other than outpatient orthopedics, I was understandably disappointed. Let me clarify...I dreaded making this decision.

As a result, I maximized the number of outpatient orthopedic rotations that I could select and hesitated when required to select my final settings. Subsequently, I chose to go to the Mayo Clinic in Rochester, Minnesota and complete my short term rehab, skilled nursing facility rotation. My decision had everything to do with my high regard of the Mayo Clinic and nothing to do with the geriatric setting.

In hopes to not sound like an overly enthusiastic clinical educator trying to promote a certain “undesired” setting to a disgruntled PT student, I can genuinely say that this rotation was amazing. Through only two months of service, I realized my connection with the geriatric population. I discovered that I enjoyed getting these “athletes” home (or more independent) more than I ever enjoyed getting more traditional athletes back on the playing field.

Time passed, school ended, and I needed to decide the setting in which I was going to practice; outpatient or geriatrics. I had other outpatient rotations that were highly influential, and my two greatest mentors practiced in the outpatient world. However, I could not ignore the satisfaction I felt when a grateful elderly patient was discharged home. After receiving multiple job offers in both settings, I had to make a selection. What was I to do?

As you probably suspect, I ended up taking a position at a SNF. I was also fortunate enough to receive one-on-one mentoring with their clinical specialist to more familiarize myself with the setting, since I had only one SNF rotation in PT school.

I love my job, my patients, and my decision. I become more passionate each day, which lead me to reach out to the SOG web site for ways in which I help promote geriatric PT. I have since joined the SOG Membership Committee and PR Committee to help change the perceptions of PT students and young

professionals (myself included) of this frequently overlooked but wonderful geriatric community.

Michael Newlin, PT, DPT, CSCS, lives in KY. He received his Bachelors Degree in Exercise Science at Ashbury University and his DPT from the University of Kentucky PT School.

Reminder

Please make sure the Section/APTA has your correct e-mail address.

We email important updates to keep you informed.
Contact the Section Office at geriatrics@geriatricspt.org,
call 866/586-8247 or go to APTA's website:
www.apta.org to update your membership information.

Thank You!

50% OFF Topics in Geriatrics: Volume 3

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Topics in Geriatrics: Volume 3 for only \$100!

Volume 3 Topics Include:

- **Physical Therapy Applications for Assessing and Counseling Older Drivers** - Cheryl LaFollette Anderson, PT, PhD, MBA, GCS
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- **Fall Prevention** - Celinda P. Evitt, PT, PhD, GCS
- **Health Promotions in Geriatric Care: The Collaboration Between Physical Therapy and Public Health** - Kathryn K. Brewer, PT, GCS, MEd
- **Exercise Prescription for Older Adults** - Dale Avers, PT, DPT, PhD and Patrick VanBeveren, PT, DPT, MA, OCS, CSCS
- **Successful Aging: Biopsychosocial and Environmental Implications for Physical Therapist Practice** - Mary Thompson, PT, PhD, GCS

CEUs are no longer available for Topics in Geriatrics: Volume 3. To order please visit the Section on Geriatrics online store at <http://www.geriatricspt.org/store/index.cfm>.

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ANNUAL CONFERENCE UPDATE

*Tamara N. Gravano, PT, DPT, GCS
Chair, Section on Geriatrics Membership Committee*

The following Section on Geriatrics Members were recognized at APTA's Honors and Awards Ceremony on Thursday, June 27 at the APTA Conference and Exposition in Salt Lake City.

Michelle M. Lusardi, PT, DPT, PhD: Lucy Blair Service Award
David A. Pariser, PT, PhD: Lucy Blair Service Award *
Victoria S T Tilley, PT, GCS: Lucy Blair Service Award
Sandra B. Davis, PT: Marilyn Moffat Leadership Award
Anne L. Harrison, PT, PhD: Dorothy E. Baethke-Eleanor J. Carlin Award for Excellence in Academic Teaching
Jennifer E. Stevens-Lapsley, PT, MPT, PhD: Jack Walker Award
Debra A. Lasure, SPTA: Mary McMillan Scholarship Award, Physical Therapist Assistant Education Program

** Awarded posthumously*

The PTA Recognition of Advanced Proficiency Program recognizes physical therapist assistants (PTAs) who have achieved advanced proficiency through education, experience, leadership and as part of the PT/PTA team in a specified area of work. The following Section members were also recognized at Annual Conference for achieving advanced proficiency:

Melanie Cain - Musculoskeletal	Ann Marie DeAntonio – Geriatric
Leonard Hardy – Geriatric	Lynn Hernandez – Geriatric
Lisa Jones – Acute Care	Nancy Olson - Musculoskeletal
Lisa Lamb Rhodes - Geriatric	

The following people each gave their time to volunteer at the SOG booth at Annual Conference and meet lots of new faces interested in Geriatrics:

Verna Ourada
Joanne S. Daroy
Karen Curran
Joy Kuebler
Megan Sions

Debra Ludwiczak
Patricia Brick
Joan-Alice Taylor
Julie Burnett
Megan Wells

David Taylor
Cathy Ciolek
Patty Trela
Ronna Keagle

Jeannie Cushman
Alice Bell
Yi-Po Chiu
Bill Staples

For each hour volunteered, each person is entered in a drawing for free section membership. This year, the winner is JOY KUEBLER, of Jackson MS. Congratulations Joy!

We need your help again next year at CSM in Las Vegas. Please sign up to volunteer at the booth, and be entered into the drawing for free Section membership!

Thanks to all!
*Tamara N. Gravano, PT, DPT, GCS
Chair, Section on Geriatrics Membership Committee*



Student Assembly members Pete Tooley and Matt DeBole joined Section President Bill Staples (center) at the very busy Section Booth!

RESIDENCY CORNER: PERSPECTIVES FROM THE UNIVERSITY OF MINNESOTA

*Emily Pierce, PT, DPT
Megan Connelly, PT, DPT*

The University of Minnesota (UMN) Geriatric Clinical Residency Program in Physical Therapy began in September of 2010. It is one of nine geriatric residency programs in the country currently credentialed by the APTA's American Board of Physical Therapy Residency and Fellowship Education, and one of three credentialed residency programs in physical therapy in the state of Minnesota, accompanied by one each in Orthopedic and Sports Physical Therapy. The mission statement for the program is as follows: "The University of Minnesota's Physical Therapy Geriatric Clinical Residency is a post professional pathway for practicing physical therapists to challenge & enrich their skills in the specialty area of geriatric physical therapy, and to elevate the residents to the level of expert clinical practice. Consistent with the mission of the University of Minnesota, this Geriatric Clinical Residency Program is dedicated to the integration of clinical research, learning, and public outreach to best serve the growing & diverse geriatric population in Minnesota and beyond."

The residency program at UMN runs each year from September 1 to August 31. Highlights of this program include that residents earn more than 230 CEU credits for successfully completing didactic coursework, have the opportunity to teach a continuing education course to local physical therapists, and receive coverage of registration fees for the Minnesota Physical Therapy Association conferences and the APTA Combined Sections Meeting as well as travel funding for the latter. The program is designed to prepare students to sit for the Geriatric Clinical Specialist Exam and each of the program's first two residents passed the exam on the first attempt. This past year, the program at UMN expanded to include two residents, Emily Pierce

and Megan Connelly. The following are these students' reflections on their experience in the residency program.

EMILY PIERCE, PT, DPT



I've always been a "school" person. You know, the one that looked forward to class with teachers and peers and didn't mind that summer vacation was coming to an end, because it meant another semester of learning new things and being with people who shared the same academic and social interests. So as graduation from physical therapy school loomed ahead, I almost started to panic---no more school and classes? I had already decided I loved geriatrics and wanted to look for a position in a skilled nursing facility, as well as an employer with a strong mentoring program. I also knew pursuing a PhD was probably not in the cards for me, since I had no interest in researching or teaching at the university level. I was leaning towards choosing a position in travel therapy to gain a lot of different experiences in geriatric settings, until I heard about the specialist certification and residency offerings. Suddenly I felt at ease, that yes, this was what I was supposed to do. The University of Minnesota would become my new school, and the faculty there, along with dozens of specialists and experts in geriatrics across the Twin Cities, would become my mentors, teachers, and colleagues.

The clinical residency program at "The U" accepts one to two residents per year and is 12 months in length, broken into three semesters. It is a full-time position, including four clinical work days and one day a week devoted to the didactic curriculum, either home

study, live lectures, or observations in the community. I was placed at a suburban care facility, Saint Therese, which offers a continuum of senior housing options: independent living apartments, assisted living, transitional (skilled) nursing care, long term care, and memory care. As a staff physical therapist, I took on responsibilities of managing a full caseload as well as overseeing the work of a PTA. A vital part of the residency is the high quality mentoring---four hours must be completed each week between the resident and his or her mentor.

In addition to the standard didactic and clinical work, there is a community service and volunteer emphasis. Every month the resident provides pro-bono services at a community Diabetic Foot Clinic, which is also an excellent opportunity to play the role as mentor to current physical therapy students honing their skills in evaluation, examination, and client interaction. On a more individual level, there is a service learning component at each resident's facility where he or she is expected to volunteer and is matched up with certain older adults in order to build long-term relationships over the year and give back. This is actually the gem of the program, the part that pulls everything together, being involved in the life of a senior and seeing their role in, and how they are affected by, politics, healthcare, social customs, spirituality, and community. Recently, I was honored to be a part of my senior friend's 100th birthday, an age that seems unreachable, yet a milestone I hope to one day hit with as much pride and health as she exudes.

Over the course of this geriatric clinical residency I have gotten an in-depth education regarding the aging adult and a physical therapist's role in caring for this population. I have seen through a research project from beginning to end,

lectured to undergraduate students and fellow medical professionals, traveled to a national conference, and spoken to state and local politicians about issues facing physical therapists. My skills as a clinician have grown with confidence, repetition, and exposure to various diagnoses and presentations. The relationships I've formed with my mentor, program director, fellow resident, coworkers, senior friends, and teachers are irreplaceable. Not so long ago, if someone had told me I would have accomplished this much personally and professionally in just one year, I would have thought it impossible. It is with pleasure that I relinquish my role as "student," but never that of a learner, as I begin a path as a geriatric specialist in what I hope to be a long and fruitful career in such a rapidly growing field of physical therapy.

Emily Pierce hails from Moscow, ID, where she graduated from the University of Idaho with a B.S. in Biology in 2008. In 2012 she graduated from the DPT program at the University of Kansas Medical Center in Kansas City, KS. After the geriatric residency she plans to gain experience in various older adult settings and return to the Northwest as a travel physical therapist.



MEGAN CONNELLY, PT, DPT



I first learned about the concept of physical therapy residency programs while at the APTA Student Conclave in 2010, when I was in my second year of PT school. I decided on the spot that I would pursue one after graduation. It just made so much sense. Like Emily, I was already not looking forward to the end of school. I loved classes and learning as much as I could. I had enjoyed my first internship, and I was eager to get into the clinic to begin to start helping the older adult population, the group with whom I always knew I wanted to work, but I was scared of soon being the individual to make all of the decisions without

a clinical instructor looking over my shoulder. How would I know what to do with my patients as a new graduate? While at Conclave, I learned as much as I could about residency programs, and decided that pursuing this course would allow me the best of both worlds. I would continue to attend classes to maximize my knowledge base about the population for whom I cared so much. I would also be working and able to start learning those skills that cannot be taught in the classroom and must be acquired in the clinic. And I would have a mentor to help guide me in clinical decision making, brainstorm ideas for my patients, and develop my skills with certain techniques.

My residency will be coming to an end this month, and looking back over the last year, I have no doubts that this was the right path for me to take. Having a mentor this first year after graduation has been invaluable. My mentor, Debbie Hanka, PT, DPT, GCS, was present the first time I did a Berg Balance Scale with an actual patient to guide me in administering and scoring it properly. With her, I first transferred one of my patients who had required a mechanical lift for months. This was something I would have been terrified to try to direct other staff members to assist me with. When I am at a complete loss as to what to do next with a patient, Debbie is there with suggestions or to assure me that I have done all that I can. When I have an idea I think might work but afraid it seems too unorthodox, I can get her opinion and have her on hand in case its implementation doesn't go according to plan. There are so many aspects of patient management Debbie has helped me learn to consider that I didn't previously know I should even be thinking about. She has helped me to navigate my role of supervising PTAs, and provided guidance for interactions with patient families and physicians. Debbie has also provided the necessary support for me to feel confident making suggestions for improvements at the organizational level to help my colleagues and me better serve the needs of our patients.

My mentor has been only been one of the many resources available to me through this residency program. As a student of the University of Minnesota, I have had full access to their library

and all of its databases. Our classes have consisted of meeting with numerous geriatric clinical specialists and other experts in the field of geriatric healthcare. With only two of us in the program, these classes are all informal, with the opportunity to ask as many questions as we have, to try new techniques and get individualized feedback, and to pick the brains of these gurus by saying, "so I have this patient..., what would you recommend?" Each of these individuals has provided us with a business card at the end of class and implored us to contact him or her with any further questions or issues that we face in clinical practice. What simpler way is there for a new physical therapist to grow his or her professional network?

Perhaps the most important resource, however, has been all of the older adults with whom I have interacted over the last year, through work, classes, and volunteering. I have also had the unique opportunity to reside in one of the independent living apartments on a campus devoted to providing the continuum of care to older adults. I have seen firsthand how truly diverse this population is and learned to appreciate this heterogeneity. I have been forced to question every stereotype I previously held regarding older adults and to question the limits that clinicians place on their elder clients. One of my neighbors, who I consider to have become a true friend, recently turned 100 years old. She has a job, manages her own apartment, bakes delicious lemon meringue pie, sews beautiful aprons, and can legitimately beat me at Scrabble, a favorite pastime of both of ours. Yes, she is at a high risk for falling, and no, she does not use her four-wheeled walker with 100% safety. However, I would be the first to challenge anyone who claimed she is not capable of making her own decisions or living in her independent apartment. I believe that living among older adults helps me to remember both sides of the patient-clinician relationship. I'm not entirely certain how to describe this phenomenon, but I can recognize both the frustrations of my co-workers as they deal with "difficult" patients and the frustrations of my neighbors who confide in me their woes about the healthcare system. I can more easily recognize what is important to my

patients, and I am reminded to treat them with dignity and respect. I have enhanced my communication skills and have been forced to reflect on both the volume and tone of voice that I and so many others tend to naturally adopt when talking to older adults. I truly think that living among older adults has positively shaped who I am as a clinician, and that my neighbors have taught me more about being a good physical therapist than anyone else could have.

In the past year, I have learned more, experienced more, met more people who will influence the rest of my career, than I ever possibly could have in one year, or even several years, without the residency program. My clinical and decision making skills, and my

confidence have grown exponentially. Although I view the end of the program with some degree of sadness, I do not have the same trepidation I had at the end of PT school, not because I think I have learned all I need to know, but perhaps because I am even more acutely aware of how much I have yet to learn. Now I know how to handle unfamiliar situations and have many resources to draw on to help me do so. I cannot think of a better way to have jump-started my career as a physical therapist than through this residency program.

Megan Connelly is originally from Mahopac, NY. She completed both her undergraduate and graduate work at the

University of Scranton in Pennsylvania, graduating with a Bachelor of Science in Exercise Science and a minor in Gerontology in 2009, and a Doctorate of Physical Therapy in 2012. After completing the residency program at the University of Minnesota, she will be returning to the East Coast where she plans to continue to work with older adults and hopes to ultimately pursue a PhD and a job in teaching physical therapy at a university.

From the CSM Chairs...

There are less than 6 months before CSM 2014!
The schedule is going to offer an exciting array of educational opportunities in the city that never sleeps--Vegas, NV.

Several preconference sessions are available to choose from on
Sunday, February 2 and Monday, February 3, 2014

Sunday: A Functional Approach to Neuro Part 1 and Tai Chi Fundamentals® Program Level One. The preconference schedule will wrap-up with an additional 3 sessions on **Monday:** A Functional Approach to Neuro Part 2, Tai Chi Fundamentals® Program Level Two, and back by popular demand, Mentoring: Residency & Fellowships.

Additionally, be prepared for another year of fantastic programming. We are excited to be able to integrate research with clinical practice. A glimpse of what is to come includes: *Risk of Falling Recommendations: GeriEDGE* presented by Drs. Michelle Lusardi, Leslie Allison, and Alice Bell; *EDGE & PTNow – Management of Hip Fracture* presented by Drs. Kathleen Mangione, Tiffany Hilton, Kevin Chui, Alice Bell, and Anthony Dalonzo; *Balance & Falls & Health & Wellness SIG: Agents of Social Change* presented by Drs. Lori Schrodt, Mindy Renfro, David Morris, and Donald Lein; Walking Speed in Clinical Practice presented by Drs. Michelle Lusardi, Stacy Fritz, Kevin Chui, Kay Wing, Ellen Hillegass, and Jennifer Stevens-Lapsley; *Seating and Mobility for Geriatrics* presented by Ms. Judy Fryermuth and Ms. Leta Kant; and *Motivating Apathetic and Depressed Clients* presented by Mr. Mike Studer and Dr. Winningham.

Check out the Section web site for more information and the APTA CSM 2014 flyer.

SLATE FOR 2013 SECTION ON GERIATRICS ELECTION

Those elected will take office at CSM in February of 2014. Online voting will begin October 1, 2013. Please watch your email and www.geriatricspt.org for more details.

Secretary (vote for 1):

Ann Medley, PT, PhD, CEEAA; Toni Patt, PT, DPT, GCS, NCS; Cecelia Griffith, PT, DPT

Section Delegate (vote for 1):

Elizabeth E. Black, PT, GCS; Steven B. Chesbro, PT, DPT, EdD, GCS, CEEAA; Patricia D. Brick, PT, MS, GCS, CMC

Nominating Committee (vote for 1):

Veronica Southard, PT, DHSc, GCS, CEEAA

Director (vote for 1):

Danille Parker, PT, DPT, GCS, CEEAA

SECRETARY

Ann Medley, PT, PhD, CEEAA

Education: BA in Biology from the University of Texas at Austin, BS in Physical Therapy from the University of Texas Health Science Center at Dallas, MS in physical therapy from Texas Woman's University, PhD in Cognition and Neuroscience from the University of Texas at Dallas

Employer and Position: Associate Director of the School of Physical Therapy, Texas Woman's University, Dallas Campus

1. What experiences would you bring to the position of SOG Secretary that makes you a strong candidate?

I have been a licensed physical therapist for 34 years. I started my career in the acute care setting working primarily with older adults as well as people following stroke. I moved to a home health setting after about 10 years in acute care and then to skilled nursing after that. I have been on the faculty at Texas Woman's University (TWU) in the School of Physical Therapy for the past 21 years. My research interests include functional assessments for older patients and patients following stroke. I was the coordinator of

the entry-level program for 12 years and was appointed the Associate Director for the School of PT on the Dallas campus last year. I have served on numerous committees at the departmental as well as university level. I have been a member of the APTA since 1978 and served the Neurology Section as Secretary of the Stroke SIG for two 3-year terms. Currently, I am member of the Finance Committee for the Neurology Section and a member of the Public Relations Committee of the Section on Geriatrics. At the state level, I am on the Board of Directors for the Texas Physical Therapy Foundation (TPTF). I also review continuing education for the Texas Physical Therapy Association and grants for TPTF. I have been a member of the Geriatric Section since 2009 and earned my CEEAA in 2010. I enjoy being a member of the Section and have learned a lot through conference courses as well as volunteer activities. Section activities in both Sections have taught me a lot about the APTA as well as the individual Sections. I especially enjoy the opportunity to interact with other physical therapists who also share a love for treating older people. Both of my administrative positions at TWU require strong organizational

skills, clear communication, and the ability to work with multiple individuals simultaneously. My strengths include attention to detail, strong organization skills, timely completion of tasks, and very good interpersonal skills. I also have a long history of service activities both at the University and within our professional organization. If elected, I would be honored to serve the SOG as the Secretary.

2. How would you promote communication to enhance participation of and responsiveness to members? I would encourage the use of social media and e-mail communication as well as printed materials to communicate with the membership. I believe that we also need to develop ways to get members as well as nonmembers to visit the Section's web site. The SOG should consider developing a research review panel similar to that used by the Neurology Section. The panel would review current research publications and compile a list of publications that would be of interest to the Geriatric Section members. Links to the full text version of the publications would also be included whenever possible.

3. What is the greatest challenge facing the geriatric practitioner and how can the SOG help? I see several challenges for the geriatric practitioner:

First, we must ensure that PTs are viewed as the exercise experts for our aging population. One way is to encourage all members of the Section to earn the CEEAA offered through the Section. The Section should continue to support this educational opportunity.

Recently, the Partnership for Health in Aging developed Multidisciplinary competencies in the care of older adults at the completion of the entry-level health professional degree. Subsequently, the SOG developed PT specific essential competencies. All clinicians who treat older patients should complete a self-analysis of the care they provide to ensure they are meeting these competencies as well. If they find weak areas, then they should seek educational opportunities to bring them to entry-level competence. The Section can survey members to discover which competencies members may lack and then develop educational opportunities for its members to meet this need.

Lastly, putting research into practice is essential to quality care for our patients. The Section currently supports research activities through research awards but we also need to develop a research agenda for the Section. The agenda needs to be shared with the members and additional support for these activities needs to be provided.

SECRETARY

Toni Patt, PT, DPT, GCS, NCS

Education: BS in Physical Therapy from St. Louis University, St. Louis, MO, tDPT from A.T. Still University, Mesa, AZ

Employer and Position: Staff physical therapist at Cornerstone Hospital (LTAC)

1. What experiences would you bring to the position of SOG Secretary that makes you a strong candidate?

I have been a therapist nearly 30 years, almost of all that has been treating the geriatric population in some form. I am familiar with our patient population. I try to keep current on literature and changes in reimbursement. My computer skills are excellent as are my skills for searching the web. Over the last few years I have become more and more involved with the APTA and the future of our profession. Most importantly I love what I do and the population I work with. It is that passion that will make me a good secretary. If you love what you do you'll always do your best.

2. How would you promote communication to enhance participation of and responsiveness to members?

As Secretary I would like to see a condensed version of meeting minutes posted on the web page. That will enable members to know what is going on in the Section. The web page is user friendly but could be improved by reorganization. Things that are important to members and visitors need to be front and center. The link for resources is difficult to find as is the link for the listserv. I would start with a survey of the membership to determine what they feel is important and would like to see.

3. What is the greatest challenge facing the geriatric practitioner and how can the SOG help?

With the continued cutbacks in government spending, the struggle for adequate reimbursement for our services will be an ongoing challenge. We can expect continued decreases in Medicare funding. This could take the form of less reimbursement for DRGs and lower therapy caps for outpatient services. Therapists will feel this in a tighter job market, lower salaries, changes in censuses, and more stringent admission guidelines for inpatient and skilled nursing facilities.

The SOG can help by keeping members informed of upcoming

changes in the rules and reimbursement structure as well as explaining those changes in simple language. It can also alert members to upcoming votes so that congressmen and women can be contacted. The SOG can also provide resources for contesting denials and exceptions to the therapy cap.

SECRETARY

Cecelia Griffith, PT, DPT

Education: BHS-PT from University of Missouri, tDPT from Rosalind Franklin University of Medicine and Science

Employer and Position: Clinical Implementation Specialist-Therapy at HealthSouth

1. What experiences would you bring to the position of SOG Secretary that makes you a strong candidate?

Having over 3 decades of experience in the field of physical therapy, and nearly 4 decades in health care, I have practiced in almost every setting and with almost every age group. However, the majority of that practice has been in geriatrics, primarily those with neurological impairments. This led me to become active in both the SOG and the Neurology Section of the APTA. While I have not yet had the honor of serving in an elected position within the SOG, I have served in several positions within the Neurology Section's Balance and Falls SIG including, Secretary, SIG Nominating Committee, SIG Nominating Chair, and SIG Chair. My work history has not only provided me with experience in patient care, but also in other aspects of health care including management, corporate compliance, case management, education and development, and health informatics. My experience with leadership and governance roles extends outside of the Physical Therapy profession, primarily with community organizations such as 4H and within our church. All of these experiences have helped me to understand the needs of organizational members and the need for a variety of methods in order to effectively communicate with them.

- 2. How would you promote communication to enhance participation of and responsiveness to members?** First, we need to examine the membership demographic and their communication preferences. What percent of our membership is over age 60? Age 40-60? Age 30-40? or under age 30? These groups vary in how they prefer to receive communication. Once we can identify their communication preferences, we need to explore avenues to meet those preferences. Do we expand our use of electronic and social media? Do we need to provide a limited amount of paper communication? What communication channels will allow us to reach the largest percentage of our membership without alienating the remainder? After we are able to establish the most effective method(s) of communication, it should open the doors, so to speak, to increase their responsiveness to said communication as well as promote participation in Section affairs and events.
- 3. What is the greatest challenge facing the geriatric practitioner and how can the SOG help?** Geriatric practice can be extremely complex, and I don't think we can always boil it down to one single challenge that supersedes all others. Those who practice in rural settings face different challenges and barriers than those who practice in metropolitan areas. Each region faces different challenges due to cultural and ethnic differences in the makeup of their population. Navigating the world of reimbursement is a huge challenge facing us all. There is one challenge that I think is often overlooked by the geriatric practitioner, and in fact hasn't been largely recognized until the last decade. That is health literacy. What we often perceive as "noncompliance" or an "unwillingness to change" among our geriatric clients simply boils down to a communication barrier. We use methods of communication that do not foster self-efficacy: we tell them what to do instead of asking them what they want to know or change. We use language that can sometimes be challenging for

the most experienced health care practitioner to understand and expect them to not only remember it, but to apply it! If we want to make a long term difference in our patients' lives, we have to take a step back and understand how best to communicate with them about the things they feel that they can change. Once we can understand and overcome the challenge of health literacy, coupled with self-efficacy, our ability to assist our patients in making changes that will impact them for the remainder of their lives will be significantly improved and "noncompliance" will be a thing of the past.

DELEGATE

Elizabeth E. Black, PT, GCS

Education: BS in Physical Therapy from University of New Mexico, BSW from Kansas University

Employer and Position: PT Case Manager at Presbyterian Home Healthcare, Owner of Movement Matters

1. What skills and experiences qualify you to serve as Section Delegate?

My background as a chapter delegate and as a Section, national APTA, and chapter leader has prepared me for the position of Section Delegate.

I have been a physical therapist for 20 years with a previous work history in business management and social work. I have worked as a homecare PT for the last 18 years. With my current company, I have had multiple roles including clinical work, quality assurance and audits, clinical informatics, documentation and program development, and staff training. I have my own business, Movement Matters, providing consulting and individual private pay client services. I became a Geriatric Clinical Specialist in 2010 and this has enhanced my interest in public policy and how PTs can participate outside of our more traditional practice settings.

Throughout my PT career I have been active in APTA, starting out

with leadership positions in the New Mexico Chapter at the District level and on the New Mexico Chapter Board of Directors for 10 years, including 4 years as Chapter Treasurer. I served as my chapter's Chief Delegate for 5 years 2007-2011, with an additional two years as a chapter delegate in 2006 and 2012. I was a member of the APTA Task Force on Governance Review Subgroup on Sections from 2011-2012. I spoke on the floor of the 2011 House in support of Section Delegates having a vote. I am hopeful that a similar RC as presented at the 2013 House will eventually pass leading to Section Delegates having a vote.

I have been a member of the Section on Geriatrics for the 18 years I've worked primarily with the older adult population. I have served as the Section's New Mexico State Advocate since 2007, promoting Section membership at New Mexico APTA chapter conferences, the NM Association of Homecare and Hospice, and mentoring individual PTs. I am a member of the Executive Committee of the New Mexico Older Adult Falls Prevention Coalition, part of the Falls Free Initiative. Our Coalition promoted a state legislative memorial to set up an Older Adult Falls Task Force to evaluate current approaches to community-based fall prevention and develop strategies for effective change. I am participating in this Task Force with recommendations to go to the legislature this fall. The past 4 years I organized annual National Falls Prevention Day activities including balance screenings with other therapists and students. In addition, I participate in the Home Health Section's Finance Committee (2007-present) and Government Affairs Committees (2009-present) and am a member of the APTA Hospice and Palliative Care Work Group (2012-present).

My primary areas of professional interest are fall prevention, hospice and palliative care, public health, and ethics.

2. How do you envision the role of Section Delegate? As the data supporting the recent APTA Governance Review indicates, many APTA members identify and participate more through their Section membership than through their chapter. I would like to see the membership of our Section become more engaged in House of Delegate issues, starting with education in Section meetings, *GeriNotes*, and SoG NewsBrief emails. I see the potential of engaging our members in identifying key issues that would benefit from developing RCs in the House, which focus on our goal to achieve optimal physical function and mobility in older adults.

As New Mexico Chief Delegate, I initiated a process for chapter members to be educated on House of Delegate issues through a series of e-mail blasts and a forum with a survey at the chapter's spring meeting. I educated and updated the chapter's Board of Directors and chapter members throughout the year to promote year round governance. As a delegate I participated in chapter, regional, and small state caucuses to discuss, refine, and promote RCs and candidates. I embrace using technology such as when I set up a wiki site online to facilitate communication in discussion of House issues, and I also value face-to-face communication.

3. Are there particular issues facing the profession currently that will require leadership by the Delegate for the Section on Geriatrics? I would like to continue the discussion to establish the Section delegates having a vote. This bylaw change requires a 2/3s vote in the House and RC4b came very close to passing this year. I believe the discussion of this issue and its eventual passing will change Section members' relationship to APTA in a very positive way.

"Transforming society by optimizing movement to improve the human experience." Our new APTA vision will require ongoing promotion, discussion, and education to the membership, and to individuals and groups outside of our profession.

There are many issues that pertain to our Section goal of achieving optimal physical function and mobility in older adults. Some of these include: reimbursement for health and wellness programs for older adults, new models of care with the evolving health care reform, and alternative payment systems in all practice settings.

DELEGATE

**Steven B. Chesbro,
PT, DPT, EdD, GCS, CEEAA**

Education: BA in psychology from Northeastern State University, BS in physical therapy from Langston University, MS in college teaching from Northeastern State University, MHS in physical therapy from the University of Indianapolis, Graduate Certificate in Gerontology and EdD in Occupational and Adult Education from Oklahoma State University, and DPT from the MGH Institute of Health Professions.

Employer and Position: Dean, College of Health Sciences; Professor, Department of Physical Therapy at Alabama State University - College of Health Sciences

1. What skills and experiences qualify you to serve as Section Delegate?

It is an honor to be slated by the Nominating Committee for the position of Delegate for the Section on Geriatrics. I have a number of skills and experiences that qualify me to serve in this capacity, keeping in mind that if elected I would be serving as a member of the Board as well. I served as Chief Delegate for the District of Columbia Physical Therapy Association (DCPTA) from 2004-2008, and served on the House of Delegates' Committee on Approval of Minutes in 2007. I also participated in both the Northeast Caucus and Small States Caucus groups. I am familiar with the governance structure of the APTA through my service as an elected member of the DCPTA Board (2003-2008), as both Chief Delegate and Vice President (2003-2004).

As a clinician, educator, and researcher, I have experiences that provide me with an appreciation for many of the policy-making issues that come before the House of Delegates. As a clinician, I have been a private practice owner which gives me a unique perspective on issues affecting health care operations. As an educator, I am familiar with how current policy issues impact provider development, and the many variables that come into play when creating or modifying policy related to professional education. As a researcher, my work has focused on educational interventions in geriatric practice, and identification of peripheral arterial disease in older adult populations. These experiences provide me with an appreciation for the role of the Association and Section when considering the needs of physical therapists and physical therapist assistants who are engaged in clinical practice, education, and/or research.

2. How do you envision the role of Section Delegate? The Section Delegate has the responsibility, first and foremost, to represent the Section on Geriatrics. The Section represents a specific population of therapists, therapist assistants, and students who have an interest in the health and well-being of older adults. Given the demographics of our society, and the percentage of older adults who are consumers of physical therapy services, the Section should have a strong voice in the decision and policy making arm of the APTA. The Delegate's role includes communicating with the members of the Section about issues being brought before the House, and encouraging the members of the Section to consider recommending amendments, motions, and resolutions that may benefit the Association and the consumers we serve. The Delegate should be an advocate for the profession of physical therapy, the Section on Geriatrics, and the consumers being served by Section members. Beyond communicating with the members of the Section, the Delegate should actively caucus with components and

Sections to share ideas, opinions, and perceptions about actions to be taken in the House. Collaboration is required when bringing RCs to the House of Delegates and it is the responsibility of the Section Delegate to participate in the dynamic process of the House.

The Section is responsible to the membership to ensure that the work of the organization is completed. As a member of the Board of Directors of the Section, the Delegate also has the responsibility to actively participate in the functions of the Board. This includes expressing his or her viewpoint in any and all discussions related to the governance of the Section.

3. Are there particular issues facing the profession currently that will require leadership by the Delegate for the Section on Geriatrics?

As a member of the APTA since 1989, the Section on Geriatrics since 1997, a Geriatric Certified Specialist since 2002, and CEEAA since 2009, I have kept myself informed of the issues facing both the profession and the consumers it serves. Leadership provided by the Section Delegate will relate to both the governance structure of the APTA, and the Board of the Section. The Section Delegate is expected to provide leadership when governance issues are brought to, or should be brought to, the House of Delegates. This expectation requires the Delegate to be current on issues and topics relevant to the needs of the Association, providers and consumers of physical therapy services, physical therapy students, and the mission and vision of the Section. This includes implementing the key goals of the APTA's Strategic Plan as presented at the 2013 House of Delegates:

- effectiveness of care to improve quality of life;
- patient and client centered care across the lifespan;
- professional growth and development; and
- value and accountability.

The Delegate is expected to demonstrate leadership when

performing his or her role as a Section board member. This includes implementing the major goals of the Section's Strategic Plan, which include:

- support autonomous physical therapist practice with the aging population;
- pursue best physical therapy practice for optimal aging;
- support members to advocate for the needs of the older adult to accomplish optimal aging; and
- establish the Section on Geriatrics as the premier resource for physical therapists and physical therapist assistants working with older adults.

Each component of the Strategic Plan requires that the Delegate demonstrate leadership within the Section and within the House of Delegates. I strongly believe that Section Delegates should be able to represent their constituents by voting in the House of Delegates, and expect the issue to come up again in 2015—the next year the House will address bylaws.

DELEGATE

**Patricia D. Brick, PT, MS,
GCS, CMC**

Education: Associates in Applied Science in Physical Therapy from Atlantic Cape Community College, BA in Psychology from Richard Stockton College of New Jersey, Master of Science in Physical Therapy at Neumann University

Employer and Position: Staff Physical Therapist at AtlantiCare Home Health care, Physical Therapist and Owner of TLC Rehab and Wellness

1. What skills and experiences qualify you to serve as Section Delegate?

I believe I am ready to serve as a Section Delegate. I have served as a Delegate for my state component for more than 10 years; initially at large, 2 terms as President and now 2 terms as Chief Delegate. I have attended more than a dozen regional caucus meetings in the Northeast, interacting with the current Geriatric

Section Delegate. I have learned the organizational structure of the House and the nuances that help get things done. I have represented my component with a global focus, a long range thought process, and inclusionary mind set. I have always viewed the House and its decision making authority as one that is responsible to make decisions for the good of the profession and in so doing we support the narrower scoped issues of the Sections. I believe I can bring that global, inclusionary thought process to bare as a Delegate for the Geriatric Section to be heard in the Caucus and in the House.

2. How do you envision the role of Section Delegate?

I see the role of Section Delegate as one of advocacy and information. I have watched the House struggle over proposed evolution of our organization as a whole and with regard to Sections. I believe that Sections like Geriatrics, who are based on a population segment, need to be able to share knowledge with other components and provide expertise to apply to broader conversations and decisions. I see the Geriatric Section Delegate being a stakeholder in policy, payment, models of delivery, ortho, neuro, womens health, to name a few of those conversations and decisions. We need to be at our internal tables of discussion as well as those in the external sector. I can be a strong Section Delegate to help add to those conversations and decisions.

3. Are there particular issues facing the profession currently that will require leadership by the Delegate for the Section on Geriatrics?

There are so many issues facing the profession of Physical Therapy right now, every component needs to lead our members to a professional place that makes them leaders in their careers and in their communities. We need to help our members realize that they have so many opportunities to share their knowledge in ways that can have a bigger impact on society, that it is ok to reach outside our intervention box and use their knowledge to collaborate with other stakeholders who design

items and space for older adults and create policies on transportation and access and payment for those kinds of things. I think the Geriatric Section Delegate should be looking for ways to collaborate and innovate with others to make our new vision a reality, to “transform society by optimizing movement to improve the human experience.”

I would be honored to give my time, talent, and treasure to the Geriatric Section as Section Delegate.

NOMINATING COMMITTEE

**Veronica Southard,
PT, DHSc, GCS, CEEAA**

Education: Bachelors in Physical Therapy from Hunter College, Advanced Masters in Physical Therapy from LIU, Brooklyn, DHSc from University of St. Augustine

Employer and Position: Associate professor, Physical Therapy program at NYIT

1. What skills and experiences qualify you to serve on the Nominating Committee? I believe that one of my strongest qualities is the ability to work with others to complete a task. My past experiences on the other committees have been positive and productive. I am prepared to seek the opinions of others in order to complete the activity. As a member of the Geriatric Section; this is my second term as Vice Chair of the Health, Wellness, and Promotion SIG. I have been active in the development of the Exercise for Special Populations COPD brochure, part of the committee that made recommendations for the Functional limitations guidelines, and I am presently contributing to the Fit after 50 brochure. I think it is important to be a strong collaborator to find the best candidates for each position. I have good communication skills, a tough shell, and I am not afraid to think outside the box. I have been a member of this section for a long time and believe I have what it takes to be an effective member of the Nominating Committee.

2. How would you identify and mentor new leaders within the Section? I look forward to having the opportunity to mentor and identify new potential leaders for our Section. I would look for interested individuals that have maybe not had the ability to lead because of other obligations. It doesn't have to be a new graduate; it can be anyone that has been unable to become involved in the past. Some people that attend the business meeting may not say much, but have great ability to be active in some of the Section's functions. One way we can find possible candidates would be to use, Survey Monkey to assess members potential for participation. This would allow all the members of the Section the opportunity to respond. This would also be good because only small number of members can attend the annual meeting or CSM. Another possibility might be to assign a mentor to candidates at the time of registration for the GCS exam. The mentor could help the candidate prepare, and the candidate would have an opportunity to do the same next year for another person preparing. The mentorship role need not disappear after the exam. The mentor, now having a relationship with the mentee could share different opportunities that are available and invite that person to participate in a Section role or activity.

A blast cast, maybe in the form of a video e-mail, would also be another method that could be used to recruit new members for tasks. The video could describe what the position is and the amount of time the person needs to dedicate to it. Lastly, this might sound outlandish, but maybe we should consider developing a mechanism that applies the time spent on a committee toward annually required state CEUs.

DIRECTOR

Danille Parker, PT, DPT, GCS, CEEAA

Education: Bachelors of Health Science and Masters of Physical Therapy from Nova Southeastern University, Doctor

of Physical Therapy from Loma Linda University

Employer and Position: Clinical Assistant Professor, Director of Clinical Education at Marquette University Department of Physical Therapy

1. What experiences would you bring to the position of Director that makes you a strong candidate? I have had the privilege of being involved in the Section on Geriatrics (SoG) through a variety of service roles. Serving as committee member initiated my understanding of the organization and the goals each committee strived to achieve. As Regional Course Committee Chair for the last 5 years, I have taken part in increased responsibilities within the Section, have developed very strong organizational and time management skills and have had the opportunity to foster growth of the CEEAA course series throughout the US. The last 3 years in my role as Director within the Section have provided me with a diverse perspective on the inner working of various committees. I have had the privilege of working closely with many committees and committee leaders and I have been able to share, support and represent these committees and their members within the Board of Directors (BoD) can easily foster a supportive and open environment between members, committees, and the BoD. Within my time of service I have worked closely with many PTs throughout the US to further the development of the geriatric practitioner. I am aware of the needs of geriatric PTs and how we at the SoG can better serve our members.

2. What current or future Section activities would you like to advance as a member of the Board of Directors and how do you plan on achieving this? An activity I would like to advance as a member of the BoD, is to increase membership

within the SoG. I believe we can accomplish this by promoting the SoG as an exceptional value to physical therapists who work with the older adult. The SoG can be the primary source of easily accessible information, providing evidence-based support on a variety of topics to the geriatric practitioner. Another activity to advance would be to continue to promote the concept of optimal aging of the older adult. We can achieve this by continuing to promote and support the CEEAA series and spreading the message that Physical Therapists are the practitioners of choice when working with an older adult to a worldwide audience. I would also like the SoG to expand and provide an increasing platform for the state advocate committee and increase our representation at the state level. The increase in SoG participation and representation

at a variety of state wide activities will allow us to reach a new audience of physical therapists nationwide.

3. What is the greatest challenge facing the geriatric practitioner and how can the SOG help?

There are numerous challenges facing the geriatric practitioner today. At the forefront is the current Medicare reform and declining reimbursement rates. As advocates to its members, the SoG must continue to work in conjunction with the APTA and their legislative ties to foster a cost effective, yet not cost prohibitive, rehabilitation environment. Another challenge is the ever-growing expectations and requirements placed upon physical therapist practitioners. With the increasing demands for quality and outcome driven care and performance placed on

therapists, the SoG is in a premier position to provide valuable resources, information, and assistance to clinicians to navigate the recent health care challenges. The SoG can help members makes sense of all of the changes and efficiently translate these changes into practice solutions.



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CALL FOR NOMINATIONS

Section on Geriatrics AWARDS 2013



Student Research Award

Recognize outstanding research-related activity completed by entry-level physical therapy students.

Clinical Educator Award

Recognize physical therapists or physical therapist assistants for outstanding work as a clinical educator in geriatrics health care setting.

Fellowship for Geriatric Research

Recognize physical therapists pursuing research in geriatrics which may be conducted as part of a formal academic program or a mentor ship.

Excellence in Geriatric Research Award

Honor research published in peer-reviewed journals based on clarity of writing, applicability of content to clinical geriatric physical therapy, and potential impact on both physical therapy and other disciplines.

Adopt-A-Doc Award

Recognize outstanding doctoral students committed to geriatric physical therapy, provide support to doctoral students interested in pursuing faculty positions in physical therapy education, and facilitate the completion of the doctoral degree.

Clinical Excellence In Geriatrics Award

Recognize a physical therapist for outstanding clinical practice in geriatric health care settings.

Distinguished Educator Award

Recognize a Section on Geriatrics member for excellence in teaching.

Outstanding Physical Therapist Assistant Award

Recognize a physical therapist assistant who has significantly impacted physical therapy care in geriatric practice settings.

Lynn Phillippi Advocacy for Older Adults Award

Recognize projects or programs in clinical practice, educational, or administrative settings which provide strong models of effective advocacy for older adults by challenging and changing ageism.

Volunteers in Action Community Service Award

Recognize the exceptional contribution of a physical therapist or physical therapist assistant in community service for older adults.

Joan Mills Award

Presented to a Section on Geriatrics member who has given outstanding service to the Section.

**Nominations are due November 1, 2013 and
all awards will be presented at the Section
Membership Meeting at CSM in February of 2014.**

For additional information on the criteria and selection process for section awards, please visit the
Section on Geriatrics website at www.geriaticsppt.org
or contact the office by email at karen.curran@geriaticsppt.org or by phone at 866/586-8247.

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For age is opportunity, no less than youth itself,

*though in another dress, and as the evening twilight fades
away, the sky is filled with stars, invisible by day.*

- Henry Wadsworth Longfellow

Section on Geriatrics - APTA

GERINOTES

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