GeriNotes

Academy of Geriatric Physical Therapy

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All advertisements that appear in or accompany *GeriNotes* are accepted on the basis of conformation to ethical physical therapy standards, but acceptance does not imply endorsement by the Academy of Geriatric Physical Therapy, APTA.

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:

The Academy of Geriatric Physical Therapy | 3510 East Washington Avenue | Madison, WI 53704

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/Memoriam Fund is a wonderful expressive memorial.

President's Message

Greg Hartley, PT, DPT, GCS

Hello Academy members! First, thank you all for your support as I have transitioned into this new leadership position. I have been overwhelmed by your kind words of encouragement and am excited about the direction the Academy is headed, thanks in large part to the excellent stewardship and leadership provided by our immediate past-president, Dr. Bill Staples. *Thank you, Bill.*

I write this column coming off the heels of another record-breaking CSM. With over 17,000 in attendance, CSM continues to be an exciting, jam-packed event full of opportunities to learn, network, and contribute. In addition to the typical activities, this year the Academy celebrated its 40th anniversary. We were pleased to welcome Dee Mills, daughter of our founder, Joan Mills, to the celebration. We will be continuing this anniversary celebration all year long, so watch for more exciting news about where we have been…and where we are going next!

Speaking of 'next,' the APTA House of Delegates and NEXT Conference will be here before you know it. This year, these events will take place June 25-30 in Orlando, Florida. The NEXT Conference is the latter part of the week (June 27-30, 2018) and includes exciting programming, an exhibit hall, and lots of networking and social activities. The AGPT will be there in force, so come by the booth and see us. We will be continuing the 40th anniversary celebrations; I hope to see many of you there. The House of Delegates takes place in the days preceding the NEXT Conference (June 25-27, 2018). This year's House is shaping up to be a very busy one. Importantly, there will be a motion put forth this year that will allow Sections (or Academies) to have a vote in the House of Delegates. Currently, all Sections/Academies have a delegate that attends the House and is able to bring forward motions and speak on behalf of their membership. However, currently, Section/Academy delegates are unable to cast a vote. It is time for this to change! The motion coming before the House would allow 2 voting delegates from each of the APTA's 18 Sections/Academies; thus, the campaign is dubbed "18 in '18." While Chapter delegates are knowledgeable about many areas of practice within their jurisdictions, they are elected to represent members from their Chapter. Having expert, clinically specific representatives from practice areas like geriatrics is essential in today's fast-paced, highly compartmentalized health care arena. The AGPT delegates would be able to fully grasp the complex national issues surrounding post-acute care, Medicare, empowered aging, and transformative policies that impact aging adults across the nation. This specialty-based knowledge, and the responsibility that comes with being able to cast a vote, is a necessary step in valuing the contributions Sections/Academies can make to the larger Association, the profession, and the public. *Please contact your Chapter Delegates and ask them to support "18 in '18," the Section Vote. Contact your delegate by going to http://www.apta.org/HOD/ (login required).*

Finally, if you have not yet figured out how you would like to engage more with the Academy, please reach out to me. I also want to hear your ideas about how the Academy can engage more with you! This is a two-way street. Our Academy is growing and evolving. We can use your help and your advice as we forge toward the next 40 years. I am looking forward to the next 3 years for sure!

Please contact your Chapter Delegates and ask them to support

"18 in '18," the Section Vote.

Contact your delegate by going to
http://www.apta.org/HOD/ (login required).

Editor's Message: Even Spring Makes You Think of Falls

Michele Stanley, PT, DPT, GCS, CEEAA

Copy for this issue was submitted on the first day of spring. While writing this and looking out the window at trace snow banks, my feet are itching to pound the pavement rather than my treadmill and I welcome the dirt soon to be under my fingernails as I dig in my garden. Truth is, I ended up with a knee injury that led to a TKA from a black ice fall while hiking about 5 years ago. I am healthy, active, in no sense frail, but…. a slip on a prior sunny spring day still makes me pause and decide that the treadmill is a better option most of the time or at least to take my hiking poles. In this issue, several authors again address the huge impact that falling and fear of falling has on many of our clients.

It will be May and spring will have sprung by the time you read this. That means it is time to think about NEXT, the APTA's summer conference. Held this year June 27-30 in Orlando, FL and conveniently close to the "Happiest Place on Earth" if you want to pair it with a family vacation. A peek at scheduled sections promises much more in-depth information about the movement system, emerging issues in payment, pain control, disability arising from non-communicable disease, and the Mary MacMillan Lecture: "Wisdom and Courage: Doing the Right Thing." NEXT gives "exclusive access to the profession's forward thinkers" as well as great CEUs and networking. Think about attending.

If you attended the wildly successful (17,000 strong) CSM conference in NOLA last month, I do not need to convince you that the AGPT throws a good party. There are always recap articles featuring the work of our SIGs and awardees in the May issue. Many of our SIGs have planned another round of awesome programming for CSM 2019 next January in Washington, DC.

Make sure you read Jenny Bottomley's article on the history of the AGPT from the perspective of both a past President (of the then Section) as well as past *GeriNotes* Editor. Continuing this introspective journey, over the next several issues we will examine current practices and practice settings and the underlying finances with generous contributions from our payment/practices/policy guru Ellen Strunk (catch the initial article inside). Would you like to write about what makes your practice setting good …or bad…or both? How have you tailored your practice around third-party payer constraint? What tips do you have for newer grads wanting a geriatric practice?

GeriNotes welcomes hearing from you!

CSM 2018 Recap

Sarah Ross & Mariana Wingood, Programming Committee Co-Chairs

CSM 2018 in New Orleans was full of incredible moments. This CSM goes down as another record-setter, with over 17,000 in attendance. An amazing 6,000 of those were PT and PTA students, showing what a bright and exciting future our profession holds. The Academy saw 138 new or recertified Geriatric Specialists acknowledged for their extraordinary accomplishments at the Recognition Ceremony Wednesday night. The AGPT produced a fantastic array of education sessions spanning from the Pathological Sit-to-Stand to Teaching Geriatrics PT to Dementia Care. A huge thank you is due to all of our speakers!

The Academy of Geriatrics geared up and kicked off its 40th anniversary celebration year while at CSM. The AGPT, formerly known as the Section on Geriatrics, has been focused on improving the delivery of physical therapy and care of our aging adults for 4 decades. This anniversary is an opportunity to reflect on the past and look to how we can continue to strengthen the future, not only for us but for our patients too! Kudos to Bill Staples, Jill Heitzman, and Lucy Jones for their years of service to the Academy. Congratulations and welcome to our newly installed Board members: President, Greg Hartley; Vice President, Cathy Ciolek; and Director, Jackie Osborne.

We are looking forward to a great 40th year for the Academy through 2018 and on to a bright future! When you read this, programming plans and selections will be well underway for CSM 2019. Join us in Washington, DC in January.

AGPT 40th Anniversary Celebration at CSM a Big Success!

Karen Curran, CAE; Lee Eagler, PT, DPT

Thanks to everyone who attended the Member Meeting, awards celebration, and anniversary celebration at CSM in New Orleans. We especially thank all the Charter Members, and Joan M. Mills winners, and Past Presidents in attendance and congratulate our latest Joan M. Mills Award winner, Tamara Gravano, PT, DPT, EdD. The Joan M. Mills Award is the most significant recognition that the Academy can give to one of its members. This prestigious award was initiated in 1980 to honor individuals who have generously, unselfishly, and creatively given of their time and gifts in service to the Academy. These wonderful attributes are those that typify Joan M. Mills, the founder of the Academy.

Tamara was recognized for her numerous contributions to the Academy including Director of Membership, instructor and Co-Administrator for the CEEAA certification courses, past Membership and Residency/Fellowship SIG Chair, past Chair of the American Board of Physical Therapy Specialties Geriatric Council, on the Editorial Advisory Board of *Today in PT* and reviews manuscripts for the *Journal of Geriatric Physical Therapy.* Tamara has also made numerous presentations to local and national audiences. We were so honored to have Joan's daughter, Dee help present the award this year!

Also recognized for their outstanding service were Meri Goehring, PT, PhD, GCS, and Lise McCarthy, PT, DPT, GCS, who both received President's Awards. Meri capably served as Editor of *GeriNotes*, the Academy's non-peer reviewed magazine from January 2014 to November 2017. The Editor's duties are many and we thank Meri for editing copy to improve readability, overseeing article submissions, working effectively with the publisher, meeting all deadlines, and responding in a timely manner to queries from potential authors. Meri also annually revised the author guidelines and worked closely with the Editorial Board to ensure each issue of *GeriNotes* was professionally presented and relevant to our members.

In 2014, Lise's vision for a Cognitive and Mental Health Special Interest Group led to its formation and she is largely responsible for the way in which it has grown annually. Lise has served as Chair of the SIG since its inception and has worked diligently to develop professional relationships between other geriatric national organizations to promote the benefits of physical therapy for this population. Lise has been a passionate voice for aging adults for two

Dee Mills, Tamara Gravano, Bill Staples

Previous Joan M. Mills winners helping our newest winner, Tamara Gravano, celebrate!

We also congratulate our newly installed Board members: President, Greg Hartley; Vice President, Cathy Ciolek; Director, Jackie Osborne; a nd Nominating Committee Member, Jill Heitzman

Lots of wisdom and experience in this group of Past Presidents (John Barr, Bette Horstman, Neva Greenwald, Carole Lewis, Bill Staples), with new President, Greg Hartley

Michele Lusardi, Shelly Lewis, Kevin Shaddock, Ky Pak, Pamela Dunlap, Annalisa Na, Myles Quiben

decades and she focuses on advancing the knowledge and skills of geriatric physical therapy practice in the areas of cognitive decline and pain management.

2018 "ACADEMY" AWARDS

There were many awards presented during the AGPT Business Meeting/ Awards Ceremony during CSM in New Orleans, Louisiana. Congratulations to all of our 2018 Award Winners!

Clinical Educator Award – Shelly Lewis, PT

The Clinical Educator award recognizes a physical therapist or physical therapist assistant for outstanding work as a clinical educator in the geriatric health care setting. Dr. Michelle "Shelly" Lewis, winner of the Clinical Educator award, has had a passion for clinical education throughout her physical therapy career. Her students emphasized her willingness to go "above and beyond" to ensure success and happiness of the students in the program. Similarly, they describe her teaching ability and passion for geriatric physical therapy, particularly with the ALS population, where she has helped with significant fundraising efforts and advocating successfully for policy changes. The AGPT congratulates Shelly for receiving the Clinical Educator Award!

Outstanding PT Student - Kevin Shaddock, SPT, Thomas Jefferson University

Kevin Shaddock's compassionate heart was evident throughout his nomination and support of instructors and fellow students. For the past 3 years, Kevin has served the underinsured in the Hearts of Hope pro bono clinic both as an officer and by treating patients. He also is the co-founder of the Senior Engagement Program serving older adults within the Bhutanese American Organization of Philadelphia through wellness activities, exercise, and citizen exam preparation.

Outstanding PTA Student – Ky Pak, SPTA, Somerset Community College

Ky Pak belongs to 5 APTA sections, including AGPT, and has led fundraising efforts for the 2017 VCU Marquette Challenge. At the Kentucky Student Conclave, he was named to the 2017 KPTA All-Academic Team and within the Somerset Community College PTA program, he is president of his class and the PT Student Organization.

Adopt-A-Doc Award – Pamela Dunlap, DPT

Pamela Dunlap, DPT, doctoral student at the University of Pittsburgh; major field of study: vestibular rehabilitation, balance and falls.

Fellowship for Geriatric Research – Annalisa Na, PT, PhD

Annalisa Na, PT, PhD, post-doctoral research at Departments of Physical Therapy and Orthopaedic Surgery & Rehabilitation at The University of Texas Medical Branch; research focus: improving postoperative outcomes for older adults with osteoarthritis and diabetes.

Distinguished Educator Award – Myles Quiben, PT, PhD, DPT, MS, GCS, NCS

Dr. Myles Quiben is this year's winner of the Distinguished Educator Award, recognizing excellence in teaching. Her passion for geriatric and neurological physical therapy is evident by her dual certification in geriatrics and neurology and her fellow instructors are quick to point out her dedicated, challenging, and student oriented teaching style. Students report that they feel confident in their knowledge and technical skills and they are able to translate these skills while on clinical rotations after taking her classes. Her passion for the physical therapy profession extends outside the classroom as demonstrated by her numerous leadership, service, and mentorship roles in the AGPT, FSBPT, ACAPT, Texas Geriatric Society, and Texas Physical Therapy Association and many more.

Lynn Phillipi Advocacy for Older Adults Award – Sherri Betz, PT, GCS

The Lynn Phillipi Advocacy for Older Adults Award recognizes projects or programs in clinical practice, educational, or administrative settings that provide strong models of effective advocacy for older adults by challenging and changing ageism. This year's award went to Sherri Betz, PT, GCS, for her Bone Builders Therapilates program. Sherri's nominator likens her to the late Lynn Phillippi by her 20 years of dedication to promoting positive aging as well as her ongoing service to AGPT in numerous ways including the Bone Health SIG. The AGPT congratulates Sherri Betz for her effective efforts in improving the lives of older adults!

Sherri Betz, PT, GCS

Clinical Excellence in Geriatrics – Aimee Perron, PT

The Clinical Excellence in Geriatrics award recognizes a physical therapist for outstanding clinical practice in the geriatric health care settings. This year's award winner, Aimee Perron, is a regional director for Genesis Rehab. She is known as a lifelong learner and readily shares her knowledge and expertise with Genesis Rehab co-workers through presentations and education sessions for staff. Most notably, she developed an evidence-based fall risk management for the organization.

Outside of her organization, she is an active member of the Massachusetts Falls Prevention Coalition. For all advocacy issues, she is a voice for the older adult when they cannot speak for themselves. As a leader within her company, she makes decisions based on best care for patients. Congratulations Aimee!

Aimee Perron, PT

Excellence in Geriatric Research Award – Michelle Lusardi et al

Lusardi MM, Fritz S, Middleton A, Allison L, Wingood M, Phillips E, Criss M, Verma S, Osborne J, Chui KK. Determining risk of falls in community dwelling older adults: a systematic review and meta-analysis using posttest probability. *J Geriatr Phys Ther*. 2017;40(1):1-36**.**

Student Research Award – Michael Himwan, SPT

Michael Himawan, DPT student at the University of Colorado; current research involvement in using predictive analytics to help set patient expectations following total knee arthroplasty.

Adopt-A-Doc Award – Allison Gustavson, DPT

Allison Gustavson, DPT, doctoral student at the University of Colorado; major field of study: effective rehabilitation for older adults following hospitalization.

The Awards and Research Committees would like to thank all of the nominees and their supporters for nominations received in 2018. Please consider honoring someone who is doing extraordinary work in geriatric physical therapy by nominating him or her for a 2019 award. Please see the AGPT website at https://geriatricspt.org/awards/ for a description of AGPT awards and the nomination process.

Allison Gustavson, DPT

Student Research Award – Michael Himwan, SPT

Toileting: Crucial to Independence
The Treatment Piece

Carole Lewis, PT, DPT, GCS, GTC, MPA, MSG, PhD, FSOAE, FAPTA; Beth Bright, OTD, OTR/L, BCPR

INTRODUCTION

As previously published, there is evidence surfacing to support further investigation of toileting related interventions by occupational and physical therapists. It is the goal of this second article to define contributing factors to toileting dysfunction and propose suggestions for rehabilitation intervention. Once the need for intervention has been identified, it is important for therapists to take into consideration the components or related tasks that are leading to difficulty with toileting. In an article published in 2008, researchers identified the following variables as affecting toileting: muscle strength, vision, cognition, balance, vestibular function, sensation, endurance, coping, gross motor coordination, and fine motor coordination.[1] After identifying which variables should be addressed, a clinician can further investigate the impact on other areas of performance or occupational tasks that may also be impacted. Occasionally, toileting dysfunction may go unaddressed due to the limited nature in which a therapist primarily engages with client's self-care. Finally, toileting interventions can create more of a challenge due to the limited nature of seating and transfer devices to assist toileting functions for older adults with physical impairments.[2]

SITTING BALANCE AND TRUNK CONTROL TREATMENT TECHNIQUES

We recommend starting treatment with activities that focus on sitting balance and trunk control. A fun way to work on balanced sitting is a modification of an approach used by DeSeze and colleagues.[3] In this approach, DeSeze et al[3] used a laser pointer apparatus attached to the person's head in sitting. The 30-minute treatment consisted of pointing to objects at varying heights and widths by moving the head and trunk to point the laser beam at the object. This approach can be modified by using a flashlight attached to a headband (available at hardware stores) and placing objects or pictures around the room that the person must "light up" by sitting unsupported and looking up, down, and side to side.

Another set of interventions are derived from Karthikbabu et al's study[4] which showed that doing the following exercises were effective for improving trunk stability:

In a seated position:

(1) Flex and extend trunk at hips (hip hinges)
(2) Laterally flex trunk side to side
(3) Pelvic clocks
(4) Trunk rotations
(5) Forward, backward, and diagonal reaches

Transfer Training Treatment Techniques

Simultaneously, or as the person's sitting balance improves, therapists can begin to work on transfer training. Nuzik et al[5] found a good deal of similarity in the way that people transfer or get up and move from sitting to standing. Therefore, generalizations can be made about the complicated process of transfers. Nuzik et al[5] divided sit-to-stand transfers into two phases: the flexion phase and the extension phase. In the flexion phase, which is the first 35% of the activity, the person goes into neck, trunk, hip, knee, and ankle flexion. In the remaining 65% of the sit-to-stand activity, the neck, trunk, hip, knee, and ankle go into extension. The pelvis, which is initially posterior, rotates anteriorly. The hip is in flexion for the first 40% of the activity and goes into extension for the last 60% of the activity. The knees go into extension throughout the activity. The trunk moves vertically after 45% of the movement has taken place. The real key is that after 35% of the activity, the person begins to lift the hips off the seat. At that point, everything goes into extension. The hip lifting highlights the importance of hip extension in a patient's movement from sitting to standing.

In order to treat deficiencies in the transfer process, the rehabilitation specialist should begin working on activities that will facilitate the patient's ability to perform the component motions. For example, initial activities based on Nuzik et al's[5] work may include forward weight shift, anterior pelvic shift, neck flexion followed by neck extension, and knee extension during trunk extension. Some techniques that focus on middle to ending motions include hip lifts from chair, truck flexion extension activities, knee extension exercises, standing hip extensions, and hip thrusts combined with head extensions.

It is important to teach both hip and knee flexion and extension. The rehabilitation specialist should analyze the task to determine where the hips work, where the knees work, and how they work, so that treatment focuses on the appropriate phase of the activity. Working on hip movement generally improves the anterior movement of the pelvis, as well as trunk and knee flexion. A Bobath technique that has been used for many years recommends, for example, having patients slide their hands along a chair in front of them to encourage flexion of the trunk for the first 30% to 40% of the sit to stand. Addressing toileting interventions may require further investigation into hip extension at the point of reversal of momentum during sit-to-stand. This will provide the clinician with insight into strength and range of motion that is required for toileting tasks. Identify how the patient's center of mass impacts

postural stability and distal mobility of the arms. Toileting tasks require dynamic movement in seated and standing positions and a better identification of a patient's center of mass can enhance the occupational performance. Task completion is not the only factor that clinicians are concerned with regarding toileting intervention. A patient's speed of the sit-to-stand movement task, trunk rotation and flexion, and accuracy with tasks may require verbal and tactile cues to alter quality performance.

When using the techniques noted above, it may be necessary to allow for mental practice as well as physical practice. Malouin and colleagues[6] showed that mental practice helped to improve in limb loading for the sit-to-stand movement pattern. The program includes treatment 3 times a week for 4 weeks. During the sessions, patients performed 5 mental sit-to-stand repetitions separated by one physical repetition. A sample session may include treatment instruction (use scales, force plates, etc), mental repetitions for target movement, auto estimation of motor imagery vividness, physical repetition, and rest.

The final approach to address the component of the sit-to-stand piece of toileting follows the old adage "practice, practice, practice." Tung et al[7] in 2010 showed effectiveness of a simple sit to stand program administered by a physical therapist assistant. The experimental group improved weight acceptance through the affected foot while the control decreased their ability to accept more weight through the affected foot. The program worked on foot placement, forward movement of the trunk, verbal feedback, varied seat heights, and surfaces. The physical therapy assistant monitored progress and increased the number of sit to stand as the patient improved.

CONCLUSION

As the above information suggests, addressing toileting dysfunction requires a broad approach addressing multiple factors. Establishing a baseline, addressing targeted deficits, and ensuring carryover by practicing toileting routines may be a highly effective way to minimize functional impairments related to toileting. Therapists are fully equipped to address toileting related needs of clients in multiple care setting. This article serves as to provide evidence to support further advancement of toileting interventions for the geriatric population.

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Beth Bright is an Assistant Professor and the Assistant Director of Academics at Huntington University's Doctoral Occupational Therapy Program. She has been researching to further identify contributing factors to fall risk and the development of a community screening form.

Policy Talk
Regulatory Round-Up: You Should Know

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

2018 has certainly had its share of cliffhangers and surprises in its first 100 days. As this article is written, we are only 74 days into the new calendar year and while there are many things we do know, there are just as many that we do not. On February 6, 2018, the **Bipartisan Budget Act of 2018**[1] was passed by both Houses of Congress. This bill contained several provisions related to Medicare and the Medicare extenders. Let's take a few minutes and focus on what we DO know.

Medicare Part B

THE THERAPY CAPS ARE GONE!! This represented a huge victory for the APTA and all its members and partners. A 20-year battle to remove the arbitrary limit on rehabilitation services for Medicare beneficiaries was finally successful. However, with the good news comes some unexpected news. So, what does this mean for therapists and our practice?

What is NEW?	What is NOT NEW?	How is PRACTICE affected?
Patients do not have to be told that their rehabilitation services are limited to a certain dollar amount per year – in any setting!	The services provided must still meet the definition of medically necessary, and require the skills of a therapist to deliver.	An Advanced Beneficiary Notice[2] must still be given to the patient when: • Services are no longer medically necessary • Services do not require the skills of a PT or PTA • Services are not covered by Medicare per National &/or Local/National Coverage Decisions
Even with the repeal, the KX modifier **remains.**	The KX modifier is attached to services to indicate the provider of the service 'attests' to the fact the service is medically necessary.	Therapy practices will have to continue to put the KX modifier on claims for services > $2,010 to indicate they are medically necessary.
The targeted manual medical review process remains for services above a certain "threshold," but that threshold is **lowered from $3,700** per calendar year **to $3,000 per calendar year** through 2027.	Therapists are accustomed to medical review for therapy services. The 'targeted' process means that all claims above the threshold will not be reviewed.	Only a percentage of claims above $3,000 will be subject to review. Providers who meet certain criteria will be targeted, such as those who have had a high claims denial percentage or have aberrant billing patterns compared with their peers.
Congress extended the 1.0 physician work Geographical Practice Cost Index (GPCI) floor for two more years - through 12/31/2019.	The GPCI is used along with Relative Value Units by Medicare to determine allowable payment amounts for procedures. It is a mechanism to account for the geographical variances in delivering services. There are multiple GPCI's – for work expense, practice expense, and malpractice expense.	The following states will NOT see a decrease in their Part B payments related to the work GPCI: AL; AZ; AR; CO; Fort Lauderdale, FL; Miami, FL; Rest of FL; Atlanta, GA, Rest of GA; ID; East St. Louis, IL; Rest of IL; IN; IA; KS; KY; New Orleans, LA; Rest of LA; Southern Maine; Rest of Maine; Rest of MI; MN; MS; Metro Kansas City, MO; Metro St. Louis, MO; Rest of MO; MT; NE; NH; NM; Rest of NY; NC; ND; OH; OK; Rest of OR; Rest of PA; PR; SC; SD; TN; Austin, TX; Beaumont, TX; Rest of TX; UT; VT; VA; VI; Rest of WA; WI; WY.

What is NEW?	What is NOT NEW?	How is PRACTICE affected?
Congress extended the Home Health (HH) Rural Add-On of 3% through 12/31/2018 for home health services provided in rural areas with a population density of ≤ 6 person per square mile. Future recommendations will be based upon analysis that is due no later than 1/1/2023.	This add-on was effective in 2017 and no action by providers is necessary.	Beginning 1/1/2019, and subsequent years, the HH rural add-on payment will vary by year across 3 different tiers of rural counties in which HH services are furnished: (1) rural counties in the highest quartile of all counties with respect to the number of Medicare home health episodes furnished per 100 individuals who are entitled to, or enrolled for, benefits under Part A or Part B (but not enrolled in a plan under Part C); (2) rural counties with a population density of 6 or fewer individuals that are not in the above highest quartile of home health utilization; and (3) all other rural counties.
Medicare Advantage (MA) Special Needs Plans (SNPs) are permanent.	Medicare Advantage (MA) Special Needs Plans (SNPs), Dual-Eligible SNPs (DSNPs), and Chronic Condition SNPs (C-SNPs) are intended to target care for vulnerable populations and improve care management.	Several reforms are designed to improve care management. For instance, requirements for enhanced coordination between states and the federal government for beneficiaries eligible for both Medicare and Medicaid (D-SNPs) – especially regarding appeal and grievance protocols – and requiring these plans to have direct contracts with states in which they operate. Beginning CY2020, care management strategies employed by Chronic Condition Special Needs Plans (C-SNPs) will be subject to heightened standards.

Since nothing is free, there were certain areas where payment was changed in an effort to "pay-for" the removal of the therapy cap. Here are a few that will affect PT services.

What is NEW?	What is NOT NEW?	How is PRACTICE affected?
The 2019 update to the Physician Fee Schedule was decreased from 0.5% to 0.25%, expecting to save $1.8 billion over 10 years.	This decrease does not go into effect until 1/1/2019.	There is still time to advocate for removing this provision before 1/1/2019.
Another "pay for" was the last-minute addition of a payment differential for services provided by PTAs. Effective 1/1/2022, services delivered by PTAs (and OTAs) will be paid at 85% of the fee schedule amount, rather than the 100% they currently are. This is expected to save $1.2 billion over 10 years.	PTAs are a vital part of the therapy team. These changes will not take effect until January 1, 2022. The 85% differential is similar to how nurse practitioners who provide services under the supervision of a physician are currently paid by Medicare.	APTA and the Therapy Cap Coalition, including the AOTA, will be working to determine the best way to address this new policy to insure access is not limited and the policy is favorable to PTAs and the profession.
The Skilled Nursing Facility update to payment rates is modified to 2.4% for FY 2019, expected to save $1.925 billion over 10 years.	This decrease does not go into effect until 10/1/2018.	There is still time to advocate for removing this provision before 10/1/2018.

The Home Health agency update to payment rates is modified to 1.5% in CY 2020, expected to save $3.5 billion in 10 years.	This decrease does not go into effect until 1/1/2020.	There is still time to advocate for removing this provision before 1/1/2020.
Home Health agencies will be required to bill in 30-day units of service.	The PPS system by which payments are determined is not going to change in the short term.	Home health agencies are currently paid based on 60-day episodes. Beginning 1/1/2020, the "unit" of payment will be reduced from a 60-day payment to a 30-day payment.
The Secretary of HHS is directed to "eliminate the use of therapy thresholds in case mix adjustment factors" for determining home health payment rates effective 1/1/2020.	Congress, MedPAC and CMS are all forging ahead with plans to revise the case-mix models in both the home health and the skilled nursing facility settings to remove the perception that therapy use drives care decisions.	Over the remainder of 2018, CMS will continue to identify and prioritize recommendations specific to revising home health payment. There will be notice and comment rulemaking on a case mix system with respect to PPS for home health services expected in 2019.

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Student Prespective: Taking Time Away from Class

Jennifer Scharenbrock, SPT

I had never visited the third floor of the Madison Public Library previously; typically used as a gathering space, there had been no prior motivations to drop by. On this Friday morning, I ascended the stairs with a purpose, to learn about a volunteering opportunity called Ballroom Basics for Balance™ (BB4B). Ballroom Basics for Balance was established in 2014 but I had learned of it in 2016 during my first summer semester at the University of Wisconsin-Madison. One of the co-founders, Susan Frikken, had invited my classmates to help with the course starting in the Fall—two of us had answered the call. I discovered that the dance class caters to the older adult seeking to improve their balance, thereby reducing the risk of falling. The task of the volunteers (generally physical or occupational therapy students) entails creating a safe space for the participants to push their personal limits and make balance improvements. Protecting individuals from falling turned out to be just the beginning of what I was going to learn throughout my year of volunteering with the organization.

The BB4B course, offered to independently mobile older individuals in the Madison community, strives to improve balance and provide falls prevention. The participants range in age from 55 to 91. The class brings individuals from the community together to engage in dance and music while learning about ways to improve one's balance with a base built on scientific evidence and the experience of the health care providers assisting with the class. Promoting health and creating a safer society are the organization's overarching goals. The duration of the commitment falls between 8 and 12 weeks and includes a variety of different dance styles. Participants have varying levels of dance experience and the course has the flexibility to be made easier or harder depending on the needs of those involved. Currently, the organization collects data at the beginning and end of each seasonal class to better inform their processes. The volunteers help with set-up, take-down, administering balance testing, and keeping participants safe. The following experiences are a few of the items gleaned from my year of involvement.

As a first-year physical therapy student, many of the responsibilities performed as a volunteer were new to me. I helped to administer the Timed Up and Go[1] falls prevention screen for the first time that September and learned how to dance the merengue. Many of the experiences were brand-new to me and at first I approached the experiences with trepidation. Quickly my nervousness morphed into an eagerness for further knowledge and experiences. BB4B helped to build confidence in my abilities to interact with clients and administer rehabilitative measures. I engaged with community members, danced (without prior experience), and answered questions about my profession. I learned much about falls and how they can negatively affect an older adult. Before the end of my time volunteering, I had even prevented one spill through sta-

bilizing unsteadiness. I found that the participants were predominantly healthy and I learned that each person was being proactive about his or her health. Participants attended the lessons to experience an enjoyable form of movement. They seemed thrilled to learn different dance types, especially those they had not experienced previously. The hula dance and Irish jig were especially popular classes—everyone laughing and smiling more than usual on those days. Through dance, the participants could move and improve their balance via an activity that does not feel like forced exercise.

I learned a great deal about healthy community dwelling older adults and the gathering of a diverse group of individuals taught me that there is more than one way to age healthfully. Specifically, I was struck by the participant's other interests and experiences they were engaging in within the Madison community. Many of the participants that I met made music through singing or playing an instrument and regularly play with a group in the community. A few others were also involved in auditing courses on the University of Wisconsin-Madison campus, taking a class to learn something new and enjoying the process of learning. One of the participants told us how she took up drawing as a hobby in the eighth decade of life and sold those drawings to raise money for her favorite charity. Many of the participants would also donate their time to help those in need. The list of interests for the two groups that I interacted with was extensive and taught me a great deal about staying active throughout life through personal hobbies and interests.

The course offered me time to take a break from my coursework, allowing me to connect with others and be present in the moment. During the two-hour time block when I thought I was "taking a break" from learning, I was unintentionally learning an abundance of information. In looking back on my time during the first few semesters of physical therapy school, I will not remember the specific grades that I received but I will remember my time and experiences connecting with others and giving my time.

Two final takeaways from the experience are kindness and gratitude. Beginning on the first day of class, each participant projected kindness to all volunteers. They were interested in our experiences and were eager to assist in our learning. They were also endlessly thankful to all the volunteers for being present. Within our educational lives and our professional lives, it becomes easy to forget to be grateful and to practice kindness but it can be crucial to the care of our patients and clients.

In summary, working with community dwelling older adults has a multitude of rewards, only a few of which I have addressed here. I learned about my capabilities in the first stages of my physical therapy career, the abundance of routes to aging healthfully, the ability to take joy in an exercise program, and the importance to remember to practice kindness and gratitude. My experience working with older adults in BB4B was delightful and I would argue that I got just as much, if not more, from the participants as they received from me.

For more information about Ballroom Basics for Balance, please visit the website at: ballroombasicsforbalance.org

REFERENCE

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Celebrating 40 Years
A Historical Walk from Foundation to Our Ruby Year

Jennifer M. Bottomley, PT, MS, PhD

The ruby is a gem that signifies light to the darkness. As legend indicates, the ruby encourages following your heart and teaching one to enjoy being in the physical world. The ruby has been thought to increase the perception of the spiritual energy that exists throughout and transmits into the physical realm of matter creating awareness and movement. The ruby is the gift given to acknowledge a 40th anniversary. The Academy of Geriatric Physical Therapy (AGPT) is a gem so like a ruby. The AGPT is a unique and precious gem that has brought light to geriatric physical therapists and geriatric patients, encouraged members to follow their hearts, provided spiritual energy increasing the physical energy, awareness, and motion throughout the realm that matters – our older adult patients and clients. Like a ruby, the AGPT has been buffed and shaped by time. As we acknowledge our history and the many accomplishments of the AGPT (formerly the Section on Geriatrics), we also look ahead to another 40 years. In the section's 40 years of existence, we have much to commemorate, many to honor, and many wonderful events to recognize and remember.

Wow – Has is really been 40 years since our founders met in Joan M. Mill's living room to discuss the formation of a special section within the APTA focused on the practice of Geriatric Physical Therapy?

The AGPT has experienced a tremendous amount of progress and change over the past 4 decades. The health care environment in which we now practice is considerably different than it was when the inspiration to develop a section specific to the needs and interests of those therapists caring for older adults was pursued. The vision of our founders was remarkable and right on target. It was ahead of the "age wave." The necessity for the establishment of the then called *Section on Geriatrics* was evident at the outset and that need has grown 40-fold since the seed was planted. The Academy has become a strong advocate and influential leader for the unique therapeutic and legislative requirements of the elders we serve, not only within the APTA, but on a national/federal policy level and an international level with our involvement within WCPT and other international organizations.

Our beginning seemed so simple and yet it was so complex in establishment and development. The Academy was conceived initially out of need. There was a paucity of research in geriatric physical therapy, a lack of education in the area of geriatrics in every school curriculum across the nation, and a missing link between those therapists treating geriatric populations and our Mother-Ship, the APTA. The perception by our own peers regarding those of us who worked in geriatric facilities was often negative and truly not accurate. We were not just working at a Nursing Home because we did not want to work that hard…the opposite was the case. Geriatric physical therapists were out to change that perspective and demonstrate our inherit worth and value in improving the quality of physical therapy care provided in geriatric facilities and the quality of life for the older adults that we have the opportunity to care for. Our ruby, the AGPT led the way forward.

At a meeting of 4 physical therapists in March of 1976, the first attempt to organize the *Section* developed the following purpose for the existence of the proposed specialty Section. This purpose would be to "provide a means by which members who have an interest in Long Term Care may meet, confer, and promote interest in Long Term Care." The primary goal developed at this initial meeting was to "improve physical therapy care for Long Term patients by generating educational resources, supporting research, and setting up standards of care for physical therapists in Long Term Care." After petitioning for the *Section* and an initial failure of the petition in the APTA House of Delegates, our founders pressed on. As if they had the benefit of a crystal ball, our founding team regrouped and determined a more focused definition of the Section would be a better way to go. They refined our purpose and goals, changed the name from the *Long Term Care Section* to the *Section on Geriatrics,* and re-petitioned the APTA to establish a Section specific to the physical therapy needs of a geriatric patient population. The APTA House of Delegates formally accepted and established the *Section on Geriatrics* in *June 1978*, 40 years ago. A cause for celebration of our 40th Anniversary in Orlando at APTA's NEXT 2018 is clearly at hand.

At the first official meeting of the "Section on Geriatrics" in 1978, 2 specific goals set the stage for the next 40 years of growth and development. These goals were to:

- procure from government agencies reimbursement for the treatment of older persons; and
- include in the curriculum of physical therapy schools courses in gerontology.

There has been considerable enrichment and evolutionary change within the Academy since then; however, those two initial goals are still a key part of the Academy of Geriatric Physical Therapy's current working goals. This is reflected in the present goals, strategic plan, and in the Position statement (below) of the Academy (see the AGPT website). The goals currently state that the goals are to:

- provide direct care to geriatric clients in an acute, long term, home health, hospice, or outpatient setting;

- supervise health care practitioners involved in the care of the geriatric client;
- are involved in the education of health care practitioners specializing in geriatrics; and
- develop and/or implement programs involving the aging adult.

In the current dynamic strategic plan, the goals are to:

- support autonomous physical therapist practice with the aging population;
- pursue best physical therapist practice for optimal aging;
- support members in advocating for the health, wellness, fitness, and physical function needs of the aging adult; and
- establish the Academy of Geriatric Physical Therapy as the premier resource for physical therapists and physical therapist assistants working with adults.

Though enhanced and providing greater specificity, the original goals continue. Another landmark year is 2020, and it is coming soon. In two years we will reach one of our established goal years – 2020 as a target date established and approved by the APTA House of Delegates. Our position statement is as follows:

> **Section on Geriatrics Position Statement: 2020 PT Practitioner for the Aging Population By 2020**, physical therapists practicing with the aging population will be autonomous practitioners of choice for exercise, physical activity, prevention, and optimization of function in all settings. Practitioners in geriatrics, applying their knowledge of the indicators and consequences of the aging process, will promote remediation of impairments, activity and functional limitations, participation restrictions, and disabilities and will promote prevention, health promotion, fitness, and wellness. Physical therapists practicing with the geriatric population will be evidence-based practitioners, applying the appropriate level and specificity of exercise and other interventions that will improve and maintain function and quality of life. Physical therapists practicing in geriatrics will incorporate the values of altruism, compassion, commitment, competence, integrity and respect into all patient/client interactions. They will be advocates for their patients/clients, serving as a resource directing them towards appropriate health interventions outside the scope of PT practice, and actively lobbying for legislative changes that will benefit the older population. Approved by the APTA Board Committee to Review Component Documents, in a letter dated 9/18/06.

These stated goals reflect a refinement and enhancement over the past 4 decades, yet the theme and direction over the past 40 years seems to be steady and the thread has been carried through the AGPT tapestry since the beginning in 1978. The influence of our prophetic and fearless leaders, those founders who envisioned the development of a Section specific to the needs of our aging adults and those physical therapists treating them, has been steadfast. It is surely apparent that the AGPT leadership has continually reorganized and expanded the role of the AGPT upon the foundation it was given. There are some wonderful perspectives on the AGPT website providing historical synopses from many of the Academy's past presidents. It is a wonderful walk down memory lane and I highly recommend it is well worth the read.

Joan M. Mills, the driving force for the creation of our Section, was the first President. She was succeeded by Osa Jackson (2nd President), Bette Horstman (3rd President), Clara Bright (4th President) who oversaw the 10th Anniversary celebrations, Carole Lewis (5th President), Dale Avers (6th President), Jennifer Bottomley (7th President) who had the good fortune to shepherd the 25th anniversary celebrations in Tampa, John Barnes (8th President), Bill Staples (9th President) and now Greg Hartley, our current and 10th President. Each president had remarkably committed executive and board members, committee chairs, and committee members. As you read through the website, many of the builders and nurturers of the AGPT are discussed. There are way too many to list in this article.

Joining the "Section on Geriatrics" in 1978 - in today's market was quite a bargain. At the first Section Board Meeting in 1978, the *Committee on Competencies* was established and the budget was set at $1000. Dues were $10 a year and there were 51 members. Do the math. We did not have much money to work with. Expenses for travel to and from meetings were paid out of the pockets of our committed original leaders then and for many years to come. It was not until the mid-1980s, during the presidency of Carole Lewis (5th President) and then Dale Avers (6th President), that we were even partially and then fully reimbursed for travel. By the time I assumed the Presidency, executive and board members received full reimbursement for travel to conferences and Section-related activities. Today membership dues are $55 a year, still a small price to pay for all the resources, services, educational opportunities, specialization, legislative support, practice updates, incredible website, our rich and welcomed publications, mentorships, fellowships/residencies, collegiality, and all those other unspoken benefits of membership offered by the AGPT. It is truly an amazing membership bargain for $55!

An interesting piece of trivia for the AGPT, if a member trivia game should ever be developed, is that there are now two times more members on the current AGPT Executive Board and Board of Directors combined than there were at the first meeting as the "Section" in 1978! Yes, that is 2:1. If you read prior President's anniversary articles, you will see that up until about 10 years ago this ratio was 1:1! What this reflects is an absolute increase in the leadership of the Academy. The more committed individuals working towards common goals increases productivity. This productivity is exceptionally visible. The leadership body has grown and so has the membership. Paid membership of the AGPT has grown from 51 in 1978 to the current membership steadily approaching 5,800 (website = 5,715) as we celebrate

4 decades… and continue to grow. These increases reflect the substantial escalation of interest and practice that has occurred in geriatric physical therapy over the past 40 years.

As reflected in previous historical walks down memory lane by this author and others in benchmark years (Anniversaries) publications of *GeriNotes*, the then *Section on Geriatrics* experienced a marked increase in activities and available services for the membership over time. There was a continual and substantial amount of hard work to develop and enact specialization and establish the certification process of geriatric specialists in physical therapy. The specialist certification program identifies physical therapists with advanced clinical knowledge and experience. The lion's share of the specialization efforts took place in the second decade of AGPT's existence. Our first certification of specialists in geriatrics occurred in 1992, at which time we certified 14 specialists. By our 25th anniversary (our Silver year) in 2002, Clinical Specialists had increased to 516 and as of 2018 there are 2,418 certified Geriatric Clinical Specialists with a notable 285 being certified this year (2018) alone. Awesome!

An additional complement to becoming a GCS is to become a Certified Exercise Expert for Aging Adults, CEEAA. One of the many educational programs available through AGPT, this certification provides advanced instruction and practical experiences to understand the different dynamics needed to increase strength, endurance, and functional abilities in our aging population. The AGPT leadership recognized that academic curriculums provided instruction of exercise for the healthy, younger adult and not for the frailer older adult with multiple physiologic, biomechanical, endocrine, etc changes that should be put into the equation when prescribing exercise for older adults. With this in mind, an AGPT Task Force provided their expertise in the development of the CEEAA certification instruction, clinical implementation, and ultimate certification. Courses for certification are available on the website. You will need a larger letterhead to fit all of your credentials…yet another and a different facet to our AGPT gem.

Home study courses were created and initiated in 1998 and continue to be available online. The format has changed over time; these courses are a means of obtaining continuing education units (CEUs) through self-paced, home-based study. Other AGPT educational programming is also available online through Webinars and Webcasts. In addition to home study modules, *GeriNotes* CE exams are also a superb mode for case-based learning and honing clinical skills. Regional programming provides links to other CE courses available for face-to-face learning experiences. This is not an all-inclusive review of the many available educational resources on the website.

Research is another area of progress. The demand for *evidence-based practice* has exponentially increased the number of laboratory and clinical studies. Though research has always been a foundation upon which the AGPT was built, recent research initiatives by the AGPT in conjunction with WCPT and APTA, as well as the Academy's fiscal commitment to the Foundation for Physical Therapy's Clinical Research Network and beyond has provided clinicians and academics with an endless flow of solid research. This clearly cemented one of the initial Section goals (1978) in the formulation of a specialty section in geriatric physical therapy. The APTA's provision of *Hooked on Evidence* program served as a starting point and a target for the systematic progression establishing the scientific basis of physical therapy practice. The AGPT's ability to fund research and award researchers has helped in nurturing many aspiring clinical and academic researchers. As a clinician and an academic, I can testify to the invaluable contribution of AGPT sponsored research, development of the *Journal of Geriatric Physical Therapy* providing research specific to our field, and emphasis of evidence-based practice in all educational programming. This has served our patients well. The geriatrics focused research by my DPT students has not only enhanced the general practice standard in clinical settings but has also served to continually enrich my personal clinical and teaching skills. I am sure this is true for many clinicians. Starting with small grants, through continuous presidential support of Academy funding for the Foundation, the AGPT is now funding important research projects ear-marked for geriatric-based research.

Strategic planning processes were initiated early by the leadership for managing AGPT business and activities. This is now a working, dynamic document that provides an on-going procedure to steer, influence, and guide the Academy's activities. The need for a comprehensive plan for the development of the AGPT was recognized early on by leadership; visionaries put a mechanism in place to sustain and progress our work. The Strategic Plan not only enabled the AGPT to function more efficiently but provided a more efficient way of ensuring continuity of projects, action items, and accomplishments. It provided a map to follow…a GPS for AGPT. This has provided a clear historical document of the growth and evolution from the Section on Geriatrics to the Academy of Geriatric Physical Therapy. The Academy's Strategic Plan is current and available on the AGPT website.

One of the most significant advances over the past 40 years has been the splitting of our publications. *GeriNotes*, a clinical magazine, provides news of AGPT activities, information on upcoming events, and publishes clinically relevant information and resources. The *Journal of Geriatric Physical Therapy,* a peer-reviewed publication, provides research specific to geriatric physical therapy, is indexed in CINAHL, and recognized by the medical community for the richness and integrity of the articles published. The quality, depth, and relevancy of this publication has been remarkably enhanced and enriched since its conception and is recognized as a top-notch source for geriatric research on a national and international level.

Access to all of the publications and information about the AGPT is readily available online as well as our print publications. It amazes me how many times each week I go to www.geriatricspt.org and connect with the publication site. The website has grown from a single page to a multi-link webpage with connections within the site to information regarding AGPT and links to very important resources through the APTA, WCPT, social media sites, *JGPT* and *GeriNotes*, IPTOP (geriatric subgroup of WCPT and part of AGPT), and a bevy of other resources too immense to cite here.

Position papers available on the AGPT website include topics such as:

Practice Autonomy, Cultural Diversity, Geriatric Practitioner 2020, Physical and Chemical Restraints, and Physical Therapy Assistance. There was a time when locating documents, such as these, was a mountainous task. Now they are available with a simple click of the mouse. The availability of other written resources is also a noticeable enhancement over the years. Examples, such as "Essential Competencies in the Care of Older Adults at the Completion of a Physical Therapist Post-professional Program of Study." Study materials and resources are available for preparation for specialization - a goldmine of information as you pursue advancement in your professional career. I have named just a couple of the many publications now produced by AGPT and available through the website. The real point here is the time and diligence of AGPT members who produce these materials, continue to update, and revise to keep things pertinent. When I started as a member of AGPT, we had one page mimeographed copies of materials available! I also owned a Tandy computer that was as slow as molasses! The refinement of computers and availability of rapid communication has certainly resulted in a refinement of AGPT resources. Our gem is continually polished and shaped as time goes on.

Social connections to Facebook, Twitter, and Listserv also provide an interactive platform for upcoming events, conferences, and other opportunities pertinent to the AGPT membership.

Special Interest Groups (SIGs) have been multiplying, especially in the last 20 years. We know we cannot go backwards to another time, because the aging population will move on without us. The SIGs developed are in tune with this movement forward and AGPT continues to maintain the leadership position through the SIGs. Current SIGs are focused in the following areas:

- Balance and Falls SIG
- Bone Health SIG
- Cognitive and Mental Health SIG
- Global Health for Aging Adults SIG (our direct link with IPTOP of WCPT)
- Health Promotion and Wellness SIG
- Residency and Fellowship SIG

The AGPT SIGs have impressively changed and evolved to meet the needs of the membership. The collaboration with other Academy's and Sections within the APTA as well as the international link with IPTOP open the world to us. The SIGs provide a format in a changing world for physical therapists to manage the changes as they occur instead of being managed by them. The AGPT champions the interests of geriatric physical therapists who are being asked to do more with less. We must manage changes in a way that translates into the highest level of care in our practices As the SIGs are remodeled and reshaped to meet the needs of our older adults, the focus is modified to keep on top of the change.

The AGPT has established an international relationship with the worldwide members of WCPT. An aging population is a global challenge. It was deemed, at last summer's WCPT conference in Cape Town, South Africa, that our international society needs to maintain and increase our connectivity. Sharing resources, international research links, and educational opportunities are numerous in opportunity. I was delighted by the number of AGPT members who travelled to South Africa for this conference and who attended most of the International Physiotherapists working with Older People (IPTOP) events and celebrations. The AGPT should be commended for the continued engagement with IPTOP, providing a liaison and chair of the Global Health SIG, for the efficient exchange of resources, ideas, and initiatives. We have had the opportunity to contribute to the position paper of geriatric physical therapy that is now available on the World Health Organization website. Disney was right… it is a small world after all.

The AGPT has established numerous awards. When I first joined the Section in 1982, we had less than 5 awards granted, not including our nominations of Section members for APTA awards. We had the Distinguished Educator, Clinical Excellence, Excellence in Research Awards, and the most prestigious award, accurately named The Joan M. Mills Award. That is 4 awards. We awarded them in the last 10 minutes of our member's meetings. The awards ceremony has now been separated from the member's meeting as it encompasses 3 research awards, 8 professional clinical and academic awards, AND 4 student awards. Now, this list of awards includes recognition of outstanding achievement in clinical and academic research and practice and recognizes student involvement with the Academy. In many cases financial awards towards research, advocacy, and mentorship are involved. This is something our founders could have never instituted with a budget of $1000. In 40 years we have experienced the development of Research awards for: Adopt-A-Doc Award, Excellence in Research, Fellowship for Geriatric Research; Professional Awards for: Clinical Educator, Clinical Excellence, Distinguished Educator, Joan M. Mills, Lynn Phillippi Advocacy for Older Adults Award, Outstanding PTA, Volunteers in Action, and Clinical Residency/Fellowship Grant. Student Awards, established in the last 15 years include: Consumer Brochure Contest for Students, Outstanding PT & PTA Student Awards, a Student Award for Research, and Student Membership Award. This is a remarkable accomplishment – the ability to finance and administrate 16 different awards. Bravo AGPT!

It is a positive improvement to realize increasing inclusion and involvement of the Physical Therapist Assistant and Student Physical Therapist in AGPT governance and activities. Now the AGPT is comprised of ALL Physical Therapist professionals. What a welcome advance for AGPT. The early leadership spoke often of completing our unity by adding PTAs and students. There was resistance from the top and financial restrictions within the AGPT. Nonetheless, both PTAs and students are invaluable members of our team in many geriatric facilities. Members were steadily persistent, unremitting, and we should celebrate this marvelous improvement…following our hearts, providing intangible energy, increasing awareness, and producing motion throughout the realm that matters…adding more facets to our gem.

Unrelenting energy and an appreciation and sensitivity for cultural diversity of members and patients have been directed toward increasing awareness. It is a core value of the AGPT. Through publications and ongoing initiatives and an emphasis in education, cultural diversity continues to be a part of the

principles established by the AGPT. Since the AGPT membership serves an older population from diverse cultural and ethnic backgrounds, cross-cultural understanding is an integral part of clinical, educational, and research skills. The Academy continues to provide its members with opportunities to develop awareness of and sensitivity to cultural and ethnic issues. Our accomplishments as an Academy serve as a model for many of the other APTA components.

From its beginning, the AGPT offered a bold vision of what we wanted to be: an innovative Section of the APTA committed to nurturing our leaders and professionals, committed to delivering high-quality, skillful, evidence-based physical therapy for older adults. While much has changed over the past 4 decades, the AGPT has remained true to this vision of education, research, and communication. As 2018 advances and we look to the future, we hope to continue to provide our members with the many resources available through the AGPT. I would venture to say, we have accomplished so much in a relatively short period of time.

Forty years have passed since the inauguration of the Section on Geriatrics, now the Academy of Geriatric Physical Therapy. It has been 40 years of growth and evolution, shaping, and remodeling our Academy to meet the needs of our profession in the treatment of the older adult population. As the specialty of geriatric physical therapy has developed so has the improving the mobility and functional abilities of the older adult population. Our Ruby year is a landmark in a journey that has encountered many hurdles and challenges. However, our journey has also experienced and been marked by many successes. The Academy of Geriatric Physical Therapy is an exceptional and valuable gem that has brought light to geriatric physical therapists and patients, encouraged the AGPT to follow our hearts, provided spiritual energy increasing the energy throughout the realm that matters – our older adult patients and clients. There is so much more that needs to be done.

AGPT State Advocates: Local AGPT Leadership at Work

Heidi Sue Moyer, PT DPT; Beth Black, PT, GCS

The Academy of Geriatric Physical Therapy's State Advocates are AGPT members working on local issues within their respective states, advocating for optimal aging, and best practice physical therapy. Currently there are State Advocates in 35 states, with some states having multiple State Advocates for a total of 46.

Some of the highlights of State Advocates activities in this past year include:

- Organized **Falls Prevention Awareness Day** events, fall risk screenings, and/or staff fall risk education in Alabama (Laura White), Arkansas (Jennifer Vincenzo), Delaware (outgoing SA Megan Sion), Georgia (David Taylor), Hawaii (Mary Grace Gayatinea), Indiana (Swarnalatha Tumukuntia), Kentucky (Beth Norris), Maryland (Linda Horn) Mississippi (Joy Kuebler & Sherry Colson), North Dakota (Beverly Johnson), Oklahoma (Michael Hyland), Pennsylvania (Jennifer Sidelinker & outgoing Rebecca Tarbert), Washington (Ryan Murphy), and West Virginia (outgoing Corrie Mancinelli)
- Hosted dementia management course in Alabama (Laura White)
- Organized and participated in a health fair providing balance assessments, diabetic foot care, and a shoe drive in Arizona (Stefany Shaibi)
- Participated in Falls Task Force for FPTA with distribution of task force materials for Falls Education to provider practice groups in Florida (Heidi Piccione)
- Supported/facilitated GCS study groups in Georgia (David Taylor), Illinois (Jaime Fortier-Jones & Heidi Moyer), Maine (Bill Anderson & Bernadette Kroon), and Texas (Crystalyn Richard)
- Collaborated with chapter to facilitate geriatric focused education in Alabama (Laura White), Georgia (David Taylor), and North Dakota (Beverly Johnson)
- Facilitated communication between AGPT members on older adult issues, geriatric courses, meetings, etc with newsletters or use of Facebook page in Iowa (Catherine Stevermer), Illinois (Jaime Fortier-Jones & Heidi Moyer), Oklahoma (Michael Hyland), Michigan (Melanie Wells), Minnesota (outgoing SAs Susan Priem & Amanda LaLonde), Pennsylvania (Jennifer Sidelinker & Rebecca Tarbert), Virginia (Cathleen Renkiewicz), and Washington (Ryan Murphy)
- Taught community education on osteoporosis, incontinence, and balance in Iowa (Catherine Stevemer)
- Engaged students in older adult issues in Arizona (Stefany Shaibi), Delaware (Megan Sions), Iowa (Catherine Stevermer), Idaho (Cindy Seiger), Illinois (Heidi Moyer), Kentucky (Beth Norris), Maryland (Linda Horn), Minnesota (Susan Priem & Amanda LaLonde), North Dakota (Beverly Johnson), and West Virginia (Corrie Mancinelli)
- Started a chapter Geriatric Special Interest Group in Virginia (Cathleen Renkiewicz), Washington (Kele Murdin) with preliminary discussions initiated in Arizona (Stefany Shaibi), and Illinois (Jaime Fortier-Jones)
- Recorded four 30-minute Fit and Fall Proof™ exercise programs for local access TV station in Idaho (Cindy Steiger)
- Developed a relationship with a state agency that handles elder issues: Alzheimer's Association in Alabama (Laura White), Dept. of Health in Washington (Kele Murdin), and Age Friendly Jackson Hole to increase senior access in community in Wyoming (Nola Peacock)
- Held Senior Athlete Fitness Exam (SAFE) screenings with Senior Olympics in Illinois (Heidi Moyer)
- Partnered with a municipality to create a more age-friendly community: Maine (Bernadette Kroon and Bill Anderson) and Wyoming (Nola Peacock)
- Represented the AGPT at chapter conferences: Alabama (Laura White), Illinois (Jaime Fortier-Jones), Louisiana (outgoing Danny Landry), Maryland (Linda Horn), Maine (Bernadette Kroon), Minnesota (Susan Priem & Amanda LaLonde), Pennsylvania (Jennifer Sidelinker & Rebecca Tarbert), Texas (Crystalyn Richard), and Virginia (Cathleen Renkiewicz)
- Increased connections with PTAs with an interest in Geriatrics with goal of working towards the Geriatric Proficiency Certification in Minnesota (Susan Priem & Amanda LaLonde)
- Wrote article for *GeriNotes* about being a State Advocate: Illinois (Heidi Moyer) and Pennsylvania (Jennifer Sidelinker)
- Met with state legislators on scope of PT in SNF setting, PT and barriers faced in Washington (Kele Murdin)

And those were only the highlights of 2017!

If you would like more info from your State Advocate to know what is happening in your state, go to the AGPT website, www.geriatricspt.org/ Select "Members" tab, then "Contact Your State Advocate" to access your State Advocate's contact info.

Does the AGPT State Advocate program sound interesting to you? We are missing State Advocate representation within the following states/chapters:

Alaska
Colorado
Louisiana
Montana
New Hampshire
New York
North Carolina
Ohio
Oregon,
Rhode Island
South Carolina
South Dakota
Utah
Vermont
District of Columbia

Plus, there are some states looking for a "co-chair" State Advocate:

Alabama
Hawaii
Michigan
Minnesota

Requirements to be a State Advocate: you need to be a member of AGPT, have a working email address, be a liaison between your chapter and AGPT, and pick two activities to plan for the next year within your state. This volunteer position is for two years, with an estimated amount of time to perform the duties to be an average of 2-8 hours a month.

If you are interested in volunteering to be your State Advocate for AGPT or would like more info, contact the AGPT State Advocate Coordinators**:** Western Region (west of the Mississippi River), Beth Black, PT, GCS, at BBlackPT@gmail.com or Eastern Region (east of the Mississippi River), Heidi Moyer, PT, DPT at MoyerHeidis@gmail.com

Global Campaign

In 2016, the World Health Organization created a global campaign to focus attention on stereotypes about aging and designated October 1 as "International Day of Older Persons." As geriatric physical therapists, we celebrate older persons and defend against ageism, everyday. The AGPT aims to change popularly held ideas and misinformation about getting older. GeriNotes will publish random snippets and quotes about joining and enjoying the gray tsunami and encourage you to share them with your clients. Please share anecdotes and observations from your own practice and patients to inspire us all and remind us of our passion for "the touch of grey…in every silver lining" (Grateful Dead, "Touch of Grey")

"We don't stop playing because we grow old. We grow old because we stop playing." George Bernard Shaw

—Special Interest Group Reports—

Bone Health SIG 2018 Update

Sherri R. Betz, PT, DPT, GCS, CEEAA, PMA®-CPT

We had a great time at CSM this year collaborating with colleagues and members who share our passion for bone health! Expert Schroth-based clinicians, specializing in the treatment of scoliosis, Prachi Bakarania, DPT, Hagit Berdishevsky, DPT, Kelly Grimes, DPT, as well as our very own BHSIG member, Wendy Katzman, PT, DPTSc, presented an amazing and practical lecture on *Spinopelvic Parameters: Implications for Treating Adults with Spine Deformity.* Presenters taught that a person's lumbar lordosis and overall spinal alignment is dictated by the "pelvic incidence" or angle of tilt of the ileum and sacrum in relation to the femur. Participants discovered ways that a person's compensations can negatively affect his or her quality of life. The treatment approaches offered by Drs. Grimes and Bakarania were immediately applicable in the clinic. Dr. Wendy Katzman shared her latest NIH funded research showing that exercise can reduce kyphosis!

The BHSIG CSM Pre-con *Bone-Safe Yoga in Your Community* with Matthew Taylor, PhD, PT, and Sherri Betz, PT, DPT, GCS, CEEAA, PMA®-CPT, was a wonderful day of Ahimsa (do no harm) as well as breathing, mudras, centering, and learning about the true practice of yoga. We practiced biomechanical analysis and yogic presence in each pose chosen especially for the stimulation of osteoporotic bone as directed by Dr. Taylor and Dr. Betz. Attendees finished the day refreshed, strong, and literally "inspired" to incorporate more yoga in our personal practice, clinical practice, and communities.

New folks at our member meeting expressed interest in serving as officers to help us with our BHSIG mission! We have the following offices open: Vice Chair and Nominating Committee. Let us know if you are interested in joining our team!

Active BHSIG members are developing exciting bone health programs in their communities such as Priscilla Raasch-Mason's YMCA programs; Sherri Betz's Community-based osteoporosis programs at Glenwood Regional Medical Center;, Kathy Brewer's Fracture Liaison Service (FLS) at the Mayo Clinic; Ginny Renegar's inpatient and outpatient PT programs targeting the treatment and prevention of osteoporosis; and semi-retired PT, Andi Morganthaler, is offering home health Pilates-based services targeting older adults with osteoporosis. We discussed some exciting ideas for speaker programming at CSM 2019 and have invited the following speakers to apply:

- Carleen Lindsey to present Kypholordosis Flexicurve Assessment, Manual Therapy, and Exercise Interventions for Kyphosis.
- Dr. Wolfgang Kemmler - Kemmler W, Bebenek M, Kohl M, von Stengel S. Exercise and fractures in postmenopausal women. Final results of the controlled Erlangen Fitness and Osteoporosis Prevention Study (EFOPS). *Osteoporos Int.* 2015;26(10):2491-2499.
- Dr. Belinda Beck from the controversial LiftMor trials.
- Dr. Gail Greendale – from her yoga intervention to reduce kyphosis. Greendale GA, Huang MH, Karlamangla AS, Seeger L, Crawford S. Yoga decreases kyphosis in senior women and men with adult-onset hyperkyphosis: results of a randomized controlled trial. *J Am Geriatr Soc.* 2009;57(9):1569-1579.
- Dr. Ivan Bautmans - Bautmans I, Van Arken J, Van Mackelenberg M, Mets T. Rehabilitation using manual mobilization for thoracic kyphosis in elderly postmenopausal patients with osteoporosis. *J Rehabil Med.* 2010;42(2):129-135.
- Presenters Mark F. Reinking, Jason E. Bennett, and Tricia Austin: CSM 2018: *Optimizing Bone Health in Athletes: A Critical Challenge*

We would love to hear about interesting and compelling speakers that you would like to invite to present BHSIG special programming at CSM.

Call Kathleen Cody at American Bone Health (ABH) at 888-266-3015 to receive the 24-page ABH/AGPT. *Do It Right and Prevent Fractures* booklet, which was a collaborative project developed by our BHSIG and ABH!

The CPG Clinical Practice Guideline Workgroup is going strong! We are starting our AGREE II review process to evaluate current CPGs related to exercise and physical therapy interventions for osteoporosis.

—Special Interest Group Reports—

Cognitive and Mental Health SIG

Lise McCarthy, PT, DPT, GCS

Do not go gentle into that good night, ***Old age should burn and rave at close of day;*** ***Rage, rage against the dying of the light.*** —Dylan Thomas, 1951	***Do not be swayed into that good night,*** ***Old age should burn and rave with possibility;*** ***Dance, dance into the brightness of the light!*** —Lise Ellen McCarthy, 3/8/2018

First, a BIG HUG to all our PTA and PTA student members! We love you! We appreciate you! And, most of all, we need you! I am personally sending you an invitation to be members of the Cognitive and Mental Health SIG (CMHSIG)! We have BIG plans this year, and we want you to know they include you. We are actively recruiting PTA and PTA students for our CMHSIG membership. So, if you are interested in what we are doing and want to show your support for our efforts, please sign up to be a CMHSIG member on the AGPT website. Our membership is the best way to demonstrate to the AGPT Board of Directors that we are following our mission and achieving our goals.

To be a CMHSIG member (or a member of any AGPT SIG), follow these steps to sign up:

- Go here: https://geriatricspt.org/index.cfm?
- Hover over the "Join Us" button in green to the far right BUT DO NOT CLICK.
- Scroll down the drop down window AND CLICK on "SIG Memberships."
- Follow the prompt to login in, and enter your first and last name, APTA number, and email address.
- Click the boxes for the SIGs you want to join.

Second, CSM in New Orleans was BIG in so many ways! BIG in the number of attendees. BIG in the hospitality of the people of New Orleans. BIG in the number of ideas coming out of conference meetings. BIG in the creative energy bubbling up to make massive change.

And so our CMHSIG is going to follow this pattern of making BIG changes. To do this we need to grow our membership. How are we going to do this? Implementation of "Operation Chain Reaction" is the model we will use to accelerate the dissemination of knowledge we have collected over the past 4 years and to engage people at the state level.

The CMHSIG has already secured $2,000 from the AGPT Board of Directors to use to help defray costs for interested CMHSIG leaders (officers and liaisons) to attend state conferences and to help us meet the following goals this year:

(1) disseminate our information at 10 state conference AGPT booths;
(2) build our CMHSIG membership to over 1000 by end of CSM 2019;
(3) fine-tune an information sharing model for working with AGPT State Advocates and the state and territory chapters;
(4) identify CMHSIG members who will help us present CMHSIG topics at state and territory conferences; and
(5) publish our collaborative efforts in a follow-up *GeriNotes* article so that others can use this model, if they choose.

Dr. Laura White (CMHSIG co-Academic Liaison and the Alabama State Advocate) has already developed a prototype model. She along with Dr. Christy Ross (CMHSIG Vice Chair) and Dr. Jean Miles (CMHSIG co-Clinical Liaison and the Connecticut State Advocate) are working with me to lead "Operation Chain Reaction." If you are interested in participating in "Operation Chain Reaction," please let your State Advocate know, or contact me directly at lise@mipt.us.

Details about other current CMHSIG projects that are underway or being considered for development are on the CMHSIG webpage. Read the full minutes from our 2018 CSM meeting.

This is my last year as CMHSIG Chair and so my plan is to dance into the brightness of the light we are creating together! May it always be bright with possibility!

"Old age ain't for sissies" - be daring! Wishing you every success, wherever you practice!

—Special Interest Group Reports—

Residency and Fellowship SIG CSM 2018 Report

Mary Mildonis, PT, PhD

Officers:
Chair, Mary Milidonis
Vice Chair, Mindy Renfro
Secretary, Jackie Osborne
Nominating Committee, Emma Phillips & Andrew Harnish

Updates from AGPT/ABPTRFE:
Kendra Harrington. PT, DPT, MS

There are 296 total programs: 244 residencies & 51 fellowships. As of 2016: there are 16 geriatric residency programs (110 graduates). Currently there are 3 geriatric residency programs that have achieved candidacy and there is 1 in development.

Ryan Banister is the administrator/ developer of RFPTCAS. This is the person to contact with RFPTCAS questions and concerns. Kendra can provide you with Ryan's contact information.

The ABPTRFE has launched a Data Management System for applications, reaccreditations, and annual reports.

Support Residents Applications to Geriatric Residency Programs; Awarding Scholarships to Residents and Fellows (Merit based award)

Scholarship application deadline for residents is March 4 and the award is presented in May.

The scholarships are intended to assist in offsetting the costs associated with residency and fellowship programs. The Board of Directors (BOD) of the AGPT has determined that up to $5000.00 will be awarded each year depending on the applicant pool and decisions made by the scholarship committee. Each scholarship will be a minimum of $1250.00 and no greater than $2500.00.

Survey: Research and Fellowship SIG will conduct a needs assessment survey that will be sent to AGPT members; target will especially be members that are 2 to 5 years post graduation. The survey will include educational needs, perceptions of residency/fellowships, willingness to participate in residency/ fellowships, barriers to residency/fellowship education, and content areas that may be appropriate as a fellowship.

The Academy of Geriatric Physical Therapy Values:

- Older people and aging as a positive event.
- The unique contributions of physical therapy to enhance the quality of life of all older adults.
- Collaborative relationships with internal and external constituencies.
- Quality of life as enhanced throughout the lifespan by following principles of health promotion, prevention of disease, and appropriate rehabilitation intervention.
- The highest standards of clinical practice as supported by research and education.
- The current and potential contributions of each physical therapist, physical therapist assistant, and student member.
- Communication among the members.
- Leadership's accountability to the members considering their current and anticipated needs.
- The cultural diversity of each member and older adult.

Bed Height Decision Tree

Kristin Maxsimic, PT, RPSF-NDT; Traci Kennedy, PT, DPT, CCCE; Michelle Bell, MS, CCC-SLP

INTRODUCTION

Falls...the dreaded "f" word in long-term care: the abundance of research in the past decades demonstrates that falls are one of the leading causes of morbidity and mortality in the geriatric population. The longstanding effects of a fall for an individual can reach millions of dollars in cost on the health care system.[1] The catastrophic side effects appear to be heightened for institutionalized individuals (skilled nursing facility [SNF], long-term care [LTC], or assisted living facility [ALF]). In the care continuum, falls become accepted as "part of the story" for some individuals. In our most susceptible clients, those suffering the effects of a dementia diagnosis, our staff began to notice trends after falls occurred. Beds would often be placed in a low, secure position and floor mats would be prescribed to help cushion the impact if the client were to go down again. Therapists began to question: was this intervention effective, and secondly, was it the safest option for the resident moving forward? More questions than answers were generated by an abundance of individualized resident scenarios.

BACKGROUND

A literature search regarding room arrangement and bed height revealed no formalized recommendations to aid in fall reduction. Judgment and safety awareness are often compromised in clients with dementia; mobility is unpredictable. Thus, it is not uncommon to witness clients attempting mobility tasks without requesting staff assistance. Many falls occur within the resident's room. This led staff to consider setting up a client's room with conditions to optimize safety; our staff focused on beds and use of floor mats. These conditions are feasible to re-arrange and their positions were often found to be ill-prescribed for the client with confusion.

Side rail use was considered. Railings are a common feature in the acute care setting, with the primary goal to reduce incidence of falls out of bed.[2] However, over the past decade there has been a great initiative to phase out use of bed rails in the SNF and LTC settings. Evidence supports risk of accidental injury and death with use of the rails. Entrapment between the edge of the bed and rail or a fall with an attempt to climb over the rail are two common causes of injury.[2] A common trend in our facility, anecdotally, was that after a fall the first intervention was to lower the bed to the floor and place mats at bedside. While there is an argument for this conservative approach, research guided this team to investigate alternative set-ups that would better match the resident as a whole. The Center for Medicare and Medicaid Services states, "Physical restraint includes all devices and practices used by the facility that restrict freedom of movement or normal access to one's body. This includes side rails as well as facility practices such as tucking in bed sheets so tightly that the resident is unable to leave the bed."[3] It was determined by the team that a resident who is able to access the environment when the bed was placed at a traditional height could be restrained if the bed were lowered to the floor by preventing access he or she would normally have. Furthermore, evidence supports an increased risk of injury and subsequent sequelae related to individuals attempting to rise unsuccessfully from the lower surface.[1,4]

The second component of quick intervention practice at our facility was placing floor mats at the bedside. While floor mats are marketed and researched as decreasing the force of impact, they do not actually reduce the risk or rate of fall occurrence. Mats may reduce a client's potential for a fracture with a fall out of bed. However, they are a "potential hazard for ambulatory patients, especially those with impaired gaits, using walkers…"[5] The VA National Falls Toolkit reports that floor mats create a greater risk for falls, especially for those in our population who have lower extremity and balance deficits. When floor mat storage is not properly executed, it also can contribute to a resident fall, staff injury from the increased tripping hazard, and hazards to other residents who wander into a room unexpectedly. Low lighting during evening and overnight hours can heighten the risk for all populations mentioned above with use of the mats.[6]

The Bed Height Decision Tree (see Figure 1) was developed by staff in hopes of increasing consistency in determining the safest option for residents, particularly those with confusion, to reduce the risk of fall or a fall with injury from the bed. The following questions were designed to guide clinical staff through a decision tree to determine safe recommendations. The initial question, *"Is resident cognitively intact?"* is intended to capture the resident's mindset and ability to request help when seeking to get out of bed. Factors that may contribute include safety awareness, judgement, impulsivity, and problem solving.

Physical function is the next question, "*Can resident achieve ¾ stand without assist (safely or unsafely)?*" Evidence indicates the ability to complete a sit-to-stand transition is multifactorial including pain, fatigue, lower extremity strength (particularly of the quadriceps), hip and knee range of motion, trunk flexibility and strength, postural control, balance, upper extremity strength, and visual contrast sensitivity.[7] Seat height can also influence the transition with the height equal to or 120% of the individual's lower leg length being optimal as it allows for less knee extension, reduced work of quadriceps muscle group, and requires less forward lean keeping center of gravity within the client's base of support. To match the resident's bed height with the lower leg length, the presence of posterior precautions follow-

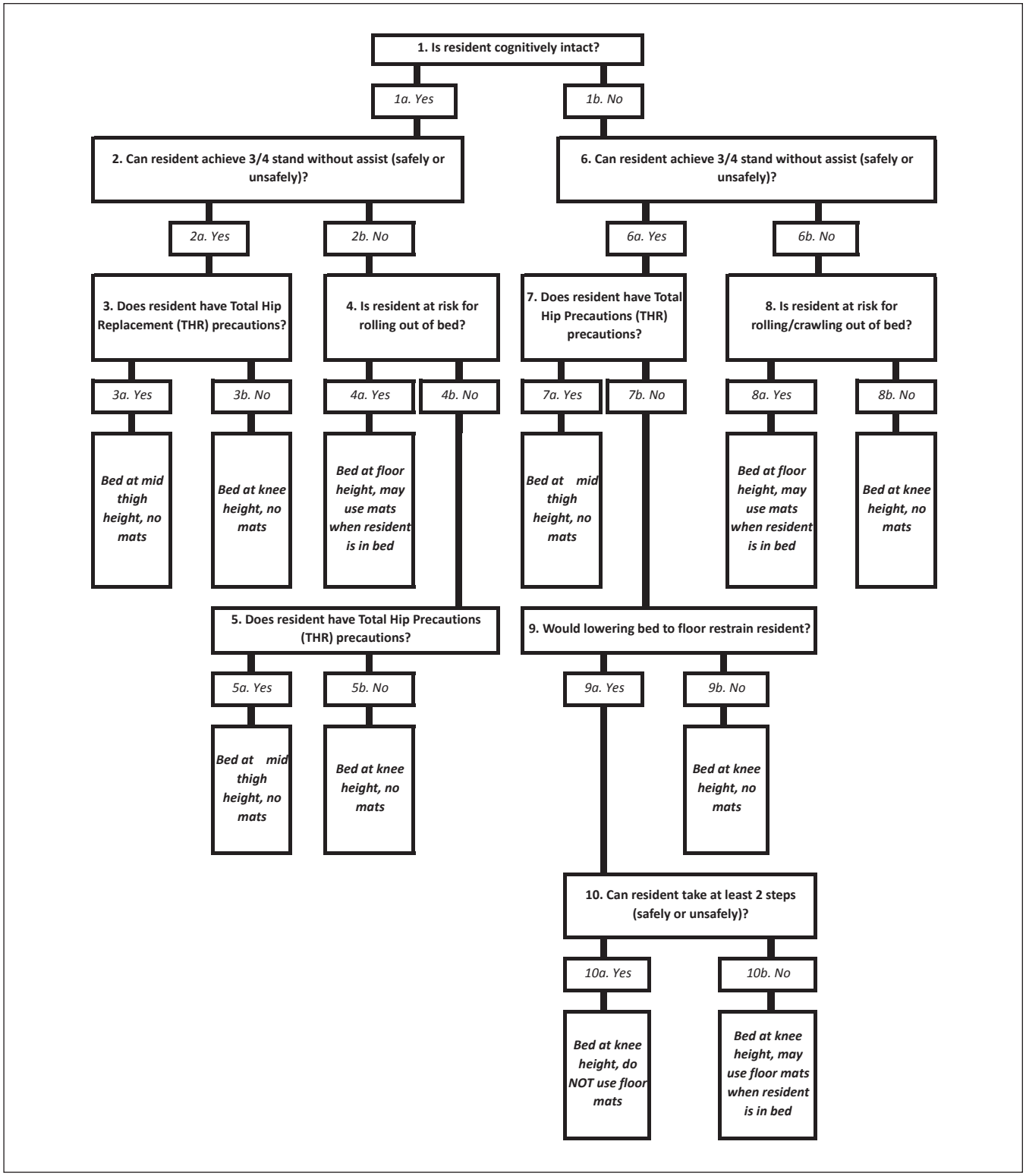

Figure 1. Bed height decision tree.

ing a total hip arthroplasty (THA) poses another factor requiring consideration.[8] The team concluded, with the presence of precautions, in order to preserve the integrity of the artificial hip joint (ie, avoiding accidental dislocation) the bed would be optimally placed at mid-thigh height of the client. In the population served at our facility, there is a select group with impaired cognition who are non-ambulatory that are a high risk for rolling or crawling out of bed. For these individuals, lowering the bed to the floor would not pose a restraint as the resident does not have the ability to stand from a traditional or elevated bed surface. If this group of individuals were to make their way out of bed (intentional or not), the potential negative outcome related to impact with the floor increases on an unpadded surface. This is group of individuals may benefit from the "traditional" low bed and floor mat set up. Trip hazard is a moot point for the client

as they are non-ambulatory and client risk of injury from impact with the floor outweighs the potential staff trip hazard.

The final question along the right side of the decision tree is "*Can resident take at least two steps (safely or unsafely)?"* This question attempts to capture the client's ability to move away from the edge of bed or the seating system without a physical assist. If the ability to take steps is present, irrespective of safety, the presence of floor mats or a padded surface could induce a fall rather than reduce the risk as intended. Factors include impaired lower extremity sensation, balance deficits, and as Capezuti and colleagues[7] state "nursing home residents, regardless of ...impairments or environmental barriers...will continue to get out of bed." This is further supported by Shats and Kozacov[9] who found in the geriatric population nearly 80% of falls occur when the client is alone, rather than with a caregiver.

It is the responsibility of caregivers to optimize the environment to promote client safety, with attention to client trends and behaviors that are deeply ingrained. Following development of the algorithm, the proposed protocol was presented to a fall-reduction committee within the facility. Adjustments were made to clarify the definitions of knee and mid-thigh height as well as discussion of documentation of recommendations. Methods to communicate recommendations were established. Implementation of the algorithm began with a rollout to the administrative nursing team. This was followed by training of licensed nursing staff that included case study work to increase comfort level working through the decision tree. The decision tree was added to our electronic medical record (EMR) with the goal for recommendation to be determined upon client admission to the facility as well as with any significant change in medical or mobility status. It was determined that both nursing and physical therapy staff would share the responsibility of this assessment. This is consistent with shared responsibility in the development of transfer status recommendations and care plan. To reduce errors, the EMR pushes staff through the algorithm. If the first question is answered **yes,** the EMR pushes staff to the left-hand side of the algorithm where a ***no*** would push them to the right side. Each answer leads staff to the next appropriate question, minimizing human error in misreading the algorithm as a whole. Once the final question in a series is answered, the recommendation populates to the screen automatically. After saving the entry, the bed height recommendation auto-populates to the client's care plan and the nursing assistant's flow sheet to notify direct care staff to the appropriate setting for each individual. As the intention of the algorithm was to reduce falls in the facility, the information flows to a worksheet used during interdisciplinary fall meetings that occur each shift on all nursing units.

CASE STUDIES USING THE PROTOCOL

Case studies have been developed to demonstrate use of the algorithm with different client scenarios.

Case 1

Resident A was admitted to the SNF following a mechanical fall at home resulting in quadriceps tendon rupture status post surgical repair. This client is a 70-year-old male with history significant for Parkinson's disease, Parkinson's dementia, Type II diabetes mellitus (DM), obesity with a body mass index of 42, degenerative joint disease, hypertension, multiple falls with fracture, and chronic lower extremity edema. Following skilled rehabilitation, the client transitioned to a LTC within the facility as he was unable to return home with his spouse due to the excessive burden of care and an inability to ambulate. At therapy discharge, he was able to perform supine to sit transition with modified independence and moderate assist for sit to supine. He could perform a slide board transfer with supervision after set-up at best and was able to stand with contact guard assist (CGA) at best. Client performance was highly variable throughout his course of therapy; sometimes he was unable to complete sit-to-stand transitions. He was modified independent with self propulsion in his wheelchair (w/c) within the facility. The client had a history of falls within the facility including one where he was found on bedside mats, bed in low position, reporting "I put myself there." The second fall occurred in a common area of the unit where the client was attempting to transfer himself from his w/c to a stationary chair at the table without assist. Staff reported witnessing the client standing at bedside or in the bathroom without assist. **Use of the algorithm to determine equipment:** Flowing through algorithm question 1, **NO,** client is not cognitively intact given his dementia diagnosis. Next question, can client achieve ¾ stand (safely or unsafely) without assist would be answered **YES** as he has been witnessed on multiple occasions standing alone. **NO,** Client does not have posterior hip precautions as there was no mention in the history of THA. Lowering the bed to floor could potentially restrain the client; environment now prevents client from performing mobility task he is otherwise able to perform. Finally, can the resident take two steps safely or unsafely. **NO,** client is unable to take steps once standing resulting in answer of "*Bed at knee height, may use floor mats when resident is in bed."* With this recommendation client now has access to his abilities by being able to stand from a reasonable height, with a known tendency to attempt self transfer. As he is unable to step away from the starting surface, the floor mats are indicated to protect the client if he were to go to the floor mid-transfer. The concern for an unstable standing surface is outweighed by the force reducing properties of the mat since the client does not take steps.

Case 2

Resident B was admitted to the SNF following right below knee amputation secondary to calcaneal osteomyelitis and failed conservative treatment. He is a 74-year-old male with history of CAD with coronary artery bypass graft x 4, COPD, peripheral vascular disease, DM, chronic kidney disease stage 3, left thalamic CVA, closed head injury, and hypothyroidism. Client transitioned to LTC following a skilled stay as he was unable to return home alone given his burden of care and cognitive deficits secondary to dementia. Client's functional mobility at transition: modified independent bed mobility, CGA sit to and from stand transitions as well as surface to surface with use of right prosthesis. He is able to walk up to 120' twice with the use of a front wheeled walker and prosthesis, CGA from a caregiver. Client is able to self propel his wheelchair independently on the unit. Client's history

of falls related to attempts to transfer himself or getting up without staff assist (in one instance client was attempting to care for another resident, on another occasion client was attempting to take care of dishes following a meal). **Use of the algorithm to determine equipment: NO,** Client is not cognitively intact, given dementia diagnosis. **YES,** Resident can achieve partial stand without staff assist, despite recommendation for staff assistance given poor safety and balance deficits. **NO,** Client does not have history of THA. Lowering his bed to the floor could restrain the resident as he lacks strength to overcome excessive hip and knee flexion position from the lowered surface. **YES,** resident is capable of taking steps away from the edge of bed given ambulation distance and only requiring steadying assist from staff as outlined above. Therefore, client would benefit from bed at knee height, floor mats would not be indicated in this situation. Placing the bed at a traditional knee height allows for optimal position for client success in an attempt to self transfer, mats could pose a hazard as he is capable of taking steps away from the edge of bed (creating unstable surface, particularly given BKA status and use of prosthesis). Argument could be made for a different route through the algorithm if questions were answered assuming the client did not have his prosthesis donned. Primary caregivers would need to determine the client's most frequent status when in bed (with or without prosthesis) and consider the client's ability to achieve a partial stand or attempt at self transfer without prosthesis. Answers above were given due to the client's nature of wearing his prosthesis for the entire awake day.

Case 3

Client, a 76-year-old female, presents for skilled rehabilitation following left THA with posterior approach and precautions. She is able to perform bed mobility with modified independence. For transfers and ambulation, she requires stand by assist to supervision primarily related to her need for instruction related to her hip precautions. She has a history of avascular necrosis of the left hip with subsequent osteoarthritis, rheumatoid arthritis, thyroid disease, anxiety, lumbar stenosis with neurogenic claudication, myofascial pain syndrome, and history of humeral fracture with open reduction and internal fixation. Client resides at a local ALF with plans to return there following discharge. **Use of algorithm to determine equipment: YES,** client is cognitively intact. **YES,** she is able to achieve a ¾ stand without assist as outlined above only requiring supervision for safety. **YES,** resident does have posterior hip precautions, therefore, bed will optimally be positioned at mid thigh height without floor mats present. If client chooses to attempt to self transfer or ambulate, particularly given her difficulty adhering to her precautions independently, the elevated bed surface would help reduce risk of excessive hip flexion beyond precaution recommendation. Would advise therapy team to continue to address mobility from traditional heights to allow for appropriate return home. However, when left in room alone to maximize safety mid-thigh is suggested. As previously mentioned, floor mats would pose a potential hazard creating unstable standing surface and could influence an unnecessary fall.

AREAS FOR FURTHER RESEARCH

Investigation of appropriate bed height in the SNF and LTC setting found evidence-based recommendations to reduce fall risk specific to this population are non-existent. Published works that were discovered related to our topic revolved around bed rails and restraint reduction. Bed height was addressed, primarily isolated to the acute care setting rather than facility-based LTC. In the acute setting, the majority of falls were related to elevated bed surface for ergonomic safety of caregivers, coupled with the use of bed rails.[7,10] This information was difficult to apply; acute care regulations related to restraints vary from those adopted in our LTC setting. Discussion determined that excessively lowering the bed surface could restrain a client. Bed rails are not an option as they are now non-existent in our facility due to risk of entrapment, restraint, and potential risk of injury to client from railing itself or attempts to maneuver over or around the railing. Audible alarms have also been phased out of the organization; this compounds the need for appropriate recommendations of room set-up when leaving clients unattended. Much of the research we discovered did not directly apply to our institution. Future research into environmental fall reduction strategies would ideally be geared toward facility-dwelling adults, particularly those with dementia diagnoses.

CONCLUSION

In conclusion, we have attempted to develop a standardized method to determine a safe bed height to reduce falls with injury. Our focus has been primarily on the LTC client with a dementia diagnosis, given the frequency and severity of falls with injury in this population within our organization. We were mindful of additional constraints such as operation of a restraint-free environment, absence of audible alarms, and automatic decision by licensed staff following a fall to lower the bed surface and place floor mats. The reality of completely eliminating falls within our facility is unrealistic. However, a goal of reducing the number of falls or minimizing the severity of injury occurred during a fall is both tangible and remains a strategic priority for our organization.

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Kristin Maxsimic is a staff physical therapist at the Maine Veterans' Home in Bangor, ME with 27 years of experience. She has worked in SNF/NF, acute care, home health, and outpatient settings. She earned a Bachelor of Science degree in Physical Therapy from Northeastern University in 1989. She is certified in NDT and as a Clinical Instructor.

Traci Kennedy is currently the senior physical therapist at the Maine Veterans' Home in Bangor, ME. She has experience in SNF/NF and hospital settings. She graduated from Quinnipiac University in 2010 with a Bachelor of Science in Health Science Studies and in 2013 with her doctorate degree in Physical Therapy. She is certified in Aquatics and as a Clinical Instructor. She coauthored an article, Utilization of mobilization with movement of an apparent sprain of the posterior talofibular ligament: A case report published in *Manual Therapy* in February 2013.

Michelle Bell has been the Rehabilitation Manager at the Maine Veterans' Home in Bangor, ME for the past 16 years. She has experience in SNF/NF, hospital, outpatient, home health, schools, and adult day programs. Michelle completed her Bachelor of Science degree at the University of Connecticut and her Master's degree at Northeastern University. She co-published the *GeriNotes* article, Power mobility device use protocol: a model for facility-specific use in September 2012.

Saying Thank You to Our Outgoing Leaders

Karen Curran

Bill Staples served as our very capable President the last 6 years. During that time, through his diligence, we were the first Section to become an Academy and now with more than half of the Sections being Academies, we are proud to have led the way to change. Bill was recognized by APTA for his service at the President's Meeting at CSM in New Orleans. As per tradition, each outgoing component president picks a song that characterizes his or her presidency. Amusingly, Bill chose "Change Your Name" by Chase Bryant!

Under Bill's leadership, the Academy maintained a strong financial position, increased membership, and started several new initiatives including the development of 3 new SIGs, increased online learning opportunities, expanded AGPT-produced evidence-based documents, and established a strong commitment to the Foundation for Physical Therapy and received the Premier Partner in Research Award in 2017.

Other accomplishments during Bill's tenure include the expansion of the CEEAA course series with plans to include a PTA course and an Advanced course, improvements to the *Journal of Geriatric Physical Therapy* that improved readership and access, continuing progress of CPGs, improved processes for the Board and Committees and SIGS including the updating of all job descriptions and the addition of 2 new committees, Communications and Education, increasing outside partnerships and advancing residencies with scholarship offerings. Bill found time to accomplish all this while running half marathons, hiking the Appalachian Trail almost every summer since 2013, traveling with students for service trips, and adding to his extensive wine collection!

Bill Staples and Jill Heitzman – thanks for your leadership!

Bill Staples and Lucy Jones

At the CSM Member Meeting, one of Bill's Board colleagues noted that Bill has been an exemplar leader, taking us forward with the move from Section to Academy, as well as encouraging all of us to be our best... all while hiking the Appalachian trail annually! Bill truly is an extraordinary human being with a passion for geriatrics that knows no bounds. Bill Staples has truly improved the lives of aging adults with AGPT leading the way! And for that and more, we extend our gratitude for a job well done!

We thank outgoing Vice President, Jill Heitzman for her dedicated service to the Academy the last 6 years where she served as Vice President and a member of the Executive Committee. Her efforts to expand and improve the SIG structure and function are appreciated. Jill was always a valuable resource for advice, mentoring, and was the go to person for a historical perspective of the Board, Committees, and SIGS. Fellow Board Member, Ann Medley had this to say about Jill, "I will miss having Jill on the BOD. She has been my go to source for context regarding various issues that have come up since I joined the BOD. Having served the Academy for many years, she has strong grasp of the history behind past and current decisions that the BOD has made. In all that she says and does, she always has the best interest of the Academy at heart. She is not afraid to take on challenging tasks, nor is she afraid to speak up when necessary." Thank you Jill, your leadership has been invaluable to the academy. We are excited to have you continue that leadership as the newest member of the Nominating Committee.

Lucy Jones served as our Director of Research and Publications for two terms and served as a great resource as the BOD liaison to the editors of the *Journal for Geriatric Physical Therapy* and *GeriNotes* and also the Research Committee. Lucy brought a thoughtful perspective on a multitude of Board issues and was always ready to take on a challenge. Fellow Director, Tamara Gravano noted that Lucy has boundless energy and enthusiasm, always positive and radiant, and there to cheer you up. She has many talents and I am proud to work with her and also call her my friend. We thank Lucy for service to the Academy.

The Academy also thanks outgoing *GeriNotes* Editor, Meri Goehring and outgoing Nominating Committee Chair, Patty Antony for their past service and we also recognize Greg Hartley's term as CEEAA Co-Administrator.

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