

GERINOTES

Academy of Geriatric Physical Therapy, American Physical Therapy Association

President's Message: Volunteerism

Editor's Message: There are Many Ways to Volunteer!

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Facilitating the Interdisciplinary Team Model Through Interdisciplinary Orientation

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Rediscovering the Flow of Communication: A Student's Perspective

Chart and Soul

Connecting, Productively

From Ohio to Quintana Roo: A Reflection on Service

Learning by DPT Students from the University of Cincinnati

In it for the Long Haul: What Being a Geriatric Rehab
PT has Taught Me About Marathon Training

Autonomous Practice in Physical Therapy to Progress the
Wellness and Function of the Geriatric Population

Filing for Public Assistance Benefits for My Parents: Where Do I Begin?

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IN HONOR/MEMORIAM FUND

Each of us, as we pass through life, is supported, assisted and nurtured by others. There is no better way to make a lasting tribute to these individuals than by making a memorial or honorary contribution in the individual's name. The Academy of Geriatric Physical Therapy has established such a fund which supports geriatric research. Send contributions to:

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Also, when sending a contribution, please include the individual's name and any other person you would like notified about your contribution. If you are honoring someone, a letter will be sent to that person and if you are memorializing someone, the surviving family will be notified of your contribution.

In the field of geriatric physical therapy, we receive many rewards from our patients, associates and our mentors. A commemorative gift to the Academy of Geriatric Physical Therapy In Honor/Memorial Fund is a wonderful expressive memorial.

PRESIDENT'S MESSAGE: VOLUNTEERISM

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



Merriam-Webster's dictionary defines volunteerism as the act or practice of doing volunteer work in community service. But volunteerism is also

giving one's time or talents for charitable, educational, or other worthwhile activities. In the United States, volunteering is as old as a barn raising. Meaningful activities through volunteerism greatly contribute to a person's ability to age successfully. Not that volunteering is only for older adults. We need to find a way for younger adults to volunteer. Many reasons and benefits exist to volunteer. These may include self-satisfaction, socialization, altruism, potential learning or acquisition of new skills, relaxation, status or reward, career opportunities, community, or organizational improvement. Donating the gift of time to a charitable organization can be a great way to support a cause. I donate several hours of my time to both the Arthritis Foundation and the Alzheimer's Association during the year.

Many people who volunteer for the APTA or one of their components say they want to "give back" to their profession and by doing this they, in turn, get something back. This *payback* can be something as little as saying thank you.

I often say about my volunteer efforts "you get a hearty handshake, a pat on the back, and a good feeling in your heart." Everyone can use a boost in self-esteem every once in a while.

With busy lives, finding the time to volunteer can be very difficult. However, the benefits of volunteering can be enormous for you, your family, and your organization or community. Volunteering should be a win-win situation. The right match can help you find friends, learn new marketable skills, make contacts for future employment, and even advance your career. Volunteering may also help protect your mental and physical health. If you're considering a new career, volunteering can help you get experience in your area of interest and meet people in the field. Even if you're not planning on changing careers, volunteering gives you the opportunity to practice important skills used in any workplace, such as teamwork, communication, problem solving, project planning, task management, and organization. You might feel more comfortable stretching your wings at work once you've honed these skills in a volunteer position first.

Volunteering offers you the chance to try out a new career without making a long-term commitment. Volunteering is also a great way to gain experience in a new field. In some fields, you can volunteer directly at an organization that does the kind of work you are interested in. For example, remember when you

first thought about physical therapy as a career, and you volunteered at a hospital, clinic, or a nursing home? You gained insights into a profession you would eventually join. Your volunteer work might also expose you to professional organizations or internships that could be of benefit to your career.

The Academy is classified as a 501(c)(3) private foundation. We are, in fact, a volunteer run charitable organization. The Academy benefits from the time and efforts of those who serve on the Board of Directors, the Committee Chairs, and Committee members. Many members who serve on committees need only give a few hours a year to help out our organization and travel is not required. Finally, I want to say thank you to all our Academy volunteers and urge everyone else to join in the spirit to give back to your profession.

WANTED: ARTICLES FOR GERINOTES

TOPICS: Anything related to older adults **CLINICIANS:** Send me an article or an idea
STUDENTS AT ANY LEVEL: Send me papers you wrote for class **EDUCATORS:** Send me student papers

Everyone loves to publish and it is easy!
Contact Meri Goehring, GeriNotes Editor, at goehrinm@gvsu.edu

EDITOR'S MESSAGE: THERE ARE MANY WAYS TO VOLUNTEER!

Meri Goehring, PT, PhD, GCS



This issue of *GeriNotes* has some messages about volunteerism that are close to my own heart. The spirit of volunteerism is very apparent in the article by

Susan Priem entitled, "Thoughts on Volunteering." Providing volunteer services to others is something that we, as a profession, are committed to, but may, in practice, find difficult. The secret, as Susan found, is to do something you love. In this case, Susan discovered a way to match her lifestyle choices with an effort to help the community engage in healthy behaviors. It turned out to be a wonderful experience for her as well as for the community. And, she is a Geriatric Academy state advocate.

Other articles, two by DPT students, and one by a physical therapist assistant remind us that taking a bit of extra time with our patients is one way to 'volunteer.' As Brett Cain (student) in his article, "Chart and Soul" and Amy Kriby (PTA) in her article titled, "Connecting, Productively," taking a few minutes to visit with someone, sit by his or her side, and hear their story might just help a patient's spiritual and/or mental health. And, despite the already busy schedules that most of us have, it is important to remember that a little extra unbillable time might make all the difference in your patients' lives. The other student article, by Trisha Armstrong, emphasizes the importance of taking the time with other health professionals to improve communications with our patients. Certainly, volunteering may lengthen your day. Yet, the time spent with occupational and/or speech therapists and/or with your patients could make all the difference in helping them to improve.

As I reflected on my own practice, I realized that I volunteer as well, but at times in a rather unconventional way. My more typical volunteer work consists of supervising PT students as they

examine, evaluate, and treat outpatients in a pro-bono clinic. This clinic provides physical therapy to the uninsured and underinsured on a 4-hour per week basis during the school terms of the university where I teach. We often see individuals who have complex problems and are not easy to examine. Many have some kind of chronic pain and may not have had much in the way of conservative treatment. Some have associated psychosocial problems that make effective education and/or treatment very challenging.

The other type of volunteer work that I do that may be considered unconventional relates to my writings. I have started writing poetry and short stories in my spare time. Some of my poems have been published in a literary journal. I am including one poem in this editorial. It relates to a large combination sub-acute and long-term care environment I once worked in. Long ago, it was considered the 'County Home' in the city where I now reside, thus the title. It is reprinted here by permission and was originally published in "The Muse International" December issue, 2013, available at <http://themuse.webs.com/latestissues.htm>.

The poem was written one early December when I was totally exhausted from the physical therapy evaluations and treatments I had provided at the facility that day, yet still inspired by the patients I had seen.

I have, since then, had three other poems published about my experiences with patients. I have also submitted a short story to a literary magazine and am awaiting a decision regarding its acceptance or rejection. I find this kind of writing is a good way for me to manage

my own feelings and to connect with others who may be moved to share or write.

The take home message is that you need not feel obligated to volunteer in any ONE way. The point is to find something to share that may be meaningful to you as well as to others. Adrienne Nova, Kenneth Miller, Matt Elrod, and Timothy Hanke found that writing information articles for *GeriNotes* is a great way to volunteer. In this issue, you will find good information regarding how running might help you practice, how home health roles have changed, how to work as an interdisciplinary team, and how clinical practice guidelines can be useful to your practice. And, we have some new volunteers this issue. Jeffrey Guild has provided some great information about autonomous practice. And Patrice Antony's article on how to file for benefits on behalf of aging parents is full of helpful information.

If you have found way to volunteer, please share your message. *GeriNotes* members would love to hear from you. And if you have not, please consider becoming a State Advocate and/or a writer for *GeriNotes*. We welcome your input.

Meri Goehring is an Assistant Professor in the Physical Therapy Program at Grand Valley State University (GVSU) and works as a clinician at Spectrum Center for Acute Rehabilitation at Blodgett Hospital in Grand Rapids, Michigan.

County Home, Michigan
Sadness and boredom prevail.
Television reverberates, odors nauseate.
Profoundly disabled, their perspectives humble.
Calmed by the sunset through the trees,
I sense the frigid lake in the sky
And wonder how to live.

AGPT STATE ADVOCATES

Beth Black, PT, GCS

Have you heard about the Academy of Geriatric Physical Therapy's State Advocates? We have many State Advocates who are working on local issues in their states. Some of the current projects include:

- Organizing state-wide Falls Prevention Awareness Day events on September 23, 2014;
- Facilitating study-groups for the 2015 Geriatric Clinical Specialist;
- Developing a relationship with a state agency that handles elder issues;
- Working with the local fire department to train caregivers how to safely evacuate residents from a 6 bed care facility in case of fire or earthquake;
- Participating in the ABC Diabetes events during the summer and fall;
- Holding a consumer awareness seminar at local Senior Apartment complex/facility;
- Conducting a research project relating to re-hospitalization rates and use of rehabilitation in addition to nursing care to further reduce rates;
- Providing two-way communication between AGPT and the chapter;
- Completing and recruiting PT/PTA/ students for Senior Athlete Screens at State Senior Games in spring & fall;
- Teaching "Stepping On" Falls Awareness 7 week course & recruiting new leaders, with assist from Nevada Goes Falls Free Coalition;
- Connecting with state PT/PTA programs to involve students in community programs on volunteer basis;
- Contacting officers of state and local agencies for the aging (NCOA, AAA, Dept of Public Health, etc) to offer services (EBPs, fall screening) as a PT and to connect with them for planning future events;
- Implementing the Stay Active and Independent for Life (SAIL) program in a senior center/LTC facility or a hospital-based outpatient clinic as a community outreach program to prevent falls in geriatric population; and

- Communicating with AGPT members in your state when there are geriatric-related issues, courses, meetings, etc in your chapter.

Sound interesting? We have many State Advocates now throughout AGPT, but are missing Advocates from the following states:

Alaska
Arizona
District of Columbia
Florida
Hawaii
Indiana
Kansas
Kentucky
Mississippi
Nevada
New Jersey
North Dakota
Ohio

Oregon
Pennsylvania
Rhode Island
South Dakota
Texas
Utah
Vermont
Virginia
Wisconsin
Wyoming

If you are interested in volunteering to be your State Advocate for AGPT, please contact Beth Black, PT, GCS, AGPT State Advocate Coordinator, at BBlack-PT@gmail.com . If you would like more information from your State Advocate to know what is happening in your state, go to the AGPT web site, under the tab "Members," select "Member Resources" to access your State Advocate's contact info.



2014 AGPT Election

IMPORTANT INFORMATION:

As in past years, the election will be online and take place October 1-31, 2014.

Please watch your email and www.geriaticspt.org for more details.

If you do not have an email address on file with the Academy office, or you requested not to be contacted via email, please contact geriatrics@geriaticspt.org to request a paper ballot.

Those elected will take office at CSM in February of 2015. As per AGPT Bylaws, only PTs and PTAs vote in Academy elections.

STATE ADVOCATE CORNER: THOUGHTS ON VOLUNTEERING

Susan Priem, PT, MHS, CEEAA

Physical therapy professionals as a group have strong values to volunteer. We choose many avenues, but at this point in a 25+ year career in multiple settings and areas of physical therapy, I wanted to volunteer for something that was not giving a lecture or providing assistance in a medical tent. I wanted to use my knowledge as a PT to assist a cause that was important to me.

When I decided to give up my car and live life car-free, I became a big advocate of exercise being incorporated into a daily lifestyle. I became more and more aware of how dominated our culture is by cars and that we were giving up more and more of our infrastructure to roads. At the same time, a cycling mentor encouraged me to apply to be on the Board of Directors for the Minneapolis Bicycle Coalition (www.mplsbike.org). I was particularly interested in their goal of a *ciclovía*—closing down a major street on a Sunday afternoon to allow play in the streets without the interference of cars. This hit all my values—decreased environmental pollution, support of local business, safely engaging in outdoor activity,

consumption of healthy food, and the opportunity to try something new for physical fitness.

I began what was a remarkable journey in helping to establish Open Streets. To get an idea of the event and all the fun, go to www.openstreetsmpls.com—a first for the City of Minneapolis. In my volunteer role, I helped facilitate the activities on the street—making sure they were fun, energetic, and applicable to all age groups. My knowledge gained from working in a level one trauma center helped keep the route and activities safe. I got the chance to meet civic, business, and governmental leaders, and interact with the police and understand their perspective on safety. I had to learn to interact with the media on the spot (and doesn't our daily work with our patients facilitate that skill?). Most of all, every

event was “two miles of smiles from curb to curb” with all ages, ethnicities, and genders moving and exercising while having fun. My crowning achievement was convincing my employer, Hennepin County Medical Center, to become a major sponsor. Our physical therapy department contributed a balance challenge and our EMTs taught CPR in the street. Check out the pictures of our mascot Bernie riding a Nice Ride (our local bike sharing system). The young and old simply love Bernie!

I received back so much more than I gave. This opportunity to volunteer challenged me and at the same time allowed me to develop skills I had from my physical therapy experience, but in a unique and different setting. Being able to influence public health policy in conjunction with supporting



CPR training on the street during “Open Street” activity.



Former Minneapolis Mayor, R. T. Ryback.



Crowd during “Open Street” activity. There was an estimated 10,000 people in attendance.



Bernie the Hennepin County Medical Center mascot riding a Nice Ride, a shared bicycle system within the city.



Physical therapy department's balance challenge.

our profession is a win-win-win. I am better equipped and better connected to speak about our profession with leaders who set policy that affects the physical therapy profession and our patients. It is wonderful to be recognized as a civilian

expert on cycling, transportation, and infrastructure. I challenge all of you to seek out a similar experience (many cities now have a yearly cyclovia or open street event). Or, better yet, find something different—the results are amazing!

Susan Priem hails from Minneapolis, Minnesota. She is a graduate from the Mayo School of Health Sciences and Washington University of St. Louis. When not at work, you will most likely find her riding her bike.

Susan is the Minnesota State Advocate for the Academy of Geriatric Physical Therapy. We have many State Advocates now throughout our section, yet are missing ones from Arkansas, Arizona, District of Columbia, Florida, Hawaii, Kansas, Kentucky, Mississippi, Nevada, New Jersey, North Dakota, Ohio, Oregon, Pennsylvania, Rhode Island, South Dakota, Texas, Utah, Vermont, Virginia, Wisconsin, and Wyoming. If you are interested in volunteering to be your State Advocate for AGPT, or would like more info from your State Advocate, please contact Beth Black, PT, GCS at BBlackPT@gmail.com

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VISION 2020 AND DEVELOPING ROLES FOR THERAPISTS IN THE HOME HEALTH SETTING

Kenneth L. Miller, PT, DPT, CEEAA

The following article first appeared in the Quarterly Report Newsletter (without headings), a publication from the Home Health Section of the American Physical Therapy Association. Increasingly, physical therapists are assuming new roles throughout the various practice settings and the purpose of this article is to highlight several of these new frontiers. The original citation is: Miller KL. Emerging Frontier: Vision 2020 and Developing Roles for Therapists in the Home Health Setting. *The Quarterly Report*. 2013;48(3):1, 2-5.

INTRODUCTION

I am excited that I was asked by the publication committee of the Home Health Section to write on the topic of developing roles for therapists in home health. As it turns out, I have a rare and unique vantage point from which to write. I have the role of clinical educator for a progressive, forward-thinking non-profit home health agency. Why do I say the agency is a progressive, forward-thinking organization? Having physical therapists serve as clinical educators is a rare occurrence in the current home health environment, but may become more common place as reimbursement is more strongly linked to outcomes and patient experience. In home health, the functions of a clinical educator are generally carried out by the Director of Rehab or by clinical educators with a nursing background (also called Nurse Educators). In an informal poll of clinicians and administrators at the Combined Sections Meeting of the American Physical Therapy Association (APTA) in San Diego three months ago, I was hard pressed to find colleagues who shared my role in their respective organizations. I was told time and again that the Rehab Director conducts orientation and determines competency.

CLINICAL OPERATIONS VS PERFORMANCE IMPROVEMENT

Traditionally, the Director of Rehab works on both the clinical operations side of the organization and on the performance improvement/quality assurance side of the organization in all things related to therapy. Anything related to nursing was left to nursing.

Having worked in a “former life” as a quality control inspector for an auto parts manufacturer while putting myself through college, I understand the inner workings of the quality department and the production department as agonist and antagonist. Early on, I saw the yin and yang of this relationship. Is there any difference in a home health agency? Not really. Decisions that improve quality often reduce productivity and vice versa. It is rare when a decision is made that improves both quality and productivity at the same time. Most often, the Director of Rehab has responsibilities to both productivity and quality and is always looking for balance between both.

CHANGING VISION (INTERDISCIPLINARY VIEW)

In order to survive the value-based reimbursement system evolving in health care today, I believe organizations need to make room for professionals in existing disciplines to take on new, non-traditional roles in order to encourage a macroscopic view of operations that will enhance quality and better prepare the organization to meet the coming changes.¹ Organizations are looking to provide interdisciplinary care to patients, improve patient outcomes, and patient experience, but the interdisciplinary focus is overwhelmingly related to clinical interactions and not administrative functions. Restructuring the organization by removing the performance improvement/quality assurance responsibilities from the Director of Rehab and moving them to an interdisciplinary (inter-professional) department that includes nursing, therapy and

social work may allow for more focused decision-making. Allowing this team to view quality improvement concerns from their respective disciplines may move the organization toward solutions that are otherwise invisible from the single discipline approach. Social workers in home health organizations have the skill set to look closely at policy from macro, mezzo and micro views for fairness and equity. Social workers also look at the patient through an ecological, bio-psychosocial lens. Nurses and therapists look at the patient from a medical model perspective. Nurses and therapists each have their own discipline specific skill sets to bring to the table as well. Combining these disciplines into a team charged with improving organization performance provides a unique opportunity to examine care quality from a variety of perspectives. The role of clinical educator is usually aligned with quality assurance/performance improvement (QA/PI) rather than in clinical operations. My organization has this structure in place: the clinical educators provide for classroom training, coordinate the preceptor program and begin the transition process towards productivity based on the needs of the new employee. In this way, the focus of clinical education is on providing appropriate, quality care at all times. An illustration of this focus can be seen with a new employee orientation program that provides adequate time for the new employee to demonstrate competency and follow the regulations, policies and procedures independently. Productivity is not a priority during the orientation process, but becomes a focus once the

employee has completed orientation and has transferred to clinical operations, where he/she gradually increases his/her case load to the required productivity level. Potential pressures to get the new employee seeing cases are minimized with this table of organization structure.

For my organization, bringing experienced clinicians from a variety of disciplines together into an interdisciplinary clinical education team has allowed team members to train together, grow together and understand each other's role more fully and clearly. The nurses, therapists and social workers have exchanged cell phone numbers with each other (on their own) and have formed bonds that have positive results in the field and the interdisciplinary team meetings.

INTERDISCIPLINARY EDUCATION

In addition, being able to design and implement clinical programming for nurses and therapists within the clinical education department with both disciplines involved has offered insight into discipline-specific needs, as well as to where overlapping skills exist. The interdisciplinary nature of the clinical education department has also assisted in tailoring training to be patient-focused rather than discipline-focused. This collaboration may also facilitate more accurate OASIS data collection due to the therapists learning how the nurses answer the wound questions and the nurses understanding how the therapists answer the functional questions. Physical therapists are needed as clinical educators to improve performance and quality within their organizations, but they are also needed in clinical education roles in order to advance the profession's values for lifelong education, evidence-based practice, and professionalism. In 2000, the House of Delegates (HOD) of the American Physical Therapy Association (APTA) adopted the Vision 2020 statement as its official statement for the future of Physical Therapy.² The statement contains several key elements, including operational definitions of autonomous practice, direct access, lifelong education, evidence-based practice, practitioner of choice and professionalism. Looking at the key elements of lifelong learning, evidence-based practice and especially professionalism, it is

critical to have therapists in the clinical educator role to foster and advance these elements of vision 2020 in all practice settings. Therapists as clinical educators can model evidence-based practice in action and promote lifelong learning activities.

COMMITMENT TO SOCIETY

As we approach 2020, the APTA is now looking beyond Vision 2020, seeking to articulate the profession's commitment to society.³ "The proposed vision addresses the charge from the House of Delegates to go beyond the internal focus of Vision 2020 and reflect the contribution of the physical therapy profession to the health of society".³ The profession of physical therapy is evolving, as shown by looking at the internal focus of Vision 2020 and the outward focus of the proposed Beyond Vision 2020 statement.

In the thirty-first Mary McMillan Lecture, Dr. Ruth Purtilo presents a shifting landscape using the code of ethics as the tool to demonstrate the changes.⁴ She talks about the profession of physical therapy having three seasons. The first season is called the period of Self-Identity and this can be seen in the code of ethics from 1935, in that the patient was not the explicit focus of the statements. It was during this season that seeds were planted and the formation of the health care team was born. The second period "from the 1950s to the present" [2000], has been to show care through establishing a true partnership with patients as persons.⁴ The informed consent document was created during this period. This season coincides with civil rights advocacy, the patient's bill of rights, legislation for Medicare and Medicaid, and the constitutional right to privacy.

CODE OF ETHICS

Amazingly, the transformation from self-identity to a patient-focused identity can be seen in the code of ethics.^{4,5} In the Code of Ethics from 2000, the role of the physical therapist was defined as the focus on the patient client management role.⁵ It is the revised code of ethics [2010] that speaks to Purtilo's third season, the period of societal identity. Dr. Purtilo suggested becoming full partners with society. She states, "...physical therapists must demand appropriate care

for all patients who can benefit from more physical therapy interventions than from those of any other group or by any other means, then partner with society to find the resources to make this possible. Second, we can use what we have learned from our successes in developing a patient-focused identity to make a compelling case for how we can work with society to ensure that a well-defined area of basic patient needs can be met in the new season."⁴ The current code of ethics addresses five (5) roles: management of patients and clients, consultation, education, research, and administration.⁵ The additional roles defined in the revised code are important as the profession moves forward to stay relevant in the changing health care environment. With health care professions jockeying for position to receive Medicare dollars, it is absolutely essential and paramount for those in these roles to hold to the core values of professionalism and advocate for the needs of patients and society. Advocating for the profession first will fall on deaf ears and show the profession in a negative light as self-serving.

AUTONOMOUS PRACTICE

The concept of autonomous practice as defined in the Vision 2020 statement is integral to advancing the profession into the season of societal identity. Autonomous practice is accepting the "responsibility to practice autonomously and collaboratively in all practice environments to provide best practice to the patient/client." This does not mean practicing in isolation, but rather showing independent, self-determined, professional judgment and action. Physical therapists demonstrate core values by "aspiring to and wisely applying principles of altruism, excellence, caring, ethics, respect, communication and accountability, and by working together with other professionals to achieve optimal health and wellness in individuals and communities."² When applying these values, the therapist is sowing seeds of care and responsibility on an individual basis that will have a dramatic effect on society collectively.

Swisher and Hiller⁵ report that the two types of seeds that Dr. Purtilo spoke of — the seeds of care and seeds of accountability — were planted in the 2010

revised code of ethics, however, Swisher and Hiller report “not knowing how well the seeds will root as they do not know if the profession has engaged in a robust moral dialogue about its obligations to patients, clients, students, colleagues, organizations, and society as a whole.”⁵ Therapists working in roles outside of patient/client management have a great opportunity to plant these seeds and create dialogue for the agencies and organizations they work for and represent. Clinical educators, administrators, and researchers all have a voice to share in society, especially now that value based purchasing is on the near horizon. Therapists working as consultants have opportunities advocate for patient needs at the Centers for Medicare and Medicaid Services (CMS) Open Forums. Therapists assume additional roles in advocating for needed policy changes at federal, state, or local levels. Other non-traditional roles that therapists may fill in the home health agency include positions in the quality assurance/performance improvement department. Utilization review, medical records review (MRU), Oasis review, performance auditors and compliance auditors are some of the responsibilities in this area and performance of these functions may be more effective when there are multiple disciplines involved. The APTA HOD has adopted a statement on QA/PI that advocates member participation in quality assurance and performance improvement activities which are incorporated into daily practice. “The commitment to quality assurance and performance improvement is primarily a professional responsibility and is to be promoted and fostered by Association members through individual and collective efforts.”⁶ Therapists and nurses working in home health have trained for and received Oasis certification designations (COS-C). Isn't it prudent for both disciplines to be involved in the document review process? The APTA Board of Directors has published guidelines for peer review training with the intent of educating “physical therapists to: (1) uphold professional standards, (2) be accountable to the public, and (3) be consistent in interactions with payers and managed care organizations.”⁷ Is it not best practice to use the strengths of the broad range of professions throughout the home health agency?

CONCLUSION

In this time of uncertainty in health care, the physical therapy profession has moved into the season of societal identity. Therapists need to look beyond their traditional roles in patient care to create new opportunities to advocate, to teach, to administer, to research, to work in public health, to work in quality assurance and performance improvement. We also need to be open to future prospects for collaboration and frontiers for the profession that may be inconceivable today.

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Kenneth L. Miller is the clinical educator for Catholic Home Care and Good Samaritan Home Care where he provides staff development, orientation, compe-

tency, continuing education, and training to nursing, therapy, and social work staff using best practice and evidenced-based practice tools. Dr. Miller is a recipient of the Home Health Section Research Grant and is currently involved in a RCT involving management of chronic heart failure in the home environment.

Dr Miller is the Co-Chair of the Practice Committee of the Home Health Section of the American Physical Therapy Association (APTA), as well as a member of the Practice Committee of the Section on Geriatrics of the APTA. He may be reached at kenmpt@aol.com or Kenneth.miller@chsli.org.

FACILITATING THE INTERDISCIPLINARY TEAM MODEL THROUGH INTERDISCIPLINARY ORIENTATION

Kenneth L Miller, PT, DPT, CEEAA

The following article first appeared (without headings) in the Quarterly Report Newsletter published by the Home Health Section, of the American Physical Therapy Association. The topic of Interdisciplinary care modeling is an important one for all practice settings and thus is being reprinted here with the permission of the Home Health Section and the author, Kenneth L Miller, PT, DPT, CEEAA. The original citation is: Miller KL. Facilitating the Interdisciplinary Team Model through Interdisciplinary-Orientation. *The Quarterly Report*. 2013;48(3):12-14.

BACKGROUND

As the United States Government seeks to solve its broken health care system through efforts and mandates from the Affordable Care Act (ACA) in 2010, the health care delivery system is experiencing changes to all facets of care provision. In Title III of the Law, provisions enacted are being put in place to link payment to quality through the value-based purchasing program.¹ In addition the ACA encouraged the development of new patient care models through accountable care organizations (ACO) and payment bundling. The expansion of ACOs, bundling and Innovations projects are being implemented across the country and the full impact of these system changes has yet to be realized. The purpose of this article is to introduce an interdisciplinary orientation program designed to facilitate an interdisciplinary care delivery model to realize true efficiency in care delivery where better outcomes are achieved in fewer visits.

INTERDISCIPLINARY AND MULTIDISCIPLINARY CARE MODEL

The traditional care delivery model parallels the traditional health care provider educational model in that delivery and academic training occurs in a silo model approach where the health care professional, regardless of discipline, practices more or less in a vacuum apart from the rest of the team. This is evident by observing the lines of communication/collaboration in many organizational structures throughout health care. Even though these same organizations label themselves as *interdisciplinary*, the model is a *multidisciplinary* care delivery

model. Typically, the lines of communication run vertically from the field clinicians to their respective discipline manager or director. The horizontal interdisciplinary communication/collaboration occurs between the supervisors/managers/directors of nursing, rehab and social work. Following this communication model, the focus remains isolated and discipline centric. Even though the different disciplines meet during case conferencing, the *multidisciplinary* approach is followed. Confusion regarding *interdisciplinary* and *multidisciplinary* care exists because these terms are often used interchangeably. Multidisciplinary team approaches “utilize the skills and experience of individuals from different disciplines, with each discipline approaching the patient from their own perspective.”² Interdisciplinary team model approaches “integrate separate discipline approaches into a single consultation. That is, the patient-history taking, assessment, diagnosis, intervention and short and long term management goals are conducted by the team, together with the patient, at one time.”² The team members are encouraged to step out of “discipline silos” to work toward the best outcome for the patient.² Movement from discipline centeredness toward patient centered care and community engagement is a key to improving outcomes and is supported by the ACA.^{1,3}

The arrival of the twenty-first century prompted many organizations to assess the health care education system, including the Global Commission on Education of Health Professionals for the 21st Century.⁴ Two of the organization’s recommendations speak directly

to the purpose of the interdisciplinary orientation program that has been implemented at Catholic Home Care. The Commission recommended the “promotion of inter-professional and trans-professional education that breaks down professional silos while enhancing collaborative and non-hierarchical relationships in effective teams.”⁴ The other recommendation that speaks to the purpose of the interdisciplinary orientation program is the promotion of “a new professionalism that uses competencies as the objective criterion for the classification of health professionals, transforming present conventional silos.”⁴

Orientation

The orientation program implemented at Catholic Home Care is interdisciplinary in that the clinical educators include a physical therapist and registered nurse who co-instruct the material. The new employees (field staff) are trained together where appropriate (therapists, nurses, social workers and home health aides). For example, the OASIS training class includes the therapists and registered nurses as participants and the instructors are both therapists and nurses who provide their discipline specific perspective in a holistic way to all participants.

Competency

As for competency, the different disciplines work together where appropriate by licensure on the core competencies and core practical education. A fitting example of this is the Hoyer lift competency for home health aides. The nurses and therapists also attend the

Hoyer training for educational purposes. A pleasant byproduct of the combined class was that the nurses and therapists assisted in instructing the home health aides and each other in use of the Hoyer lift during the practical/lab part of the class. This was a spontaneous interaction that was nice to see as the field staff began to communicate with each other and support each other, breaking down the silo walls.

A pilot study introducing medical students to an interdisciplinary health care team reported that the participants increased their understanding of other health professions, including when to refer to and collaborate with the other health care professionals.⁵ One of the many benefits of providing training in an interdisciplinary model includes clarification of role identity, role ambiguity is less an issue as the varying disciplines are trained together. The field staff is better equipped to refer to other disciplines. For example, a physical therapist had a patient who needed to have grab bars installed in her home and the PT was unsure how to go about getting this done. The PT ended up texting a social worker on the team who had contacts for this service. The MSW provided this information to the PT, who then gave the information to the patient to use.

We have found that clinicians who have trained together form lasting bonds and look to each other as resources once they have completed orientation and have moved on to clinical operations. The interdisciplinary team meetings where patients are discussed demonstrate this closeness, as the different disciplines sit interspersed in the meeting. The therapists, nurses and home health aides are not all clustered together by discipline and the staff, having gone through orientation together, regardless of discipline, sit near each other. In fact, new employees, regardless of discipline, have exchanged contact information with each other without prompting from the clinical educators and managers, showing an increased need and willingness to communicate with each other.

Patient-Centered

Another benefit of the interdisciplinary team model is regarding the shift of thinking from discipline goals towards patient-centered goals. Getting the patient involved in the plan of care

is critical to improving the outcomes. If the plan of care is solely generated by the clinician in a silo, without collaboration with other disciplines, two unfortunate things happen: (1) the care plan cannot have a layered intervention effect and (2) the patient may be unaware of the plan of care and thus unaware of his involvement in the process.

I have seen a layered intervention effect when the goals are patient centered and the varying disciplines collaborate in assisting the patient in meeting this goal. An example of a patient centered goal is as follows:

Patient goal: "I do not want to be re-hospitalized while on home care services." If the patient has heart failure as a diagnosis, one of the strategies to reduce/prevent re-hospitalization is to take daily weights. As an interdisciplinary team, the layering intervention is for nursing to go over the medical reason for daily weights in their teaching interventions, for the physical therapist to instruct the patient how to step on the scale and take their weight (ie, reinforcing the nurse's instructions) and finally, have the home health aide do the daily weights during each visit that the aide performs. This provides layering to the patient where each discipline covers the importance of the daily weights from his/her perspective and job function. If a nurse is visiting the patient 2x per week, the therapist is 2x per week and the home health aide is 3x per week, then there are 7 opportunities to discuss and perform daily weights instead of 2 if the nurse alone addressed this subject. Additionally, actually doing the weights during the various visits impresses upon the patient more urgency to perform the daily weights.

CONCLUSION

By using an interdisciplinary model with patient centeredness as the hub of the plan of care, the patient is involved in every facet of the plan of care. By being at the hub, the patient is more

involved in carrying out his part in the plan and the outcomes are sure to be better and occur in fewer visits. The interdisciplinary team approach to orientation, competency and care delivery is the way of the future and will be more apparent as the value based purchasing reimbursement changes, along with the new care delivery organizations of the ACOs, take over the health care system in this country.

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Kenneth L. Miller is the clinical educator for Catholic Home Care and Good Samaritan Home Care where he provides staff development, continuing education, and training to the rehab staff using best practice and evidenced-based practice tools. Dr. Miller is a recipient of the Home Health Section Research Grant and is currently involved in a RCT involving management of chronic heart failure in the home environment. He can be reached at kenmpt@aol.com or Kenneth.miller@chsli.org.

CPGS: WHAT ARE THEY AND HOW IS APTA SUPPORTING THE SECTIONS TO DEVELOP THEM?

Matt Elrod, PT, DPT, MEd, NCS

The concept of clinical practice guidelines (CPGs) has been around for thousands of years as a way to provide the best care for the patient. They exist for many disciplines in many forms, but in the United States, the National Guidelines Clearinghouse (www.guideline.gov/index.aspx) is the primary repository for CPGs. Currently there are over 12,000 CPGs listed on this site, each intended to improve the effectiveness, safety, outcomes, and efficiency of health care.

As you might imagine, thinking around CPGs has evolved over the years. In the early 1990s, the Institute of Medicine (IOM) released several reports on the use of a modern CPG. At that time, the CPG became more focused on using the best available evidence to develop graded recommendations.

As part of the ongoing effort to use evidence to improve the quality of CPGs, the IOM published *Clinical Practice Guidelines We Can Trust*¹ in 2011. This document states that CPGs “are statements that include recommendations intended to optimize patient care.” They “assist practitioner and patient decisions about appropriate health care for specific clinical circumstances.” Further, the IOM defines CPGs as “systematically developed statements to assist practitioner and patient decisions about appropriate health care for specific clinical circumstances.” They are graded recommendations on best practice for a specific condition or clinical question based on the systematic review and evaluation of the quality of the scientific literature. These documents are defined by a stringent methodology and formal process for development; although variation can exist, all must meet standard criteria. Recently, the National Guidelines Clearinghouse announced that it would be adopting the IOM recommendations.

Physical therapy is a relative newcomer on the CPG scene, but we’ve

been working hard to generate resources. In 2006, the Orthopaedic Section of APTA used the International Classification of Functioning, Disability and Health (ICF) to develop evidence-based CPGs to enhance diagnosis, intervention, prognosis, and assessment of outcomes for a variety of musculoskeletal conditions commonly managed by physical therapists. The Orthopaedic Section currently has 10 CPGs completed, published, and made available as open access on its Web site and is revising previously published CPGs on a regular update cycle to keep them current. The Section on Pediatrics has also developed a CPG process and recently published its first CPG, “Physical Therapy Management of Congenital Muscular Torticollis.”²

Recognizing that the APTA’s Sections represent the clinical expertise of the profession, APTA has taken the role to help facilitate the Sections’ development of CPGs as an important tool to decrease unwarranted variation in practice by providing clinicians with the best available evidence so that they can provide the best care to their patients and clients. This role is supported by the APTA strategic plan, Goal 1, Effectiveness of Care, which states: “APTA will better enable physical therapists to consistently use best practice to improve the quality of life of their patients and clients.” Under that goal, Objective A directs the association to increase the number of peer-reviewed CPGs.

The APTA has specifically responded to this goal and objective by initiating a program to provide support and funding for Sections to develop CPGs, a program that includes an annual CPG workshop. Since the program began, APTA has provided funding and support for the development of 7 CPGs. As part of this support, APTA issues a call twice a year for proposal submissions for the development of CPGs and sponsors an annual workshop to provide CPG development guidance. The

annual workshop provides training to support the Sections—the true content experts—in the development of CPGs. This event coordinates the knowledge and expertise of Joe Godges, DPT, MA, OCS, of the Orthopaedic Section and Sandra Kaplan, PT, PhD, of the Section on Pediatrics. Members identified by the Sections are nominated to attend the workshop, and priority for attendance at the workshop is given to nominees who meet the following criteria:

1. Demonstrate full support from the Section’s leadership.
2. Have a clearly-identified clinical question or topic.
3. Have initiated activities to address the identified question or topic.
4. Have identified subject matter experts and confirmed participation of members to develop a clinical practice guideline.

Through the training and the financial support, there are now 7 CPGs in development that are being funded by APTA. Those are:

September 2012: Cardiovascular and Pulmonary and Acute Care

Clinical practice guidelines for the prevention, assessment of risk, and physical therapy management with lower or upper extremity venous thromboembolism (VTE)

September 2012: Geriatrics

Development of a Clinical Guidance Statement for the Identification, Prevention, and Treatment of Falls in Community Dwelling Older Adults

September 2012: Neurology

Vestibular Rehabilitation for Peripheral Vestibular Hypofunction

September 2012: Oncology

Management of Secondary Upper Quadrant Lymphedema

March 2013: Geriatrics

GeriEDGE Evaluation of Fall Risk Assessment Tools and Fall Risk Abatement/Balance Outcome Measures

September 2013: Acute Care

Clinical Practice Guideline for the Identification and Evaluation of Post-Intensive Care Syndrome

September 2013: Neurology

Clinical Practice Guideline: Core Set of Outcome Measures for Patients with Neurologic Conditions

The APTA will continue to work with the Sections to facilitate the development of CPGs and help share the important work that is being performed. If you have any questions about APTA's role and support of the Sections, please contact Matt Elrod at mattelrod@apta.org.

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Matt Elrod is presently a Senior Specialist in the Practice Department of the American Physical Therapy Association. In this position, he provides

consultation to other APTA departments and members, liaisons with vari-

ous external organizations, and contributes to policy development to advance the practice of physical therapy. These duties include developing member resources in evidence-based practice and clinical practice guidelines, ICD10 transition, telehealth, and adoption of electronic health records. Dr Elrod has over 20 years' experience in the profession of physical therapy. He earned his physical therapy degree from the Medical University of South Carolina; Doctorate in Physical Therapy from Marymount University; and Master of Education in Exercise Physiology from the Citadel. He has worked as a physical therapist in acute care and acute rehabilitation and as an owner of an outpatient private practice. He is an APTA Board Certified Specialist in Neurologic Physical Therapy.

UPDATE FROM THE PRACTICE COMMITTEE'S SUBCOMMITTEE ON EVIDENCE-BASED DOCUMENTS

Timothy Hanke, PT, PhD

Knowledge translation is the capturing, synthesizing, and sharing of high-quality research (ie, knowledge) for the purpose of improving the provision of physical therapy through a reduction of unwarranted variation in care.¹ The most common strategy by which knowledge translation is accomplished is through the collaborative development of, dissemination of, and implementation of recommendations from evidence-based documents. The Institute of Medicine (IOM) defines an evidence-based document (EBD) as "systematically developed statements to assist practitioner and patient decisions about appropriate health care for specific clinical circumstances."^{2(p 38)} Two common EBD formats are clinical practice guidelines (CPGs) and clinical guidance

statements (CGSs). A CPG is a graded recommendation on best practice for a specific condition based on the systematic review and evaluation of the quality of the scientific literature. A CGS, sometimes called a clinical practice appraisal, summarizes best practice for an area of clinical practice based on the integration of available literature and expert opinion. The development of these documents follows a strong methodology and formal, systematic process. There are differences between a CPG and a CGS. A CPG uses systematic reviews, high-quality evidence, and expert opinion to provide action steps for the clinician on a particular health condition or topic. A CGS synthesizes evidence from already existing CPGs and adapts the CPGs' recommendations for a particular physical therapy-specific purpose.

The APTA's Evidence-based Documents Initiative was launched following a collaborative working group meeting between representatives of numerous Sections and APTA staff in 2008 and was subsequently supported by APTA Board of Directors' motions in 2009. This initiative provides structure, process, and resources for the development of EBDs that facilitate the translation of research findings into physical therapy practice. Two tangible examples of support provided by the APTA include bi-annual opportunities for Sections to submit proposals for EBD development funding and an annual APTA-sponsored workshop on CPG development.

Since the APTA initiative's inception, the Academy of Geriatric Physical Therapy (AGPT) has been busy at EBD development. First, in 2011,

AGPT leadership established a Subcommittee on Evidence-based Documents as a standing subcommittee of the Practice Committee. Subcommittee members surveyed the AGPT membership at the 2012 Combined Sections Meeting in Chicago, IL, and collaboratively determined important topics for EBD development. The first topic to be addressed was falls in community-dwelling older adults. Subcommittee members attended the annual APTA workshop on CPG development in the summer of 2012 with this topic in hand. Given the existence of numerous CPGs on falls at that time (eg, American Geriatrics Society/British Geriatrics Society Guideline, National Institute for Health and Care Excellence Guideline), the Subcommittee determined that a CGS was the best EBD choice. The Subcommittee then submitted a proposal that was funded by APTA to proceed in the development of a CGS. This CGS, titled "Identification, Prevention, and Treatment of Falls in Community-dwelling Older Adults: A Clinical Guidance Statement from the Academy of Geriatric Physical Therapy of the American Physical Therapy Association," is now in its final stages of development and will be submitted for publication shortly.

One of the advantages of a CGS is that it offers the opportunity for a gap analysis. As part of this gap analysis of CPGs on falls in community-dwelling older adults, it was determined that there exist several physical therapy-specific questions that remain unanswered, suggesting the need for a new, physical therapy-specific CPG. For example, the existing CPGs did not specifically address two important questions for physical therapists: (1) what are the best assessment tools to identify a community-dwelling older adult at risk for falling? and (2) what are the best modes and dosages of exercise needed to decrease fall rates and prevent falls?

Fortunately, there exist numerous systematic reviews and high-quality randomized controlled trials from which to answer questions about interventions for fall prevention in community-dwelling older adults. However, there is a dearth of information on assessment tools for the identification of fall risk. Therefore, to provide the necessary knowledge synthesis, the GeriEDGE Task Force (as of the 2014 Combined Sections Meeting in Las Vegas, NV, now a component of

the Subcommittee on EBDs) received APTA funding in 2013 to produce a systematic review on fall risk assessment tools and fall risk abatement and balance outcome measures to provide the needed evidence synthesis for the CPG. Most recently, in May of 2014, the Subcommittee was awarded a grant from the APTA, with matching funds from the AGPT, to fund the development of a physical therapy-specific CPG, a 3-year project to begin this summer.

As the Subcommittee completes its work on the falls CGS (which was presented at the 2014 Combined Sections Meeting, along with the work of the GeriEDGE Task Force) and prepares to begin developing a physical therapy-specific CPG on the same topic, it will also begin planning for developing future EBDs on other topics. As the planning process progresses, the Subcommittee will issue future calls for volunteers to assist in these projects.

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Timothy Hanke serves on the Subcommittee on Evidence-based Documents of the Practice Committee as well as the Research Committee of the Academy of Geriatric Physical Therapy of the APTA. An associate professor in the Physical Therapy Program at Midwestern University, Downers Grove, IL, his research spans a number of areas including age-related changes in the coordination of stepping and the use of GPS technology in tracking environmental navigation in persons with movement dysfunction. He is a member of the International Society of Motor Control.



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REDISCOVERING THE FLOW OF COMMUNICATION: A STUDENT'S PERSPECTIVE

Trisha Armstrong, SPT; Meri Goehring, PT, PhD, GCS

As learned throughout my education, aphasia is a language disorder that affects one's ability to communicate.¹ Furthermore, approximately one third of individuals admitted to the hospital with a stroke present with aphasia.^{2,3} Here I was beginning a 9-week clinical rotation on the stroke team as a third year, doctorate of physical therapy student, with no experience communicating with language deficits. At the start of my inpatient rehabilitation experience, I did not anticipate the efforts, critical thinking, and problem solving required among patients suffering from aphasia.

Let me reveal a patient interaction that defines my experience perfectly. I was working with a pleasant gentleman on the stairs and I was nervous because it was my first time taking lead in a session. Secondly, I was informed that I needed to be more "aggressive." My hands were sweating, my stomach was in knots, and subconsciously my voice was increasing. My patient just wasn't doing what I asked, and in turn my voice continued to rise. I deduced that inside I had hoped that if my words came out louder, clearer, and crisper my patient would suddenly "get it." I was extremely embarrassed when my clinical instructor had to clarify with me that my patient had no hearing impairments and I could stop shouting. This was my reality for 9 weeks, as I had no concept on how to effectively communicate with my patients.

Not only was I confused but also my patients were frustrated because they could not speak as well or did not understand things as they once did. I will never forget the time when my pleasant gentlemen stared angrily at me because I failed to effectively communicate about the task goal, locomotor training. It was evident that my patience was running thin as I was overwhelmed with defeat. My patient's eyes explained his rage; with hindsight, my personal dilemma was negatively influencing my patient. Furthermore, research has found that

health care provider's impatience can affect the motivation of patients with stroke and aphasia.² Sounds familiar to me.

Knowing about aphasia and learning how to communicate with patients with aphasia are two separate subjects. As a student, interacting among patients with aphasia solidified my knowledge on aphasia. I had hands on experience with comprehension, expression, reading, and writing deficits; as all these facets can be impaired with aphasia.² Unfortunately, aphasia is just one deficit that can occur following a stroke. Other factors including motor control and cognitive function can also impact communication.

Collaborating with the speech language pathologist provided me great insight on how to effectively communicate with my patients. I was able to sit in on a couple sessions of speech therapy with my patients and I was amazed how many methods were used to help analyze communication. I was also able to join forces with the occupational therapist in order to find successful communication approaches for each patient. Moreover, my collaborative experience opened my eyes to the power of multidisciplinary care.

This following expert from Benner and Wubel⁴ demonstrates the importance of communication: "Understanding the meaning of the lived experience of the illness may be a gift to the aphasic person, because it may move back the walls of isolation and suffering created by the disease." There is no other option, than to find a solution to break communication barriers between therapist and patient. My clinical experience shed so much light into the role of a physical therapist. We are not only health care professions, we are motivators! It is our job to advocate for our profession and our patients. This includes educating family on how to overcome the awkwardness and distance aphasia often creates.⁵

In conclusion, my passion for the neurologic population was set on fire throughout my inpatient rehabilitation rotation. My take home was quickly learned; evaluating and treating a patient post-stroke requires flexibility, patience, and a whole bunch of communication strategies. My experience was challenging, pushing me to the outer limits emotionally, but the reward of finally communicating with my patients was worth it!

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CHART AND SOUL

Brett Cain, SPT; Meri Goehring, PT, PhD, GCS

As a DPT student, I had wonderful opportunities in my first inpatient acute care setting to identify with many people from differing backgrounds. It was refreshing to listen to the many different stories people had to tell. Given this, as I approached my next clinical assignment in a long-term acute care setting, I was feeling fairly anxious and uncertain about how long it had been since this information was fresh in my mind. As I began the week prior to the rotation, I found myself feeling more certain as I studied up on acute care practice considerations. Yet, I was still not quite sure about how I would perform.

Once I arrived in the long-term acute care setting, after discussions with my clinical instructor and after receiving a detailed orientation, I started feeling much better about my ability to make a difference in patient's health and outcomes in this challenging environment. Then came the actual patient care. Over the first two weeks, I scoured my brain to remember all the bits of information that may help to make my time most effective with each and every one of the patients I was treating. It became quite exhausting trying to make every minute meaningful skilled therapeutic intervention. However, as I learned to keep up with the fast pace of care and attempted to recall every lab value, technique, and examination tool, I thought I was really stepping up and making a solid impact on my patients.

Then came 'Joe' who forced me to reconsider the impact of my treatment. Joe had been on prolonged respiratory ventilation following a massive cardiovascular event. He was elderly and had multiple comorbidities. I was able, by way of non-verbal communication strategies, to gather as much information as possible through his history and initial evaluation. While carefully managing his chest tube, PICC line, Foley catheter, multiple negative pressure wound care devices, and ventilator tubing, I assisted him to sit on the edge of his bed. His prolonged bed-rest from a significant length

of stay at a hospital and subsequently at the long-term acute care hospital allowed me the opportunity to examine his severe deconditioning. After getting him back to bed, I noticed a gripping emotion in his face. Tears poured down his cheeks as he asked me to just sit and be with him. After a few minutes of conversation both by reading his lips and sketching on his white board, I gathered that he was telling me he had just heard news that his daughter was in a serious motor vehicle accident and had broken her neck. As my heart began to break, he told me that he just wanted to go "home" as he pointed upward. I forgot my schedule momentarily as I helped console him. Despite the busy schedule, I asked and was granted permission to sit with him for a few minutes.

My point of this encounter is to remind therapists and medical professionals alike that it is easy to forget through all the details of medical and therapeutic intervention that it is people we are treating. It is easy to get caught up in the chaos of what the patient's chart says and what the BP, HR, FiO₂, MMT, hemoglobin, ROM, WB status, surgical history, etc is and completely forget that the patient has a spirit and beyond everything else, what he or she really may need at times is just to have someone to listen and be there. Can you bill for this ethically? No, you cannot. And, your day may be a bit longer. But I urge you in whichever setting you are in to remember that you are not treating the patient's chart or the lineup of numerous patients scheduled in your morning or afternoon, you are treating the human spirit as a component of holistic treatment, and sometimes, like my wake up call, it may be more important than all the rest.

I saw him for two more visits with several meaningful moments spent together in conversation until he went... home.

Brett Cain is recent graduate from Grand Valley State University's Doc-



torate in Physical Therapy program in Grand Rapids, Michigan. He is passionate about quality care and his personal investment across multiple specialty areas in physical therapy. Brett is in pursuit of job placement in both orthopedic and neurological practices.



Meri Goehring is an Assistant Professor in the Physical Therapy Program at Grand Valley State University (GVSU) and works as a clinician at Spectrum Center for Acute Rehabilitation at Blodgett Hospital in Grand Rapids, Michigan.

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Trisha Armstrong is a third year student in the Clinical Doctorate of Physical Therapy Program at Grand Valley State University. Following graduation, Trisha aspires to work among the neurologic and geriatric populations. Please contact Trisha at tarmstrong.pt@gmail.com.



Meri Goehring is an Assistant Professor in the Physical Therapy Program at Grand Valley State University (GVSU) and works as a clinician at Spectrum Center for Acute Rehabilitation at Blodgett Hospital in Grand Rapids, Michigan.

CONNECTING, PRODUCTIVELY

Amy Kirby, PTA

I was hurriedly walking out of the nursing home, fatigued after a long day at work. As I arrived at the exit door, a petite, older lady was sitting at the window with her forehead resting against the glass, mumbling. It gripped my heart, so I approached her. I slowly bent down on one knee and asked her if she was okay. She replied, "No, honey." I asked her what was wrong and if she needed anything. She simply said, "No one will listen to me. I just want someone to listen to me." I pulled up a chair.

Throughout my career as a PTA, I have worked in numerous settings, including ALFs, SNFs, inpatient hospitals, and outpatient and inpatient rehab facilities. I love all the settings in which I have had the privilege to work, as well as all the patients I have had the privilege to treat. A simple theme runs through every facility of every company: *be productive*. I think that as therapists we can all agree that it is important to be productive. After all, it is what provides our salaries and creates a thriving business. However, I think that with all of the demands of being productive, we have lost sight of our personal touch. We cart patients from one activity to another counting minutes and scrambling to document. I feel we should stop and reflect. Did we really connect with the patients we treated?

One of my personal goals while offering therapy is to make a connection with each and every patient. I attempt to treat each one as if they were a member of my own family. I think this is a reasonable goal. This effort builds trust because patients see genuine concern. It is actually possible, and almost effortless, to connect with patients while performing functional tasks, exercises, or gait training. Connection should be easier still in a geriatric setting, where we often spend more time with those patients than some of their family members.

I have encountered many types of patients. Please allow me a few moments to introduce you to just a few of them. (I

have changed names to protect privacy.)

Brad was admitted to our facility and hospice with only a few expected weeks to live. He was unable to walk, but was optimistic. He became stronger and requested therapy. He had contractures of all his extremities and required a lot of stretching. He thrived in therapy and was taken off the hospice list. The last therapy session I had with Brad he was walking with a rolling walker with two people assisting.

Thelma was already at our facility when I began working there. She had been offered therapy in the past, but declined. I took a few extra minutes each day to visit with Thelma and befriend her. During one of our chats we made a connection, so I presented Thelma with my spiel about the importance of therapy. Thelma still refused. Almost every day I stuck my head in her door or sat and talked with her, but Thelma repeatedly refused. Her family, the staff, and our therapy team knew her potential, but Thelma did not want any part of it. To this day Thelma is my friend, but still refuses to participate in therapy.

Bob was an older gentleman who was admitted to hospice. He had a terminal expected outcome and begged for therapy right from the start. Bob wanted to remain high functioning for as long as possible. Bob had the mental capacity of an 8 year old. He was walking with a rolling walker and one person assist prior to developing a cold. His medical condition grew worse very quickly. His family was notified, but lived at a great distance. Bob was terrified of dying alone. Many of the staff, including myself, sat and held his hand, often after hours, around the clock, awaiting the arrival of his family. I was the one holding Bob's hand when he passed.

Carl was an elderly and stern gentleman. In my hurry to accomplish my task at hand, I forgot to inform him of my reasoning for attempting to tie theraband around his legs. I wanted to strengthen his hip abductors, but he be-

came agitated and screamed at me. Probing further into his reason for screaming, I discovered that Carl had served our country in WWII and was a prisoner of war for an unknown amount of time. Carl, very rightfully, refused to ever be tied up again.

Ray, a middle-aged man who loved to talk more than exercise, was eager for any and all therapy. He was often early to therapy and stayed late. He was frequently caught talking to his peers instead of exercising when my back was turned. If Ray saw me looking or walking in his direction, he promptly resumed the exercises and counted out loud..."98, 99, 100." To this day his nickname is still "99, 100."

Why do I share these personal stories of my patients with you? As therapists, you will encounter many people like Brad in your career. They progress, inspire, and remind us *why* we chose this field in the first place. You get the opportunity to help and to witness those "Brad's" walk again.

Never give up on your "Thelma". Take the time to encourage them, even though you may feel deep down they will never participate. Let the "Thelma's" grow your perseverance, having the faith that one of them, one day, will trust the friendship you took the time to grow and will finally participate.

If a "Bob" ever reaches his hand out to you, take it. Don't pass him off to someone else and be robbed of that blessing. Let that "Bob" remind you to stay after work, just because it is the right thing to do. Let your "Bob" keep your heart tender to those who are hurting, scared, or just need a friend. Never be afraid to let your patients touch your heart, because if you open it, many will.

The "Carls" of this world need an appreciative hug and word of thanks from us. Their service allows us our daily freedoms. Listen to their stories, one hundred times if needed, knowing that they are one of thousands that have a personal story to share of our freedom.

There is wisdom to be gained if we listen to our elders. And, yes, even those with Alzheimers.

Laugh with your "Ray" every day. Laughter *is* the best medicine! Your patients will have many forms of humor that will keep you in stitches. You will learn many one-liners from all of them.

We should not be afraid to make those connections. Our true compassion for patients enhances our jobs and their *lives*. One day it will be our family mem-

ber, or us, that will need treatment. I do not want to be the lady at the window wishing someone would listen to me. Do you?

Amy Kirby currently works at several locations, PRN, with numerous geriatric patients in pursuit of her Bachelors of Exercise Sports and Science Degree at University of South Carolina, Upstate,



Greenville, SC. You may contact her at kaykee69@gmail.com.

SC. Her plan is to reach this goal within the next two years in order to teach Physical Therapist Assistants, preferably at Greenville Technical College,

CALL FOR NOMINATIONS

Academy of Geriatric Physical Therapy AWARDS 2014

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.

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

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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.

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

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Nominations are due November 1, 2014 and all awards will be presented at the Section Membership Meeting at CSM in February of 2015.

For additional information on the criteria and selection process for academy awards, please visit the Academy of Geriatric Physical Therapy website at www.geriaticsppt.org or contact the office by email at karen.curran@geriaticsppt.org or by phone at 866/586-8247

FROM OHIO TO QUINTANA ROO: A REFLECTION ON SERVICE LEARNING BY DPT STUDENTS FROM THE UNIVERSITY OF CINCINNATI

*Chalee Engelhard, PT, EdD, MBA, GCS; Rose L. Smith DPT, MEd., SCS, ATC;
Barbara Zoretic, DPT Student; Elizabeth Kolena, DPT Student;
Kymberly Marlena Thomas, DPT Student*

When you hear about a group of students traveling to Cancún, Mexico, “service learning” is probably not the first thought that comes to mind. What we often forget is for every place of luxury, there is also a place of underprivileged and poverty-stricken residents who live a life that is far from glamorous. The University of Cincinnati (UC) Doctor of Physical Therapy (DPT) program is fortunate enough to partner with a local Cancún nonprofit organization, the Palace Foundation. The Palace Foundation facilitates projects that bring hope, resources, and happiness to those in need. It is because of their generosity that we were able to provide physical therapy (PT) services to the City of Happiness: Home for the Elderly in Cancún, Mexico.

As of 2010, more than 1,325,000 people live in the state of Quintana Roo.¹ Cancún is the largest city within Quintana Roo, accommodating nearly 629,000 of the state’s residents.¹ From 2000 to 2010, the population of the city grew by 51% and is expected to maintain a high growth rate.¹ The elderly population is also expected to increase. Currently, 4.9% of the state’s residents are over the age of 60.² Additionally, 66.2% of people 85 and older in Quintana Roo have a disability.² Of the people that have a disability, 55.4% have an impairment that involves difficulty with ‘walking or moving.’² These statistics demonstrate the opportunity physical therapists have to improve function and mobility within this population.

The basic responsibilities and goals of a physical therapist, or *fisioterapeuta*, translate in a similar fashion from the United States to Mexico. Though the general practice of PT is similar across borders, the education and access to

physical therapists is limited in Mexico. According to the World Confederation for Physical Therapy, there are approximately 3,000 practicing physical therapists in the country of Mexico. These individuals received their bachelor’s degree after completing 9 semesters of classes and one year of social service with patients. There are only 10 schools that offer a degree in PT, none of them existing within the city of Cancún.³ Thus, the actual number of physical therapists in the country of Mexico can be perceived as being limited.

The combination of a lack of access to PT, the current disability statistics in Cancún, and our commitment to service, brought us to the Home for the Elderly. Nuns from the Order of the Discalced Carmelites manage the Home. Our time spent there was split, spending one day treating patients and the nuns who worked within the facility and another day providing education on better body mechanics in addition to providing care. Our educational tasks included how to provide the best care for their patients while preventing any potential injuries to themselves due to poor body mechanics during their everyday activities.

As we reflect back on our time spent on this service learning experience, we recall various moments that form the basis for 3 underlying lessons involving adaptability required within the field of PT, the power of education, and the effect of human connection on people’s

health. In traveling to Quintana Roo to provide PT services to the elderly, we were able to expand our knowledge beyond our classroom and textbooks and put into practice what we have been learning over the past few years.

A critical lesson we have been taught throughout our time in PT school is the importance of adaptability. This integral pillar to the practice of PT is one that we were able to explore and apply during our time of service at the Home for the Elderly. While at the Home, we encountered various challenging situations that required us to critically think and adjust according to the circumstances. We not only had limited resources available for us to work with, but we were also faced with a significant language barrier. Though a small number of us spoke Spanish, many had to rely on communicating with our elderly patients via an interpreter. This challenge reminded us how essential it is for a therapist to have patience and gave us the opportunity to practice simplifying our words to get our main points across.

In addition to our challenge with patient interaction, we were met with a lack of available supplies. The wealth



UC DPT Students examining x-rays in Mexico—(L to R) Kelli Barton, Elizabeth Kolena, and Marlena Thomas.

of material, equipment, and tools that are available to therapists in the United States was not at our fingertips in Mexico. We were put to the test at the Home for the Elderly as we attempted to treat patients in their bedrooms and create innovative strategies to decrease their contractures. The most rewarding part of this experience was being able to work together to find practical solutions to treat patients that could be replicated by the staff of the Home. Such was the case when we were treating one of the nuns who had been having severe knee pain for the past 6 years. Upon examination, we were able to determine that the nun had been living with a torn ACL. Because she was not able to see an orthopedic surgeon, we worked with her to find creative ways to decrease her knee pain while performing her duties and help to insure her quality of life while accommodating for her injury.

The education we provided to the nuns and workers was not limited to their currently existing injuries; we provided preventative instruction as well. When presenting our in-service, the dining room was filled with nuns who cooked, cleaned, and physically cared for the patients on a daily basis. Even those who were not scheduled to work attended to receive the valuable information on how to protect their bodies. After the in-service, one of the nuns requested further education on body positioning and mechanics specific to washing dishes. After our session, she realized that she had improper form causing her to have unrelenting back pain throughout the day. We followed her to her workspace, where she proceeded to demonstrate how she performed her tasks. We quickly discovered her problem: her sink was too deep, causing her to constantly reach forward in a way that caused abnormal stresses through her back and arms. Since this was a structural flaw within the design of the sink itself, we educated her on strategies that she could implement immediately. We taught her not to twist her back when transferring dishes from one sink to another and to stand in as best posture as possible holding the dishes while rinsing rather than bending in her normal posture. Our instruction enabled her to use her body to allow more appropriate mechanics and reduce stress caused by incorrect positioning.

Additionally, we gave her exercises to help increase the strength in her trunk and lower extremities. This was just one of the many opportunities we had to provide education to those at the Home for the Elderly.

The ability for us to share our knowledge was so special to us because our insight and education was the one thing that we could leave behind. We were able to provide the workers at the Home for the Elderly lasting lessons that they could implement into their everyday lives to improve their function and quality of life. Thus, we have revealed lesson number two: the impactful power of education.

Despite our cultural differences, there is no denying that we are all interconnected by basic wants and needs as humans: to feel loved and supported, to be nourished, and to be listened to. All of these components interact and play into the quality of an individual's overall health. Though PT was our primary service, we noted that it would be impossible to treat our patients' specific musculoskeletal complaints without also catering to the individual as a whole and addressing the basic human needs that bind us together. Our final lesson learned involves the effect of the human connection on health. We were given the opportunity to have lunch with the residents, many of which were quietly sitting alone. Some of our team dispersed among the seats, engaging each of them in conversation and sitting with them as they waited for their meals. Meanwhile, other members of the UC team began assisting the nuns in preparing the food and serving it to the residents. We helped many of the residents who were unable to feed themselves and shared in conversations about their life experiences, feelings, and opinions. We also attended a Spanish mass with the residents of the nursing home and saw their various chapels, where they taught us about their traditions and practices. Our time spent eating, listening, and learning from the grandparents, *abuelitos*, undoubtedly enhanced our ability to treat them. By taking a holistic approach to their health, we were able to connect with our patients on a human level, which truly enhanced any PT service that we provided them. In summary, one of the Cincinnati community PTs,

Cathy Guenther, who went on the trip with us shared this sentiment, "The physical therapy students and faculty balanced listening, healing, education with a gentle touch and a smile."

Currently, we are very proud to say that the partnership between the UC DPT program and the Palace Foundation continues to grow. This past March we were able to deliver several transfer boards to assist in the care of the residents at the Home for the Elderly. In addition, the UC DPT program will be sponsoring another service learning experience in Quintana Roo in October 2014. We look forward to providing more of our services to the Home for the Elderly and are honored to be one of the many contributors that provide the smiles, joy, and care that can be found in the City of Happiness.

In retrospect, we will forever look back with gratitude for all that we were able to learn during our service learning opportunity in Quintana Roo, Mexico. We will carry these pearls of wisdom as guiding principles throughout the remainder of our schooling and onward in our future practice as licensed physical therapists.

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Chalee Engelhard has been practicing 24 years and has been a Geriatric Specialist since 1997. She teaches full time at

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IN IT FOR THE LONG HAUL: WHAT BEING A GERIATRIC REHAB PT HAS TAUGHT ME ABOUT MARATHON TRAINING

Adrienne Nova, PT, DPT

I knew I wanted to be a physical therapist (PT) when I grew up back in middle school after spraining my ankle playing soccer. I admired how much knowledge my PT seemed to possess about the body, and I was amazed at how quickly she got me kicking and running again. Throughout my college running career and the first 2 years of PT school I always assumed I would end up working with athletes. But it did not end up that way!

As an athlete myself, I appreciate that sometimes immediate performance and long term health are in conflict, and I deeply admire those of my peers who are able to strike that balance and work with this population. But I discovered during my final year of PT school that my passion had transitioned towards longevity and quality of life; that I first and foremost wanted to help people stay active and mobile as they age. So 5 days a week you will find me on First Hill, working as an in-patient PT at a skilled nursing facility. Most of my patients come to us following a stay at the hospital, and we help rehabilitate and prepare them to safely return home. If you think athletes are motivated, you should meet some of my patients: there is no place like home. It is both humbling and incredibly rewarding to help someone take his or her first steps following a major incident such as a stroke, and it is exciting to teach someone how to walk normally and painfree when they thought they may never walk again. Becoming a rehab PT and shifting focus from competition to function has made me a better person: it has made me more patient, more flexible, more confident, and more creative; it has taught me how to get along with and motivate all sorts of different personalities, and it has brought new meaning to the values of teamwork and community. I also believe it has made me a better life-long athlete as it helps me put my personal injuries and goals in perspective. While I do not

work with athletes in my professional career, I believe I have learned some valuable lessons and strategies to success and longevity as a marathon athlete in it for the long haul.

(1) Compression socks: One of my favorite things about my job is the fact that I get to be up on my feet moving around all day, but the consequence is edema or fluid buildup in the legs. So I wear compression socks all day and during my run. Running compression socks can be pricey, but compression socks marketed for medical professionals are much more affordable!

(2) Run (or walk) home from work: You have to get home somehow, and who wants to sit in traffic anyway? I am fortunate enough to be able to take the bus to work, and running home makes training all the more efficient! Depending on my schedule or how I feel after a long day I might add on some extra miles, tackle some stairs, or even walk. Biomechanically, running is walking with a float phase, and the miles are still getting covered!

(3) Strength train: This part was woe-fully lacking during my college years. Before I ask a patient to walk long distances, I assess his or her gait for abnormal patterns that indicate muscle weakness/instability and prescribe targeted exercises in order to decrease/prevent pain and injury. How can I expect my own body to withstand the extra miles if I have not addressed my own weaknesses? After the Victoria Marathon in October, I had some residual knee pain, so I spent the next couple of months at the gym working on my glut strength in preparation for the Boston Marathon.

(4) Set goals: I always ask my patient what his or her goals are for PT, and a typical response is "I want to go home." Similarly, a runner may choose a race to train for. While I am all for running for the sake of running, I find it most satisfying and motivating to have something to work toward. And do not be afraid to

take it a step further and set time and pace benchmark goals for a little healthy competition!

(5) Getting older is nothing to be afraid of: I have had patients in their 90s who continue to walk miles a day. But you do need to get wiser about heeding the aches and pains of your body and realize it will take longer to recover. Maintaining good bone and joint health now can decrease your risk for joint replacement or fracture that will impact your mobility and quality of life later on. What's a couple days of rest to 90 years of an active life?

(6) Community: At work, I always smile when I see my patients interacting with and encouraging each other in their progress. And with running, community is what makes it fun! My running group Run Seattle, founded this year together with two therapist friends is just that--a "community in motion."¹ And on April 21st at the Boston Marathon, I will join an international community of 36,000 other runners in a grand, united celebration of Patriot's Day heard worldwide.

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Adrienne Nova is a 2012 graduate of the University of Washington's Doctor of Physical Therapy program, and she was a Division 1 varsity athlete at the University of Portland. She currently works for Infinity Rehab at the Terraces at Skyline skilled nursing facility in Seattle. Adrienne is also active in the local running community and is a founding member of the new Seattle running group Run Seattle. She will run in the Boston Marathon for the first time this year.

AUTONOMOUS PRACTICE IN PHYSICAL THERAPY TO PROGRESS THE WELLNESS AND FUNCTION OF THE GERIATRIC POPULATION

Jeffrey R. Guild, PT, DPT, CSCS

INTRODUCTION

The physical therapy profession has evolved over the past several years as evidenced by the new vision statement by the American Physical Therapy Association (APTA), approved in 2013. Now the national organization for medical professionals, who specialize in human movement and physical function have a vision statement that states, “Transforming society by optimizing movement to improve the human experience.” Along with the new vision statement are guiding principles, one comments about the sedentary nature of our current society and suggests the physical therapy profession get involved with engaging consumers, reduce preventable health care costs, and promote wellness through physical activity.¹ Given the focus of the APTA and changes in Medicare guidelines in 2014, there is an expanding opportunity for physical therapists to practice autonomously to positively impact society. The focus of this article is to discuss specific strategies for physical therapists to practice autonomously in geriatric populations to prevent falls, as well as to improve the health and wellness based on the evidence, health care trends, and current Medicare guidelines.

MEDICARE AND ITS NEW GUIDELINES

Whether intended or not, the Physician Quality Reporting System (PQRS) Measures, according to the Centers for Medicare and Medicaid Services, ushers in new opportunities for physical therapists to administer leadership in various aspects of wellness and prevention. As the movement experts who specialize in gait, balance, and functional strength in the medical field, physical therapists are in the position to act to prevent falls, coinciding with Medicare promoting all

health care providers to act in fall risk assessment and fall reduction in older persons.

The new Medicare guidelines require all health care providers to perform a falls risk assessment and provide plan of care for any person over the age of 65 if there is a history of two or more falls in the previous year, or one fall with injury.² The plan of care must consist of the consideration of vitamin D supplementation and either education or referral for exercise with the components of balance, strength, and/or gait.³ The clinical recommendations emphasize the assessment to be performed by a clinician with appropriate skills and experience and to emphasize an “individualized,” “multifactorial” intervention.^{2,3} Valid functional outcome measures that address fall risk, gait, balance, and functional strength have been a key part of physical therapy for many years. Physical therapists are *the* medical professionals with “appropriate skills and experience”³ and are best suited to assess and treat those over the age of 65 who may be at risk for falls.

Medicare allows a Medicare Beneficiary to receive treatment from a physical therapist as long as the person is under the care of a physician and a prescription or evaluation is signed by an appropriate health care professional within 30 days of the initial treatment.⁴ In other words, Medicare allows more reimbursable direct access treatment than may be perceived by many rehabilitation professionals. In addition, Medicare does allow two conditions to be treated at the same time.⁵ These guidelines allow physical therapists to take the initiative to screen persons referred for other ailments and to be treated at the same time for fall risk, movement dysfunctions, assuming

the modified plan of care can be certified by another appropriate health care provider. When a proactive approach is taken by the physical therapist, the benefits include reducing health care costs to society, and growth of physical therapy services. Often times multiple neuromusculoskeletal impairments affect one another, and treating simultaneously may assist with recovery for both conditions. For instance, an individual post lumbar surgery who receives gait training and fall prevention treatment is likely to walk with a more appropriate gait pattern, resulting in less muscle tightness and guarding, and thus, providing a better environment for tissue healing. This individual will also be less likely to sustain further trauma if falls can be prevented.

Even further on the forefront of wellness, new Medicare guidelines allow reimbursement for the development and management of a maintenance program to prevent or slow the decline of physical function.⁶ This type of a maintenance program may be administered by a physical therapist and is covered under Medicare if skilled clinical judgment is needed for the development and maintenance of such a program, or if medical complexity warrants such clinical judgment.⁶ Since falling is so complex,⁷ the monitoring and reassessment of a maintenance program by a physical therapist over time allows the therapist to manage the wellness through exercise, movement, and community/social access for the long term. This monitoring is a key part of a fall prevention program and provides the physical therapist the opportunity for additional assessment of other movement-related dysfunctions and referral to other health care providers, if needed.

COMMUNITY OUTREACH

With the increasing emphasis on functional outcome measures in the clinic to validate treatment, especially related to fall risk assessments, physical therapists are at an advantage when it comes to fall prevention community outreach. In this author's experience, administering clinical functional outcome measures to audiences in the community actively engages participants and creates enthusiasm when these screenings are brought to churches, community centers, and other settings. This positive response tends to be due to the fact that these validated assessment tools are physically engaging, based on physical function, and relevant to a person's daily life, and people in the community understand this when they partake in these types of events. Moreover, transitioning community-dwelling older adults who are at risk for falls to physical therapy is supported by Medicare.

Given a long history of changes in Medicare, differences in practice acts of individual states, and culture within the medical community, physical therapists may perceive barriers that are not actually there when it comes to reaching out into the community and those who may benefit from rehabilitation services. For instance, despite practice acts in states that prevent its residents to access rehabilitation treatment without a referral, no practice act in the United States prevents physical therapists from performing evaluations or screenings without a referral.⁸ Moreover, state practice acts aside, a physician visit before the treatment of physical therapy is not necessarily required under Medicare unless desired by the referring provider.⁴ This freedom for physical therapists embedded within the Medicare guidelines allows community-dwelling older adults ease of transition from screening to treatment.

In many cultures and communities, falls may be perceived as inevitable, as opposed to something to be proactively prevented. The United States is moving into a time when a generation that encompasses an extraordinarily large and growing percentage of the population⁹ will now be at greater risk for falls. Given the vision statement of the American Physical Therapy Association and the

education, training, and skills of physical therapists, physical therapists should take responsibility to become *the* health care providers to promote methods of fall prevention in our society.

Administering Fall Screenings in the Community

The evidence supports education about fall prevention does not reduce fall risk,⁷ and physical therapists, as the human movement professionals, must promote increased physical activity in the older population if fall prevention is to be achieved.⁷ Encouraging and engaging community-dwelling older adults in physical activity during the education process is a great way to start behavior and lifestyle changes. Participants at community outreach events will likely find the clinical outcome measures used regularly in physical therapy clinics socially stimulating, fun, and interesting.

Simple outcome measures such as the Timed Up and Go (TUG) test¹⁰ and gait velocity measurements¹¹ are quick and simple tests to predict fall risk, and these functional measures can be used to support treatment under Medicare and commercial insurance. Since both of these measures only moderately predict fall risk,^{10,11} more elaborate outcome measures such as the Functional Gait Assessment,¹² miniBESTest,¹³ and the Berg Balance Scale¹⁴ are more valid screenings for predicting fall risk among higher functioning individuals. The more comprehensive measures also address specific physical aspects that may predispose an individual at risk for falls (ie, inappropriate or insufficient balance responses, dependence on vision for balance, and adjusting to various surfaces).

COMBINING ALTRUISM WITH BUSINESS

Direct access of physical therapy services does not add to increased patient volume or medical costs due to overutilization of physical therapy services.¹⁵ One could interpret this data to mean that unnecessary physical therapy services are not used in direct access settings. However, one may question whether this lack of increase in volume of care is actually a good thing, especially when it comes to fall prevention. Roughly a third of those over the age of 65 fall every year.⁷ Physical therapists are well

suited to treat the physical and behavioral causes of those falls. Since falls cost the United States health care system at least \$13.5 billion per year,¹⁶ it is advantageous to the individuals at risk, Medicare, the health care system as a whole, and the developing businesses of physical therapists for more of those fallers to be identified and treated. Medicare placing fall prevention on health care providers through its reimbursement powers reinforces the need for *more* individuals to be assessed and treated for fall risk. A comparison was made utilizing direct access for therapy services in the Netherlands after a direct access law had been implemented. Leemrijse and colleagues¹⁵ identified that older individuals were more likely to continue to contact their physician for referral to physical therapy than their younger counterparts. Younger individuals were more likely to fully utilize the direct access to physical therapy once it was legally available.¹⁵ Fall prevention community outreach provided directly to the people could remove this age barrier and funnel those who are at risk for falls directly into fall prevention programs, as recommended by Medicare, in states that allow direct access to its residents. For those states without direct access, removing such patient access restrictions will be more cost-effective for the state and health care systems^{15,17} without any increased risk to the population.¹⁷⁻¹⁹

From a business perspective, physical therapy clinics may benefit from spending time, money, and resources in order to develop community outreach and education to provide services for both altruistic reasons and to generate business, two ideas which do not have to be mutually exclusive. Another strategy may be for physical therapists who participate in private practice to engage other health care providers in new and creative ways. The new Medicare guidelines open marketing opportunities for physical therapy practices to market themselves to assess and treat balance, gait, flexibility, and strength, aspects of health that health care professionals outside of rehabilitation do not often work with on a regular basis.

CONCLUSION

Under the new Medicare guidelines, health care providers are now mon-

etarily encouraged to perform fall risk screenings and develop plans of care for patients over the age of 65. Many factors are coming together at about the same time to place fall prevention and wellness in the older population on the shoulders of physical therapists. These factors include the new vision statement of the American Physical Therapy Association; new Medicare guidelines; evidence-based practice and its expanding use, especially in outpatient physical therapy clinics;²⁰ *functional* outcome measures used in physical therapy settings that predict fall risk; and growing doctoral physical therapy programs that emphasize differential diagnosis. Given these factors and a greater percentage of the population getting older and living longer,⁹ a broad diverse medical team will be needed to deal with these health care complexities. Expanding autonomy and continued growing initiative among rehabilitation professionals will provide valuable services to the geriatric community and the health care system as a whole.

DISCLAIMER

It is not the intention of the author for this opinion piece to support or be critical of Medicare and its new PQRS guidelines, but merely to provide a vision and call to action to health care providers within the structure of the current system. For simplicity and brevity, the guideline information stated in this article is summarized, and a full detailed understanding of the new guidelines should be reviewed by the original sources.²⁻⁶

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FILING FOR PUBLIC ASSISTANCE BENEFITS FOR MY PARENTS: WHERE DO I BEGIN?

Patrice Antony, PT, GCS

WHO NEEDS BENEFITS?

With the cost of nursing homes escalating to over \$7000 per month in some parts of the country, it is becoming increasingly necessary for some families to apply for Public Assistance benefits to cover these costs. The average income from Social Security is about \$1294 per month. The average 50-year-old person has about \$43,797 in life savings. Most seniors in the United States do not have sufficient assets to cover the cost of long-term care for very long. These folks are going to have to apply for benefits to reside in a nursing home.

GETTING THE RIGHT HELP

Exactly what benefits are available will vary depending on the state where the senior resides. To get started, it is well worth the investment to consult with an elder law attorney in that area. These attorneys are specialized in the laws that affect seniors in their locale, and have special skills in qualifying and applying for benefits for people. The price for these services does not come cheap, however. It is highly advisable to get a consultation long before all of the assets have run dry. In many cases, there are ways to proactively estate plan with these benefits in mind as a future possibility. Be advised, however, that only the specialized elder law attorneys have the specifics of Medicaid and/or VA benefit program law in their backgrounds. Many well intending estate-planning attorneys have made crucial mistakes with asset titling/gifting/transfers, etc. because they were ill informed on the particulars of eligibility for the various benefit laws and rules.

PREPARING FOR THE CONSULTATION

With that said, there are still several things that families can do to prepare for this consultation. Being prepared can drastically cut the hourly rate of

the professional that you are consulting with. The intent of this article is to help families learn the various record keeping methods to make this process easier.

Bank Statements

Most benefit caseworkers want to see bank statements and financial account statements going back at least 12 full calendar months for all accounts that the applicant and spouse have owned in the previous 5 years. They will look to see if any funds have been transferred out of the applicant's name. They are usually looking for large sums that have been given away. If accounts have been opened or closed in the past 5 years, they will want 12 months of accounting for that account preceding the closure. Accounts that were closed prior to a 5-year lookback are generally not reviewed and do not need to be disclosed. Examples of types of things that are overlooked by families are:

1. CDs that were rolled over, liquidated, or transferred.
2. College funds that were set up for grandchildren and distributed in the 5-year lookback.
3. Stocks and bonds that were bought and sold in the past 5 years.
4. IRAs that were liquidated and moved to another account.
5. Accounts that were re-titled to a grown child or had a child added on the account.

The above list is by no means exhaustive, but just an illustration of how things get a little more complicated.

Most public assistance caseworkers want to see the actual statements of the various accounts that define the statement period and titling. They will generally not accept ledgers printed from an online account on a computer. They can and will accept copies of actual statements. Know that the various items

on these statements will be scrutinized.

If there were **trusts** involved with any of these assets, applicants may be asked to provide the complete trust documents for review. Sometimes things that are allowable for tax benefits under a trust can cause eligibility issues for benefit filing. Again, estate planning attorneys and financial planners may not know the program rules for the various benefits.

Proof of Income

Most Public Assistance benefits have income limits. Caseworkers are looking for specific proof of the gross income from the various sources. They generally do not accept a deposit line item on a bank statement as proof of income. This is because what deposits to the account is the net income, and they generally want to see what deductions are taken from the gross income. The applicant will need to provide proof of income (and any/all deductions defined) on something on letterhead from the source of the income. In this modern age of auto-deposits and paperless statements, this can get tricky. Family members have to have their advanced directives in place to be able to speak directly to pension sources, annuity companies, or social security to request a statement of proof of income for parents who are not able to make this request for themselves.

Foreign pension income can be difficult to prove with proper documentation. The proof of income must come from the source and it can be very difficult to get this when it is coming from out of the country. The amount of the pension will also fluctuate as conversion rates change daily. Often, caseworkers will want a full year of proof of income from these sources to ensure that the appropriate average of the income is computed for determining the patient responsibility. They may also insist that the documentation is in English.

Real Estate

Some property (homestead in particular) is considered exempt as an asset if it is titled a particular way or located in the state that the applicant resides in. Caseworkers will want proof of property owned by the applicant and will want to see specifically the fair market value of the property and how it is titled. This can usually be easily attained through the property appraiser's office. They will also request proof of homeowners insurance and property tax information.

If there is a mortgage or reverse mortgage on the property, caseworkers will want proof of the outstanding debt, who owes it and whom it is owed.

Overlooked property that will still be considered can include timeshares, lots, multiple cemetery plots, and homes under foreclosure to name a few. Property documentation for these items are not as easily attained.

1. For **timeshares**, it will be necessary to provide proof of the deed (if it is that type of timeshare). It will also be necessary to show the current fair market value of the timeshare. This can usually be attained through a reseller of timeshares that can prove a comparable sale for the timeshare in question. Sometimes the timeshare corporate office can provide you with this type of proof.
2. **Vacant lots** are still property and still hold value. Sometimes caseworkers will not accept the fair market value listed on the property tax statement for the lot. They will want to see comparable sales from local realtors to prove the value. In some states, if the vacant lot is contiguous to the homestead property, it is considered part of the homestead property and may be exempt as a result—even though it is plotted as a separate property. Sometimes, these can be investment properties that are titled to multiple people. This is important to note in computing the value of the property as it relates to applicant.
3. **Rental properties** may be considered very differently from all other property depending on which public assistance benefit you are applying for and what state you reside in. You will need to provide proof of the

exact location of the property, how it is titled, the fair market value, a copy of the lease and proof of income received, and who receives it. Other documentation that may be requested is proof of annual repair and maintenance expenses, property taxes, homeowners insurance, utilities that the landlord pays, property management fees, pest control, pool maintenance, etc. Sometimes these expenses can offset the income received on the rental, which can be crucial when income to the applicant is part of computing the patient responsibility for the benefit.

4. **Cemetery lots** can be an exempt asset as long as the applicant does not own more than one for themselves and one for the spouse. Sometimes families buy up multiple lots for a "family plot." These are actually resellable and considered a real estate asset for many benefits. The details for each plot will be requested.

If a **home is up for sale**, the value of the property may be exempt as an asset in some situations. Generally, caseworkers will ask for a proof of the listing with a realtor, or a simple ad in the paper showing that the property is for sale at fair market value.

If a **home is in foreclosure**, then documentation to that affect will be required.

Life insurance can be considered an asset if it has cash value. Applicants will be asked to provide proof of the current cash and face value of the insurance as well as clear identification of the owner and the insured named.

Vehicles are also considered assets if there is more than one vehicle per household. Generally, a vehicle registration or title will suffice to prove ownership. If there is a loan on the vehicle, the details of the loan may be requested.

Personal Information that can be required (depending on the benefit applied for) includes:

1. Birth Certificate, naturalization papers, resident green cards, or valid passports to prove citizenship status
2. Drivers License or picture ID to prove local residence

3. Back and front copies of all health insurance cards
4. Copy of Social Security card
5. Copy of marriage license(s)
6. Copy of divorce papers
7. Copy of spouse death certificates
8. Copy of veteran discharge paperwork showing military history
9. Proof of filing for veteran benefits: Medicaid wants to see that all available benefits have been applied for before they will approve a case

Advanced Directives

Caseworkers will often want to review these legal documents to ensure that they have been drafted properly and legally allow actions that have been taken with Medicaid planning.

Proof of medical expense is required for some benefits. Most benefits require proof (from the source) of health insurance premiums. This is because some states allow the applicant to keep enough income from the patient responsibility to enable them to keep paying these premiums. This makes sense as it can minimize what the public assistance benefit has to pay for.

Benefits such as Veteran Aid and Attendance also allow adjustments to the income limit if the income is offset by **medical expense**. Medical expense can include the cost of caregiver services, and, at least for now, do not require that the services be provided by licensed professionals. Children providing caregiving services can count as a medical expense if they are paid for their services. This requires very careful accounting with invoices and payments to match. The invoice should specify the type of service provided, the time put in, and the cost per hour. Of course, the funds received by the caregiver are considered a taxable wage to that individual. A CPA should be consulted to ensure that the tax reporting for both parties is appropriate. This is a difficult concept for many families. They feel that taking money from their parents for caring for them is morally wrong. The truth is that many families could have badly needed assistance under Veteran benefits if they had sufficient medical expense to meet the means test. Caregiving expense, even from a family member, is considered a medical expense. *The applicant has to be incurring*

the expense to get reimbursement for that expense. Health insurance premiums, doctor visit co-pays, medication expense, life alert system costs, hearing aides, glasses, dental expenses, diaper costs, and nutritional supplements that are prescribed by a doctor are all considered medical expenses.

Applicants who reside in an assisted living facility can provide a copy of their contract and the services provided to have all or a portion of their monthly living expense counted as a medical expense. In the past, the whole cost of the assisted living facility was counted as a medical expense. This is changing to only count the service portion of the contracted monthly fee (not the room and board portion) as medical expense.

Pre-paid funeral contracts can be considered an asset if these contracts are irrevocable. Caseworkers will want to see a copy of the full contract and proof that it is irrevocable (usually just a form provided by the funeral home and signed by the owner of the policy).

If a **qualified income trust** was utilized for Medicaid planning or qualifying, the full trust document will need to be reviewed to ensure that the document was properly executed with the appropriate advanced directives in place. The bank statements for the account utilized to implement the trust will be closely scrutinized to ensure that appropriate funding was done each and every calendar month.

If the applicant has any **annuities**, the annuity will be closely analyzed to see if it is actuarially sound, and has appropriate beneficiaries named. In the past, annuities were utilized as a way of Medicaid planning to preserve assets for beneficiaries. Many states no longer allow this type of Medicaid planning and/or require that the state providing the benefit is named as the beneficiary if the annuity is allowed. Annuities that are paid as part of a pension plan may be allowable without a problem, but caseworkers will want to review them carefully to see if they meet their state law requirements.

More and more applicants have **long-term care insurance** that assist with paying for nursing home costs. Many times the monthly payout from this source falls woefully short of the

needed amount to cover the cost. If the applicant has a long term care insurance, they will need to provide a complete copy of the insurance and proof of what it pays, when the payments started, and how it pays (to the applicant vs the provider). Sometimes, long-term care insurance that pays to the patient is considered additional income and is treated accordingly. In some cases, the payments are considered medical cost reimbursement and treated differently still, and sometimes the payments are paid directly to the provider and not considered at all.

If applicants have a **special needs trust**, the caseworkers will ask for a review of the complete trust agreement, how it is funded, and statements for the funds held. They will review the trust statements to ensure that all distributions are appropriate and in accordance with the trust rules.

If the applicant has any interest in **mineral rights from mines or wells**, proof of the annual/monthly income must be provided from the source. Often these distributions are very erratic. To complicate things further, the distributions are often diluted, depending on how many investors are named and how much product is produced. This can be a very difficult asset to document.

Personal services contracts are commonly used tools used with Medicaid planning in states where they are allowable. The caseworkers will want to review the contract to ensure that it meets the state rules for those benefits. They will also check to see that the funds were paid out on time and may request detailed, ongoing invoicing information to prove that the funds are being applied towards the intended use.

Personal Loans made or mortgages held by the applicant are common occurrences. When such situations occur, caseworkers will want to see the terms of the loans in writing with amortization schedules for payback and proof of payments received. Failure to provide proof of loan terms and payback can result in the loan being considered a gift or transfer of asset.

In some cases, **income from an applicant can be deferred to a community dwelling spouse** who has

a low income. In these cases, the spouse will need to provide documentation to show that their monthly income is not sufficient to cover their living and medical expense costs. Such documentation may include utility bills, condo fees, homeowner's association fees, telephone bills, and lot rentals.

CONCLUSION

Clearly applying for benefits is not for the faint at heart. Gathering up the needed documentation can be a full-time job for an already stressed out caregiver or spouse. Many times, the filing of these applications are being done under a tight timeline. It must be stressed here that applicants DO NOT need to have everything in hand before meeting with an Elder Law Attorney. It is helpful to have as much of this gathered as possible so that the counsel for filing for benefits can be more specific. No matter how hard you try, there is bound to be something that you still have to gather for your specific situation. Applicants are always shocked that the process is so intense. Most people think that applying for these benefits is a simple process of completing an application. In most states, the average application is about 50 pages with all of the attachments, and many are well over a hundred pages if there are multiple assets to document.

Be sure to **send copies** of all documents, and **send them either return receipt or in some form of trackable courier system**. Keep copies for your records so you can be sure of exactly what you sent should it become necessary to send additional information later.

It is best to **assemble all appropriate documentation in one complete packet**. The likelihood of separate pieces of information landing in the same file is slim, and can really delay an application processing.

Patience and persistence is key. Having a professional review your documentation prior to sending can speed up the approval and review process.

Is It Worth It??

When the benefit amounts to over \$5000 a month, you bet it is worth it! When you are the grown child trying to crawl through the process, there are many times when you will wonder what

in the world you have gotten yourself into. Hang in there. Your parent(s) deserves to have the best care possible. This may be the most important (and difficult) task you will ever do for them.

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Patrice Antony is a Florida International University graduate who has been practicing physical therapy in the Central Florida area since 1981. Patrice became a Geriatric Clinical Specialist in 1992 and received the *Clinical Excellence in Geriatric Practice* from the Geriatric Section of the APTA in 1996. She taught as an adjunct instructor in the University of Central Florida physical therapy program for 4 years and has done extensive lecturing around the country on various topics relating to

care of the elderly. She is owner and President of Elder Advocates Inc., a care management company founded in 1998 that is designed to meet the needs of the frail elderly and the medically complex client.

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Jeffrey R. Guild began his career as a strength and conditioning specialist at the Baylor Tom Landry Fitness Center in Dallas working to advance the fitness

and wellness of people with and without physical limitations and movement impairment dysfunctions. As a physical therapist, Jeffrey worked to expand the neurological/vestibular outpatient rehabilitation program at Riata Therapy Specialists in Bedford, Texas. Jeffrey pursues advanced training in neurological and vestibular rehabilitation and fall prevention, participating as a resident in the Baylor Institute for Rehabilitation and Texas Woman's University Residency in Neurologic Physical Therapy for 2014/2015.

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the University of Cincinnati's Physical Therapy Program, serves as the Director of Clinical Education and the Academic Director for the Geriatric Residency program at the VA Medical Center.

Rose L. Smith is a graduate of the University of Pennsylvania and has been practicing for 39 years. She has been teaching full time at the University of Cincinnati for 16 years within the Physical Therapy and Health Sciences programs.

Barbara Zoretic is a third year DPT student in the College of Allied Health Sciences at the University of Cincinnati. She is currently a UC graduate student assistant and Yates Scholar as well as the Student Challenge Coordinator for the Ohio Physical Therapy Association Student Special Interest Group Board.

Elizabeth Kolena is a third year graduate student in the College of Allied Health Sciences at the University of Cincinnati. She received her Bachelors of Science in

Exercise Science at Miami University and will be graduating in May 2015 with her Doctor of Physical Therapy degree.

K. Marlena Thomas is a native of Indianapolis, Indiana, and received her Bachelor of Science from Purdue University in 2012. She is currently a third year DPT student at the University of Cincinnati and will graduate in the spring of 2015. After graduation, she hopes to apply women's health topics to the geriatric population.



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