

# GERI NOTES

Academy of Geriatric Physical Therapy

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## IN HONOR/MEMORIAM FUND

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

**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/Memorial Fund is a wonderful expressive memorial.

# President's Message

Greg Hartley, PT, DPT



What is the value of membership in Academy of Geriatric Physical Therapy (AGPT) for you? The answers are likely as diverse as we are as a group.

For me, I have always valued the networking opportunities membership in the AGPT has enabled. Some of these connections evolved into professional collaborative opportunities in teaching, research, and practice. Some of them are now close and cherished personal friends, and some are Facebook friends. But all are the result of the collaborative relationships the AGPT has kindled. The AGPT offers many ways for members (and non-members) to connect, network, partner, and collaborate.

Social media is one avenue where members can connect on a daily basis. "Like" our page on Facebook and you will begin to see information relevant to all areas of practice and advocacy (search Facebook for Academy of Geriatric Physical Therapy). Be sure to like, comment, or share posts so the AGPT news items continue to show up on your feed...and so you can connect with other AGPT friends from across the country (and the world). If you have not already, follow us on Twitter (@AGPTtweets). I have to admit, I was hesitant about Twitter to begin with. But since I have started using it, solely for professional purposes, I have been blown away by the valuable information AGPT and others tweet on a *daily* basis. I stumble across nuggets of information I have used in teaching, ideas for practice, and ideas for research. It has truly been amazing! And in talking with other members, they have found Twitter to be a wonderful resource and networking platform as well. The AGPT is also developing a growing YouTube channel (search Academy of Geriatric Physical Therapy). An Instagram account will be coming in the

next several months. These social media platforms are a terrific way to engage with fellow AGPT members and leaders beyond our incredible print and website resources. They also provide a dynamic and fluid mechanism to engage with the AGPT more frequently. The AGPT's Facebook and Twitter accounts are active on a daily basis. And they allow you, our members, to connect, comment, ask questions, and provide feedback in real time. We want that!

In part, because of networking and social media, the AGPT has been able to partner and collaborate with a variety of other groups and organizations. In the 2nd quarter of 2018, AGPT sponsored ads on the Senior Rehab Project's (SRP) podcast and Facebook pages and will do so again in the 4th quarter. Dr. Sherri Betz, Chair of our Bone Health SIG, has posted two *great* videos, one geared towards patients/clients, and another geared towards PTs and PTAs. (Available on our website, <https://geriatricspt.org/special-interest-groups/bone-health/>, and on our AGPT YouTube channel.) The Bone Health SIG, in partnership with the American Bone Health (ABH), has developed an informative poster/infographic you can give to patients or place in your clinic (also available at the website link above). And speaking of bone health, I am very proud that AGPT is one of the 81 charter international organizations to endorse the Global Call to Action on Fragility Fractures from the Fragility Fracture Network (FFN) of the Bone and Joint Decade. You will hear much more about that soon, but you can learn more about it here: <http://fragilityfracturenetwork.org/cta/>. Collaboration with SRP, ABH, and FFN were possible because of networking between our fellow members and other groups, with AGPT as the common denominator.

In the future, you will begin to see even more collaboration between AGPT and other organizations like the Arthritis Foundation, the Alzheimer's Association, the National Parkinson's Foundation, the National Senior Games

Association, and others. The AGPT is also collaborating with other Academies and Sections within the APTA, so watch for joint efforts between AGPT and the Academy of Neurologic Physical Therapy (ANPT), the Academy of Orthopaedic Physical Therapy, the Home Health Section, the Section on Women's Health, the Sports Section, Health Policy and Administration-The Catalyst, and others! A joint event between AGPT and ANPT already occurred at the NEXT Conference in Orlando and was a big success!

I would also like to take a moment to thank the immediate past editor of AGPT's peer-reviewed journal, the *Journal of Geriatric Physical Therapy* (JGPT), Dr. Richard Bohannon. Dr. Bohannon elevated the impact of the journal (especially internationally), and expanded its capacity during his tenure as editor. Thank you for your years of dedicated service Dr. Bohannon! And AGPT extends a warm welcome to Dr. Leslie Allison, JGPT's new editor. In keeping with this message's theme, Dr. Allison has plans to expand the reach of JGPT through podcasts, social media, and other creative ways to disseminate science and seamlessly translate evidence into day-to-day practice. We look forward to these creative additions to an already amazing journal!

In closing, "like" us on Facebook: <https://www.facebook.com/geriatric-spt.org/> (or search Facebook for Academy of Geriatric Physical Therapy), follow us on Twitter: <https://twitter.com/AGPTtweets> (@AGPTtweets), and watch our growing video library on the AGPT YouTube channel here: <https://www.youtube.com/channel/UCxaYr-jn2e1EG31dqWbb1FCA/featured> (or search YouTube for Academy of Geriatric Physical Therapy). **Engage with us on these platforms to make your experience even better!** The AGPT wants to hear from you! We want to help you grow, learn, engage, volunteer, and collaborate to be the best PT or PTA your patients/clients and our society deserve! #bettertogether, #AGPT, #PTFam, #GeriPT

# Editor's Note

Michele Stanley, PT, DPT



September is a huge month for the AGPT and *GeriNotes* community:

- (1) September 22, 2018. The annual Falls Prevention Awareness Day (FPAD) raises awareness about how to prevent fall-related injuries among older adults.

Falls Prevention Awareness Day | National Council on Aging (NCOA)  
<https://www.ncoa.org/healthy-aging/falls-prevention/falls-prevention-awareness-day/>

Take pictures and write up your own FPAD event to share!

- (2) September 23-29, 2018: Inspiring Wellness: Active Aging Week  
[www.activeagingweek.com](http://www.activeagingweek.com)
- (3) Celebrating partnership with 80+ international organizations participating in the Global Call to Action on Fragility Fractures  
[https://www.injuryjournal.com/article/S0020-1383\(18\)30325-5/fulltext](https://www.injuryjournal.com/article/S0020-1383(18)30325-5/fulltext)

We live in a big world with multiple cultures, customs, and people but...at least if we are fortunate, we all age. It is appropriate that we take our place on the team to prevent the fractures associated with poor health (which often means older people) and to demand the best possible care that current evidence demonstrates when one of us does experience that fracture. In conjunction with this initiative, this issue of *GeriNotes*

- explores the way that elderly receive care elsewhere in the world and opportunities for physical therapists to broaden their cultural horizons and become active members of global health teams. Some interesting reading... if you are intrigued, join the Global Health for Aging Adults (GHAA) SIG – report inside.

- (4) Another BIG deal this month: Ellen Strunk guides our understanding of the HUGE change coming to the skilled nursing facility near you on October 1. Will this end or just change the working physical therapist's productivity woes (similar changes also in inpatient rehabilitation facilities and home health agencies – different time tables)? This is a good time to think about what outcomes measures really mean.
- (5) Look for the poster prepared by the Cognitive and Mental Health SIG, designed as a handy clinical reference on delirium – a first for the *GeriNotes* publication. Does

your SIG have a hot button topic that you would like to highlight for everyone's awareness? Contact the editor for a "how-to."

- (6) "GET LITerature: The Latest Examinations and Interventions for the Older Adult" *GeriNotes* proudly announces the advent of a regular column by our own Dr. Carole Lewis. GET LIT will feature different patient populations and relevant evidence-based measures for assessment and treatment, presented in an inspiring and thoughtful way.
- (7) Last, but not least, get the summary report of what happened at the House of Delegates this summer – they were busy! Ellen Strunk is our Academy delegate and invites questions and comments. Please see the full report of action on all the bills on the AGPT website.

By the way, the heavy lifters from AGPT with the fragility project are:

- Kate Mangione, PT, PhD  
[mangione@arcadia.edu](mailto:mangione@arcadia.edu)
- Sherri Betz, PT, DPT  
[sherri@therapilates.com](mailto:sherri@therapilates.com)
- Greg Hartley, PT, DPT  
[g.hartley@miami.edu](mailto:g.hartley@miami.edu)

Reach out to them with thanks and congratulations.

## Love a Good Story?

Looking for 2-3 members who can create videos to highlight the AGPT.

Previous video experience is helpful.

Contact Rania Karim: [karimr@marshall.edu](mailto:karimr@marshall.edu)



# 2018 Academy of Geriatric Physical Therapy Election

Those elected will take office at the AGPT Member Meeting in February of 2019 at CSM in Washington, DC. Online voting will begin on October 1, 2018, and continue thru October 31, 2018. Please watch your email and [www.geriatricspt.org](http://www.geriatricspt.org) for more details. Contact [karen.curran@geriatricspt.org](mailto:karen.curran@geriatricspt.org) to request a paper ballot. Per bylaws, only PTs and PTAs are eligible to vote.

## TREASURER (VOTE FOR 1)

**Kate Brewer, PT, MPT, MBA**

*President and Owner,  
Greenfield Rehab Agency*



**What skills and experience do you bring to this position to assure maintenance of complete and accurate financial records for the Academy of Geriatric Physical Therapy?**

I am honored to be considered for the position of Treasurer for the Academy of Geriatric Physical Therapy for another term. In order for our component to be effective for the membership we serve, we must be thoughtful and detailed when keeping financial records and managing the resources of the organization to allow us to meet our goals and plan for continued growth. As the owner and President of Greenfield Rehabilitation Agency, I am responsible for the financial operations and management for over fifty clinic locations that serve the geriatric population. I have many years of experience on ensuing accuracy and appropriate planning to allow an organization to address current needs and plan for future growth and expansion.

In addition to my past term as Treasurer for the Academy, I have served as Treasurer for my State Chapter which has provided me with the tools necessary to operate within APTA's overarching goals while still planning for the unique needs of our component. I would bring value to the AGPT and their leadership team through my experience to help us con-

tinue to promote this valuable and vital part of the practice of physical therapy.

**How would you communicate recommendations for Board members to improve budget planning in each of their specific areas of responsibility?**

The resources of the Academy should be planned and utilized for activities that are synchronized to the strategic plan. Any financial outlay should have a transparent link to a goal that the Academy has identified so the membership can plainly see why the funds are being spent and the outcome that is looked for. The financial support is necessary to ensure activities are executed, essentially the means to accomplish the outcome we are looking for.

If a board or committee member is struggling with how to improve how they budget for their activities, I would encourage them to align their planned activities to show how they support the strategic plan and it will fall into place. If it does not, perhaps that activity needs to be re-evaluated.

## DIRECTOR (Vote for 2)

**Kenneth L. Miller, PT, DPT**

*Board Certified Geriatric Clinical Specialist, Certified Exercise Expert for Aging Adults, Master Trainer, TeamSTEPPS*



### Education

1995 BS/MA in Physical Therapy from Touro College, Dix Hills, NY  
2007 DPT from Touro College, Bay

Shore, NY

Adjunct Professor, Touro College, Bay Shore, NY

Clinical Educator, Catholic Home Care, Farmingdale, NY

**Position/Employer: Physical Therapist, Central Arkansas Veterans Health Care System**

**What experiences would you bring to the position of Director that make you a strong candidate?**

When I was asked to run for office to be a director in the Academy of Geriatric Physical Therapy, my first thought was, do I have the skills to successfully serve in this role? I answered the call with a resounding, YES! I believe I am a strong candidate as I have been a physical therapist for over 22 years working with older adults in multiple practice settings. I have served in supervisory roles always looking to improve the quality of care the patients are receiving. I have served on the nominations and practice committees of the Academy of Geriatric Physical Therapy for over 8 years and have served as Chair of Practice for another component organization of the American Physical Therapy Association.

My passion has always been for the betterment of practice our patients receive while at the same time advocating for the clinician providing the care to be properly valued and respected. I have facilitated and co-authored many practice resources including toolkits for the care for incontinence, sleep disorders, pain management, and mental health/cognitive disorders.

As your director, I strive to advocate for the older adult and our profession

to remove barriers to care and promote best practice. More recently, I have been getting involved at the policy level to share the value of physical therapy to the stakeholders responsible for access to care. I plan on continuing this work to help our patients get access to the best care possible.

**What current or future Academy activities would you like to advance as a member of the Board of Directors and how do you plan on achieving this?**

As your director, I would like to see the Academy partner with other organizations with similar mission and vision statements to advance ideas to move from sick care to well care adding primary prevention for our older members of society. As the government makes cuts to reimbursement for rehabilitation services across the post-acute care continuum, physical therapists must follow the evidence to new opportunities in primary disease prevention through the power of physical activity.

Spreading this message couldn't be easier with the use of modern day social media. Engaging society through Facebook, Twitter and other applications, are key ideas to disseminate best practice information to clinicians.

**What is the greatest challenge facing the geriatric practitioner and how can the Academy help?**

I believe the biggest challenge facing physical therapists working with older adults is the fact that physical therapists are professionals that are viewed as a modality such as an order for a medication. It is the fact that PT is ordered, rather than being consulted, which must change. For physical therapists to realize the vision to transform society, we must demonstrate our value to society through the quality of care provided and outcomes made. For this to happen, we must transform ourselves to root out unwanted variability in practice, utilize the best available evidence to achieve our patient's goals in the most efficient manner possible. The Academy has the structure in place to move us towards best practice for the betterment of society.

**Susan Wenker, PT, PhD**

*Board Certified Clinical Specialist in Geriatric Physical Therapy – Emeritus  
Certified Exercise Expert for Aging Adults*



**Current Position**

Assistant Professor  
(CHS)  
Department of Family Medicine and Community Health  
Doctor of Physical Therapy Program

**Education**

University of Wisconsin La Crosse,  
Physical Therapy  
University of Wisconsin Madison, PhD

**What experiences would you bring to the position of Director that make you a strong candidate?**

My breadth of experiences facilitate effective communication skills amongst multiple stakeholders. These experiences include being the current Director of Practice where I have had the pleasure to work with past and present members of the Executive Board, other Board of Directors, SIG chairs, and committee members. Additionally, I bring insights from multiple perspectives including academia, clinic, and research. My involvement in these areas provide me with talking points and the ability to hold my own at times when a spirited dialogue is required. My organizational skills along with the ability to observe trending issues provides a nice mix of completing tasks while advancing projects. Last, I bring pure grit and work ethic to the position of Director. The desire and enjoyment found in working with others whose sincere interest is in working with older adults creates a desire of being involved to support older adults, the members, and to move the Academy forward.

**What is the greatest challenge facing the geriatric practitioner and how can the Academy of Geriatric Physical Therapy help?**

Several activities are currently in the hopper and I anticipate these initiatives will snowball into future projects. For example, Dr. Keith Avin, as Chair of the Practice Committee, guides several sub-committees and groups in the development of Evidenced-based Documents

(see *GeriNotes*, July 2018, Vol 25 No. 3). Additionally, the Practice Committee is in the development phase, in concert with the Academy, to improve methods of disseminating this information to a variety of audiences (eg, older adults, members, other organizations). As Chair of the Payment and Legislative Committee, Ellen Strunk, PT, MS, continues to stay on top of reimbursement and legislative changes with her up-to-date reports and summaries as well as having a strong presence in the House of Delegates. Last, Dr. Barbara Billek-Sawhney has worked tirelessly on the Home Study Course (HSC) series and we are in the early investigation phases of how to connect the HSC series with continuing education courses created and sponsored by the Academy. Their work is very important and as their BOD liaison I will continue to advance and support them in their roles.

**What is the greatest challenge facing the geriatric practitioner and how can the Academy help?**

To me the greatest challenge is multifaceted and therefore presents smaller barriers culminating in the "greatest challenge." Ultimately, providing efficient, effective, high quality care that results in the best outcome for that particular patient is the greatest challenge. A number of factors contribute to this challenge; educating and harnessing the energy of students who are sincerely interested in working with older adults, educating clinicians about aging and continually working to chip away at ageist attitudes, sustaining an ongoing dialogue with reimbursement systems to advocate for patients/clients, and a movement toward the application of big data to create critical pathways and effective treatments. Each of these challenges create opportunities for improvement that are underway by the Academy and APTA. However, the last piece of this puzzle is to remember the "art" of physical therapy. Amongst all of the big data, the evidenced-based documents, and tests and measures there is a human that sits, lies, or stands in front of us and we need to foster a connection that demonstrates professionalism, kindness, and empathy - a human connection. As PTs we will best help our patients if we can understand who they are, limit our assumptions, apply the research and

LISTEN; hear their full story before we jump to predetermined patterns. Continually connecting with patients is all of our responsibility.

## **NOMINATING COMMITTEE** **(Vote for 1)**

### **Lee Ann Eagler, PT, DPT**

*Board Certified Geriatric Clinical Specialist*



#### **Current Position**

Assistant Professor at the University of Lynchburg

#### **What skills and experiences qualify you to serve on the**

#### **Nominating Committee?**

For 5 years I was the Chair of the Awards Committee for the Academy of Geriatric Physical Therapy (AGPT). Through this role, I have had the opportunity to meet many people who have been leaders who could potentially connect me to new leaders. Similarly, I have had the opportunity to meet individuals who are achieving great things. Having resources to identify leaders is helpful to the nominating committee role.

Likewise, attending Board meetings and talking with those in leadership positions has given me the opportunity to better understand the roles and responsibilities of the elected positions within the AGPT. Furthermore, if elected, I would continue learning from past and current leaders as well as reading job descriptions to improve my understanding of the demands of each of the jobs.

#### **How would you identify and mentor new leaders within the Academy?**

To identify new leaders, I would first plan to be where there are members. This would mean making time at CSM to work at the member booth, attending AGPT meetings, and meeting people at posters and presentations. And once I meet people, I can then follow-up with them to identify any desire for a leadership position as well as strengths that person may have. I can also educate members on what leadership positions are available as well as what duties are

included. Sometimes, finding good leaders is only a matter of asking the person to consider the position.

To mentor leaders, it would be my job to pass the most relevant information to the leaders based on strengths and weaknesses. The APTA has recently compiled evidence-based mentorship information for leaders. However, many people don't have time to read or review so much material so matching the most relevant information to the person is important and following up to review or offer additional resources would be essential.

I look forward to serving AGPT in this important role if elected.

### **Lucy Jones, PT, DPT, MHA**

*Board Certified Geriatric Specialist  
Certified Exercise Expert for the Aging Adult*



#### **Employer/Position**

Rehabilitative Therapy Services, owner, Therapy Choice, Geriatric Specialist in the home health setting

#### **Education**

Doctor of Physical Therapy, University of Indianapolis, Masters of Health Administration, University of Missouri, KC, BS Physical Therapy, University of Pennsylvania

#### **What skills and experience qualify you to serve on the Nominating Committee?**

I have had the privilege of serving the Academy through the years, previously serving on the Nominating Committee until 2010. Members were nominated with varying backgrounds, ages, and experience with the Academy. We actively searched for those who would enhance our efforts to provide optimal board composition to fulfill our AGPT mission of promoting best practice and to advocate for older adults. As Chairperson, AGPT had a full slate for the elections. As a member of the AGPT Nominating Committee, my charge would be to submit capable and equipped members for election who would positively enhance the Academy's contribution to the APTA mission of transforming society

by optimizing movement to improve the human experience.

In my various roles of service to the Academy, Finance Committee, question review for Specialist Accreditation for Certification Exams, APTAnj member of Geriatric Special Interest Group with inception in 2010, and with facilitating Geriatric Specialty Exam study groups, I have interacted with numerous smart, effective leaders in their respective practice sites. The participation in AGPT continues as CEEAA faculty, coordinating the AGPT website redesign, Web-Media group facilitator, AGPT Board member, Task Force for Partnership, student resume review, and past Board of Director for Research and Publications. The AGPT has exciting forward-thinking students and members ready for a new challenge within the Academy. I have worked as a Geriatric Certified Specialist and worked in various settings throughout my practice serving the older adult. I have established networking opportunities with involvement with AGPT, expanded at CSM and NEXT connecting with members and potential members, interacting with the participants of CEEAA courses as we seek to improve best practice. Working with 17 Committees and 6 Special Interest Groups to review and revise the website content accurately for a year was a fabulous way to become more familiar with each Committee Chair, and their respective leadership and strategic plan for their group. As a Director for AGPT, I met with the *JGPT* and *GeriNotes* editorial boards, and our Research Chair at CSM as they planned and developed their plans and strategy for the following year. Writing and encouraging others to write is always a thrill, especially for the individual who sees their submissions in print! As a member of the New Jersey APTA Chapter, the Fall Prevention Day in September is a treat to see statewide how we can facilitate education and awareness. My colleagues in New Jersey are interactive, and leadership capabilities are exciting.

The Academy has exciting days ahead, and as a member of the Nominating Committee I will continue to interact with our membership on social media, in person, at CSM, and at the CEEAA courses. Seeking qualified leadership has been a passion since I first became



involved with the Academy. I will strive to connect with members, cultivating expertise, involving those to move practice forward, encouraging advocacy, promoting a desire to collaborate, and encouraging a passion and willingness to be stretched as our next leaders. We all are on a continual learning and growing journey in life, and I hope to serve the AGPT and you, the members, in this exciting way.

**How would you identify and mentor new leaders within the Academy?**

I believe that one of my strongest qualities is the ability to engage and encourage others to collaborate, create an enthusiastic environment, follow the contribution they can make to the Academy, and recognize the leadership skills they possess in this process. Identifying new leaders is more than filling a slot on the ballot. It is encouraging potential leaders who carry a passion and drive to pursue their knowledge, proficiency, and desire to develop and expand their leadership and knowledge base with their colleagues.

The word “mentor,” according to the Merriam-Webster dictionary, comes from the Greek character in Homer’s Odyssey, a trusted friend of Odysseus was entrusted with education of his son. It is a personal picture of a mentor as an experienced, wise, and trusted advisor. How does one become a trusted and wise advisor? I had several mentors who took their job very seriously. One mentor encouraged me to take the GCS exam as an expansion of my practice. Another lead me to pursue my DPT after I had already had a Masters of Health Administration, after thinking I was going down a different path. I was mentored over several years by a friend to consider applying for a position as a Director on the AGPT Board.

Two ways come to mind immediately as we reach out to mentor fellow members. First, the AGPT offers a congratulatory breakfast the morning after the GCS installation ceremony. This is an opportunity for relationships to solidify and mentors to be identified as these candidates return to their practice set-

ting. Secondly, it is an opportunity to expand and cultivate relationships. The AGPT can initiate a leadership development team, facilitating a path forward for those interested in training, expanding their service, expertise, and knowledge of the leadership challenges facing AGPT. This can facilitate committee involvement, and assist members to see a way they may engage in service to the Academy.

Mentoring involves observing, passion, drive, encouraging practice development, capitalizing on the mentees successes, and promoting confidence for reaching new challenges. There are numerous roles in the AGPT in which members may step up in an area of interest. This is the beginning of recognizing our own leadership skills as you take the next step to your leadership development. I can lead you on your journey. Come talk to me, whatever the election results, and you can be on your way to your personal leadership challenge.

# VOTE



## 2018 AGPT Election

### IMPORTANT INFORMATION:

As in past years, the election will be online and take place October 1-31, 2018.

Please watch your email and [www.geriaticspt.org](http://www.geriaticspt.org) for more details.

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

Those elected will take office at CSM in January of 2019. As per AGPT Bylaws, only PTs and PTAs vote in Academy elections.



# Policy Talk: Have You Heard? Functional Outcome Measures Are Here

Ellen R. Strunk, PT, MS

Your first response is probably that functional outcome measures are not new and so why the fuss? You would be mostly correct. Physical therapists and physical therapist assistants whose practice includes older adults in all settings have used various tests and measures in practice for years. In fact, the AGPT-sponsored Certified Expert in Exercise for the Aging Adult (CEEAA) course is wildly popular because it provides participants with the research, science, and application of a variety of standardized tests and measures. The Centers of Medicare and Medicaid Services (CMS) have also put standardized tests and measures front and center. Every setting therapists work in has a program in place to collect data: Acute care hospitals (ACH), long-term care hospitals (LTCH), inpatient rehabilitation facilities (IRF), skilled nursing facilities (SNF), and home health agencies (HHA) all have Quality Reporting Programs and Value-Based Purchasing Programs mandated by CMS. Outpatient providers have had Functional Limitation Reporting (FLR) but a recent CMS proposal would replace the FLR in 2019 with the Merit Incentive Payment System. The goal of all these programs is to collect information on patient characteristics, care processes, care variations, and the short- and long-term effects of that care. Collectively, it should help us to

improve the health of the population and the quality of the services we deliver.

## SO, WHAT IS HERE 'NOW' IN POST-ACUTE CARE?

Past columns of "Policy Talk" have discussed<sup>1,2</sup> the Improving Post-Acute Care Transformation (IMPACT) Act of 2014 which implemented significant changes to each of the post-acute care (PAC) settings and their applicable assessment instruments (see Table 1). The Act requires the submission of standardized assessment data by each of the PAC settings. Centers for Medicare and Medicaid Services has been hard at work developing, testing, and refining those assessment data items as well as insuring that they are interoperable. Insuring the interoperability of patient assessment data allows providers to easily exchange important data. Imagine a time when you have had a patient to examine, the information you received from the referral source was essentially administrative (eg, payer source, address, MD, and an ICD-10 code), and as a result you struggled to appear competent in the eyes of the patient. Alternatively, you spent 30 minutes trying to contact the referral source to find out more about their clinical condition and the tests or treatment they had already received. The goal of the IMPACT Act (and other CMS initiatives) is to make the exchange of meaningful information easier and a part of normal practice.

One of the data categories specifically mentioned in IMPACT Act legislation is function. IMPACT requires PAC providers of care to report standardized assessment data no later than October 1, 2018, for SNFs, IRFs, and LTCHs and no later than January 1, 2019 for HHAs. We know what the data elements are; each setting has seen them added to their respective assessment instruments over the last 3 years. They are commonly referred to as "Section GG" because this is the section of the assessment instruments they are housed in. Table 2 provides a list of the items included in each setting for self-care and for mobility.

## SECTION GG

The new measures meet the requirements of the IMPACT Act. Section GG data has been gathered in the LTCH since April 1, 2016, and in the IRF since October 1, 2016. The SNF setting started in October 1, 2016, with a partial set of the items listed in Table 2, and home health collected only one starting January 1, 2017. Skilled nursing facilities will begin collecting the entire item set effective October 1, 2018, and HHA will begin collecting the entire item set effective January 1, 2019. Data collected will be calculated and reported back to the provider as a functional outcome measure. Ultimately, CMS plans to publicly report these measures.

**Table 1.** Post-acute Care Settings and Their Assessment Instruments

Post-acute Care Setting	Assessment Instrument with Current Version Number
Long-term Acute Care Hospital (LTCH)	Continuity Assessment Record and Evaluation (CARE) 4.0
Inpatient Rehabilitation Facility (IRF)	Patient Assessment Instrument (PAI) v1.15
Skilled Nursing Facility (SNF)	Minimum Data Set (MDS) v1.16
Home Health Agency (HHA)	Outcome Assessment and Instrument Set (OASIS) v.D

**Table 2.** Section GG Item Sets: The Table Illustrates the Items Collected in Each Post-acute Care Setting's Assessment Tool

GG0100. PRIOR LEVEL OF FUNCTIONING	LTCH	SNF	IRF	HHA*	RATING SCALE
Self-care		X	X	X	3 = Independent
Functional Cognition		X	X	X	2 = Needed Some
Indoor Ambulation	X	X	X	X	Help
Stairs		X	X	X	1 = Dependent
GG0110. PRIOR DEVICE USE	LTCH	SNF	IRF	HHA*	
A list of devices and aids used by the patient prior to the current illness, exacerbation or injury.	X	X	X	X	A check indicates the item was used
SELF CARE	LTCH	SNF	IRF	HHA*	RATING SCALE
Eating	X	X	X	X	6 = Independent
Oral Hygiene	X	X	X	X	5 = Set up/Clean up
Toileting Hygiene	X	X	X	X	Assistance
Wash Upper Body	X				4 = Supervision or
Shower/Bathe Self		X	X	X	touching assistance
Upper Body Dressing		X	X	X	3 = Partial/Moderate
Lower Body Dressing		X	X	X	Assistance
Putting on/Taking off footwear		X	X	X	2 = Substantial/
MOBILITY	LTCH	SNF	IRF	HHA*	Maximal Assistance
Roll Left and Right	X	X	X	X	1 = Dependent
Sit to Lying	X	X	X	X	
Lying to Sitting on Side of Bed	X	X	X	X	Possible Score
Sit to Stand	X	X	X	X	Range for Self-Care:
Chair/Bed to Chair Transfer	X	X	X	X	8 to 48
Toilet Transfer	X	X	X	X	
Car Transfer		X	X	X	Possible Score
Walk 10 feet	X	X	X	X	Range for Mobility:
Walk 50 feet with Two Turns (or Wheel)	X	X	X	X	14 to 84
Walk 150 feet (or Wheel)	X	X	X	X	
Walk 10 feet on Uneven Surfaces		X	X	X	<i>*Note: Items to</i>
1 step		X	X	X	<i>assess wheeling in</i>
4 steps		X	X	X	<i>patients who use a</i>
12 steps		X	X	X	<i>wheelchair are in GG</i>
Picking Up Object		X	X	X	<i>but not included in</i>
					<i>the functional outcome measure</i>

\*The items will be included in the OASIS-D effective for all episodes of care initiated on/after 1/1/2019.

Abbreviations: LTCH, long-term care hospitals; SNF, skilled nursing facility; IRF, inpatient rehabilitation facility; HHA, home health agencies

Yes, that means that a consumer of PAC services or a family member looking for the most appropriate care setting for their loved one could access the scores for the specific LTCH, IRF, SNF, or HHA they are considering. It also means that for the first time in the history of the profession, there has been one mandated functional instrument outcome measure for all PAC providers.

Does this mean that other functional outcome tools will be unnecessary in these settings? Absolutely

not. The primary goal of many LTCH, IRF, SNF, and HHA patients is improvement in function; physical therapists are accustomed to assessing and documenting patient's functional status at admission and at discharge. We also use many assessment tools to identify the underlying impairments that are contributing to the decline in function. The CMS outcome measure using Section GG will not replace the need to use evidence-based standardized tests and measures that are critical to

guiding care plans. It is true the measure will be used to evaluate not only the effectiveness of the rehabilitation care provided to individual persons but also the effectiveness of the LTCH, IRF, SNF, and/or HHA.

## FUNCTIONAL OUTCOME MEASURES

Table 3 illustrates the number of measures across PAC settings that use information from Section GG. The first one, *Percent of Patients with an Admission*

**Table 3.** Standardized Functional Measures Applied Across Post-acute Care Settings

Measure Title	LTCH	SNF	IRF	HHA
Percent of Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function	X	X	X	X
Change in Mobility Among Long-term Care Hospital Patients Requiring Ventilator Support (NQF #2632)	X			
Discharge Mobility Score for Medical Rehab Patients (NQF #2636)		X	X	
Discharge Self-care Score for Medical Rehab Patients (NQF #2635)		X	X	
Change in Mobility Score for Medical Rehab Patients (NQF #2634)		X	X	
Change in Self-care Score for Medical Rehab Patients (NQF #2633)		X	X	
Total Change in Mobility*				X
Total Change in Self-care*				X

\*Proposed Measures for the HH Value-Based Purchasing Program. Specifications not finalized yet.

Abbreviations: LTCH, long-term care hospitals; SNF, skilled nursing facility; IRF, inpatient rehabilitation facility; HHA, home health agencies

and Discharge Functional Assessment and a Care Plan That Addresses Function, is only a process measure. This means the purpose of the measure is to determine how many patients admitted to these settings have **all** the Section GG self-care and mobility items assessed both at admission and discharge, in addition to having a discharge 'goal' set at admission. The remaining measures are all outcome measures. This means the purpose of the measure is to determine the difference between the total admission score and the total discharge score for those items. This article is going to focus on only 4 of the measures listed in Table 4:

1. Discharge Mobility Score for Medical Rehabilitation Patients (NQF #2636)<sup>3</sup>

2. Discharge Self-Care Score for Medical Rehabilitation Patients (NQF #2635)<sup>4</sup>
3. Change in Mobility Score for Medical Rehabilitation Patients (NQF #2634)<sup>5</sup>
4. Change in Self-Care Score for Medical Rehabilitation Patients (NQF #2633)<sup>6</sup>

Each of these measures have been endorsed by the National Quality Forum (NQF), an independent, nonprofit organization that endorses and recommends health care quality measures. The NQF plays an important role in reviewing, endorsing, and updating quality measures with the goal of helping providers improve and helping policymakers (ie, CMS) determine if their interventions are working.

The references to the measure specifications for each setting are provided at the end of the article. That is because while all the settings collect the same Section GG items on their patients, the settings do have different parameters by which they calculate the results. For example, in the SNF, scores are only calculated on patients receiving services under their Medicare Part A benefit. However, in the IRF, scores are calculated on patients receiving services under their Medicare Part A or C benefit. Home health scores are calculated on patients receiving services under Medicare, Medicaid, or any Advantage program. Furthermore, because each setting's patient populations are unique, there are different risk adjustors applied to the calculations in each setting.

**Table 4.** Denominator Exclusions for the Skilled Nursing Facility Change in Mobility/Change in Self-care Measure

1. Residents with incomplete stays. This includes residents who are unexpectedly discharged to a short-stay hospital, an inpatient psychiatric facility, or a long-term care hospital. It also includes residents who die while in the SNF or leave a SNF against medical advice. Lastly, it includes residents with a length of stay less than 3 days.
2. Residents who are independent with all self-care items (for the Self-Care Measure) or all the mobility items (for the Mobility Measure) at the time of admission. They would not be able to show functional improvement on the same set of items at discharge.
3. Residents with the following medical conditions: coma, persistent vegetative state, complete tetraplegia, locked-in syndrome, severe anoxic brain injury, cerebral edema, or compression of the brain.
4. Residents younger than 21 years of age. The rationale is that there is only limited evidence published about functional outcomes for persons younger than 21 years.
5. Residents discharged to hospice.
6. Residents who are not Medicare Part A beneficiaries.
7. Residents who do not receive physical or occupational therapy services.

Abbreviation: SNF, skilled nursing facility

The rest of the article will provide an overview of these 4 measures as they apply in the SNF setting. Since there are several similarities between the two Discharge Score measures and the two Change in Score measures, they will be reviewed together.

### **DISCHARGE MOBILITY SCORE FOR MEDICAL REHABILITATION PATIENTS; DISCHARGE SELF-CARE SCORE FOR MEDICAL REHABILITATION PATIENTS**

These measures estimate the percentage of SNF residents who meet or exceed an expected discharge score. The Discharge Self-Care Score Measure compares the SNF's self-care discharge scores to an expected self-care discharge score. The Discharge Mobility Score Measure compares the SNF's mobility scores to an expected mobility discharge score. There will be some patients excluded from the calculation altogether, however, if they meet certain criteria. These are listed in Table 5. Of note, one of the exclusions is when patients do not receive physical or occupational therapy services. This is an important differentiator between the process measure *Percent of Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function*. It is calculated on all patients admitted to the SNF. In other words, CMS expects providers to assess a patient's functional status at admission and discharge and set an appropriate goal – even if that goal is to maintain their current level or recognize that there will be a decline in function. A Discharge Mobility Score and Discharge Self-Care Score will only be calculated on those patients **receiving** PT and/or OT services, which indicates it will be measuring the **effectiveness** of the therapy services provided.

A risk-adjustment algorithm will also be applied to the calculation. In other words, the results will not be a simple subtraction calculation. Certain risk adjustment weights will be applied to the calculation to account for differences in patient population that each SNF encounters. If this was not done, then access to the SNF for low-level, complex patients would be at risk. A full list of the risk adjustors can be found in the resource at the end of

the article. Included are patient's age, functional level at time of admission, primary medical condition for which they are admitted to the SNF, prior level of function, prior use of assistive devices, major surgery in the 100 days prior to SNF admission, presence/absence of pressure ulcers at the time of admission, urinary/bowel incontinence, cognition and communication abilities, and the number/type of co-morbidities that the beneficiary has. After calculation of the SNF's score, it will be compared against the "estimated" discharge score for the facility based on the facility's patient population characteristics, as well as against the national average scores for discharge in mobility and discharge in self-care.

### **CHANGE IN MOBILITY SCORE FOR MEDICAL REHABILITATION PATIENTS; CHANGE IN SELF-CARE SCORE FOR MEDICAL REHABILITATION PATIENTS**

These measures estimate the risk-adjusted mean change in score between admission and discharge for SNF Part A residents discharged from a SNF. The Change in Mobility Score Measure calculates the difference between the scores in Section GG mobility items and the Change in Self-Care Score Measure calculates the difference between scores in Section GG self-care items.

There will be some patients excluded from the calculation altogether, however, if they meet certain criteria. These are listed in Table 4. Of note, is the fact that one of the exclusions is when patients do not receive physical or occupational therapy services. This is an important differentiator between the process measure *Percent of Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function*. It is calculated on all patients admitted to the SNF. In other words, CMS expects providers to assess a patient's functional status at admission and discharge and set an appropriate goal – even if that goal is to maintain their current level or recognize there will be a decline in function. However, the Change in Mobility and Change in Self-Care Scores will only be calculated on those patients receiving PT and/or OT services, which indicates it will be measuring the **effectiveness** of the therapy services provided.

There will also be a risk-adjustment algorithm applied to the calculation. In other words, the results will not be a simple subtraction calculation. Certain risk adjustment weights will be applied to the calculation to account for the differences in patient population that each SNF encounters. If this was not done, then access to SNF for low-level, complex patients would be at risk. A full list of the risk adjustors can be found in the resource at the end of the article, but they do include the patient's age, their functional level at time of admission, the primary medical condition for which they are admitted to the SNF, their prior level of functioning, their prior use of assistive devices, whether they have undergone major surgery in the 100 days prior to the SNF admission, history of falls (for the mobility measure only), the presence/absence of pressure ulcers at the time of admission, whether they are experiencing urinary/bowel incontinence, their cognitive and communication abilities, and the number/type of co-morbidities the beneficiary has.

A calculation of the SNF's score will be compared against the "estimated" change score for each facility. This is based on the facility's patient population characteristics, as well as against the national average for change in mobility and change in self-care.

### **ARE YOU READY?**

Over the past several years, we have seen a lot of alignment and movement towards a standardized measure for function in this PAC space. As 'Policy Talk' and other distinguished writers in *GeriNotes* have written about, CMS and other payers are changing the ground rules for what gets paid. Therapy services have been paid on volume for too many years: eg, the number of visits made, the number of minutes provided, the number of codes recorded. Has that contributed to a better functional outcome for the patient? The unfortunate part is *we don't know for sure*. Some therapists have never worked in a time when minutes, visits, units, and days were not a focus and point of discussion in the therapy workplace. These functional measures will allow payers, policy-makers, consumers and **therapists** to begin to understand what effective care is and for whom. It also



**Table 5.** Denominator Exclusions for the Skilled Nursing Facility Discharge Mobility Score /Discharge Self-care Score

1. Residents with incomplete stays. This includes residents who are unexpectedly discharged to a short-stay hospital, an inpatient psychiatric facility, or a long-term care hospital. It also includes residents who die while in the SNF or leave a SNF against medical advice. Lastly, it includes residents with a length of stay less than 3 days.
2. Residents with the following medical conditions: coma, persistent vegetative state, complete tetraplegia, locked-in syndrome, severe anoxic brain injury, cerebral edema, or compression of the brain.
3. Residents younger than 21 years of age. The rationale is that there is only limited evidence published about functional outcomes for persons younger than 21 years.
4. Residents discharged to hospice.
5. Residents who are not Medicare Part A beneficiaries.
6. Residents who do not receive physical or occupational therapy services.

Abbreviation: SNF, skilled nursing facility

means the effectiveness of our clinical skills in these settings will become more important to a LTCH, SNF, HHA, and IRF than how many patients we can see in an 8-hour day. Are you ready?

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acute care settings with a focus on helping customers understand the CMS prospective payment systems. She also lectures nationally on the topics of pharmacology for rehabilitation professionals, exercise and wellness for older adults, and coding/ billing/ documentation to meet medical necessity guidelines and payer regulations.

**September 22, 2018**  
(the first day of fall)  
marks the  
**10th Anniversary of  
the Falls Preventions  
Awareness Day**

<https://www.ncoa.org/healthy-aging/falls-prevention/falls-prevention-awareness-day/>

# 2018 House of Delegates Update

Ellen R. Strunk, PT, MS

The 2018 session of the House of Delegates was held June 25-27, 2018, in Orlando, FL. This year's agenda was quite busy! A total of 58 main motions were on the agenda for the 3 days. As the AGPT's elected Delegate, I am reporting to the membership the actions taken in this year's House of Delegates. Please be aware, however, that the "official" results of this year's business will not be available until September 7, 2018. Therefore, this report is considered "unofficial" but in the interest of getting the information out to the membership timely, it is provided.

The governance of the Association is a year-round process. As an elected Delegate, I read hundreds of emails that served as an important part of crafting motions, and provided a means for informative deliberations about the merits of motions. As delegate, I participate in virtual town halls, meetings of the Southern Caucus (determined by my home state), and collaborated with other State and Section delegates. Although the Sections do not have a vote in the House of Delegates, we

do participate in both debate and discussions. As AGPT's delegate, we spoke in favor of RC-44-18 and RC-46-18.

In 2018, motions were proposed by The Special Committee to Review House Documents, The Board of Directors, and several components. The Special Committee to Review House Documents brought forward 34 of the 58 motions. This Committee was formed as a result of a motion passed at the 2017 House of Delegates. Its charge was to review documents previously adopted by the House, and forward motions to amend, consolidate, or rescind documents as needed. There were many House documents rescinded. These were documents that were felt to be outdated, duplicative, and/or no longer necessary. Other House documents were brought up-to-date through amendments. There were also several motions brought forward by the Special Committee, the Board, and components. The motions that successfully passed are highlighted in Table 1. The Special Committee to Review House Documents will continue

their work this year and bring forward additional motions to the 2019 House of Delegates.

Three persons were elected to Honorary Membership in the American Physical Therapy Association: James H. Rimmer, PhD; Daniel M. Corcos, PhD; and Bonnie Polvinale. You can read more about them at <http://www.apta.org/PTinMotion/News/2018/07/09/2018HonoraryMembers/>. Unfortunately, RC-56-18, a motion to amend the bylaws to allow the Sections a vote at the House of Delegates was not considered due to limited time. However, the sections remain committed to continue pursuit of the vote.

As stated earlier, the official minutes of the House of Delegates' proceedings will be posted on the APTA's website by September 7, 2018. As your state begins to develop concepts for new motions in 2019, please feel free to share those issues with me ([ellen@rehabsourceandconsulting.com](mailto:ellen@rehabsourceandconsulting.com)), so the Academy can continue to engage all members. The full report of all motions can be found on the AGPT website.

**Table 1.** Successful Motions Brought Forward by Components, Special Committees, and the Board of Directors

Motion:	Title/Topic and Intent:	Result:
RC 1B-18	AMEND: PHYSICAL THERAPIST OWNERSHIP AND OPERATION OF PHYSICAL THERAPY SERVICES (HOD P06-02-24-48) Intent: To modify the motion passed in 2002 that APTA supported the "exclusive physical therapist ownership and operation of PT services" to say the APTA "supports and encourages physical therapist ownership and operation of PT services." This would signal the APTA's desire to enter into inter-professional and inter-institutional business opportunities and models.	Passed
RC-10-18	ADOPT: PREFERRED NOMENCLATURE FOR THE PROVISION OF PHYSICAL THERAPIST SERVICES Support Statement: To establish consistent language in all APTA documents and publications. This includes: 1. "Physical Therapist" – the professional practitioner of physical therapist services 2. "Physical Therapist Assistant" – the only individual who assists the physical therapist in practice 3. "Physical therapist services" or "physical therapist practice" – preferred nomenclature when referring to the provision of physical therapy. The term "physical therapy service" is appropriate when referring to a facility or a department in which physical therapist services are provided. 4. Professional titles – physical therapists are identified by their professional title, "Physical Therapist" or "Doctor of Physical Therapy."	Passed

RC-11-18	<p>AMEND: COMPLEMENTARY AND ALTERNATIVE THERAPEUTIC INTERVENTIONS (HOD P06-01-26-26)</p> <p>Intent: In 2013, the National Center for Complementary and Integrative Health, a center under the National Institutes of Health, changed their title to include Integrative rather than Alternative, so the intent was to update APTA language.</p>	Passed
RC-12-19	<p>AMEND: DELIVERY OF VALUE-BASED PHYSICAL THERAPIST SERVICES (HOD P06-15-17-09)</p> <p>Intent: To state that the use of biophysical agents as a stand-alone intervention or the use of multiple agents is not considered PT and is not considered medically necessary without documentation to justify them.</p>	Withdrawn
RC-28-18	<p>ADOPT: VALUE-BASED BEHAVIORS FOR THE PHYSICAL THERAPIST ASSISTANT</p> <p>Support Statement: Although the 7 core values are embedded within the Code of Ethics for the Physical Therapist, the value-based behaviors for the physical therapist assistant (PTA) were developed after the Standards of Ethical Conduct for the Physical Therapist Assistant (HOD S06-09-20-18) (Standards) were revised and therefore the Standards do not include the value-based behaviors for the PTA. These definitions are being proposed at this time because it is important to recognize a set of values for the PTA so that there is clarity on what those values are.</p>	Passed
RC-38-18	<p>ADOPT: COMMITMENT TO PERSON-CENTERED SERVICES</p> <p>Support Statement: To engage in advocacy efforts at all levels (federal, state, and local governments and organizations and institutions in which members work) to oppose threats to person centered care and to our code of ethics, which directly states that we do not discriminate on the basis of a wide range of patient characteristics, including health condition or status.</p>	Passed
RC-39-18	<p>ADOPT: APTA STATEMENT IN SUPPORT OF ESSENTIAL HEALTH BENEFITS</p> <p>Support Statement: While this position does not mandate action, the language provides guidance to APTA to support the inclusion of EHBs should it find the opportunity to do so.</p>	Passed
RC-40-18	<p>ADOPT: BEST PRACTICE IN MENTORING</p> <p>Intent: To replace HOD P06-12-16-05 Best Practice for Mentoring Early-Career Proteges.</p>	Passed
RC-41-18	<p>ADOPT: AMERICAN BOARD OF PHYSICAL THERAPY RESIDENCE AND FELLOWSHIP EDUCATION RECOGNITION</p> <p>Support Statement: In 2009, the Board transitioned oversight of residency and fellowship accreditation from a committee model to a board model, establishing ABPTRFE to oversee and manage the implementation and evaluation of the accreditation process of physical therapy residency and fellowship programs.</p>	Passed
RC-42-18	<p>ADOPT: ENHANCED PROFICIENCY AND CONTINUING EDUCATION FOR THE PHYSICAL THERAPIST ASSISTANT</p> <p>Intent: To replace HOD P06-01-22-23 Continuing Education for the Physical Therapist Assistant.</p>	Passed
RC-43-18	<p>CHARGE: ENDORSEMENT AND INTEGRATION OF THE INTERNATIONAL ASSOCIATION FOR THE STUDY OF CURRICULUM OUTLINE ON PAIN FOR PHYSICAL THERAPY</p> <p>Background: To meet the needs of our patients and meet the expectations set by these promotions and recommendations, we must ensure that physical therapists are well prepared in the USA to manage pain conditions.</p>	Passed
RC-44-18	<p>CHARGE: THE ROLE OF THE PHYSICAL THERAPIST AND PHYSICAL THERAPIST ASSISTANT IN DISASTER MANAGEMENT</p> <p>Charges: the APTA identify the professional role of the PT and the PTA in disaster preparation, response, and recovery. Further, that APTA promote the role of the PT and PTA to members and to agencies that manage disasters, so that the expertise of PTs and PTAs can be utilized appropriately.</p>	Passed
RC-45-18	<p>CHARGE: EXPLORATION OF BARRIERS TO CLINICAL RESEARCH BY PHYSICAL THERAPIST PRACTITIONERS</p> <p>Charge: Would have charged the APTA to explore access to institutional review board services for members not affiliated with institutions that provide such services to the member.</p>	Defeated

RC-46-18	CHARGE: ELIMINATING THE IMPROVEMENT STANDARD FOR RECEIVING PHYSICAL THERAPY Charge: the APTA to develop and implement a long-term plan to eliminate the improvement standard in all settings and payment situations.	Passed
RC-47-18	CHARGE: ADJUSTMENTS IN DOCUMENTATION REQUIREMENTS FOR PREVENTION AND WELLNESS INTERACTIONS Charge: the APTA to evaluate documentation requirements for physical therapists providing prevention, wellness, fitness, aftercare, and health promotion services.	Passed
RC-48-18	CHARGE: PROFESSIONAL WELL-BEING Charge: the APTA to develop strategies to address factors that challenge the well-being and resilience of PTs and PTAs, with implementation of those strategies by June 2020.	Passed
RC-49-18	CHARGE: ADVANCED PRACTICE IN PHYSICAL THERAPY Charge: Would have charged the APTA to explore advanced practice in physical therapy for physical therapists who have earned board certification or have graduated from an APTA-accredited physical therapy residency or fellowship program.	Defeated
RC-53-18	AMEND: BYLAWS OF THE AMERICAN PHYSICAL THERAPY ASSOCIATION, ARTICLE VIII. HOUSE OF DELEGATES, SECTION 3: VOTING DELEGATES, A. QUALIFICATIONS OF VOTING DELEGATES, (1) CHAPTER DELEGATES	Not Considered
RC-54-18	AMEND: BYLAWS OF THE AMERICAN PHYSICAL THERAPY ASSOCIATION, ARTICLE VIII. HOUSE OF DELEGATES, SECTION 4: NONVOTING DELEGATES, A. QUALIFICATIONS OF NONVOTING DELEGATES, (1) SECTION DELEGATES	Not Considered
RC-55-18	RC 55-18 AMEND: BYLAWS OF THE AMERICAN PHYSICAL THERAPY ASSOCIATION, ARTICLE VIII. HOUSE OF DELEGATES, SECTION 4: NONVOTING DELEGATES, A. QUALIFICATIONS OF NONVOTING DELEGATES, (2) PTA CAUCUS DELEGATES	Not Considered
RC-56-18	RC 56-18 AMEND: BYLAWS OF THE AMERICAN PHYSICAL THERAPY ASSOCIATION TO ALLOW SECTIONS TO VOTE IN THE HOUSE OF DELEGATES	Not Considered
RC-57A-18	CHARGE: REFRAME THE DESCRIPTION OF PHYSICAL THERAPIST SERVICE DELIVERY Charge: the APTA to revise all relevant documents, positions, and advocacy, in a manner that is efficient, to describe physical therapist practice to include service delivery that is broader than an “episode of care” model by incorporating the concept of a long-term to lifetime ongoing relationship with the patient and client, and to include models of care delivery that are not currently described in APTA documents.	Passed

## CSM 2019~Join the AGPT in Washington, DC

Kick off the week in DC. There are two 1-day courses: *Kyphosis Management-Manual and Exercise Interventions* and *Applying a Comprehensive Approach to Successful Aging*. Back by popular demand for a stop on the East Coast, our third preconference course is the 2-day *Tai Chi Fundamentals Adapted Program (Course 1)*.

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# Improving Health Internationally through Education for Older Adults

Nora Daly

Barbara Billek-Sawhney, PT, DPT, EdD, MS, likens her international volunteer experiences to a well-known proverb: “Give a man a fish and you feed him for a day. Teach a man to fish and you feed him for a lifetime.”

As a global health volunteer, Dr. Billek-Sawhney has shared her knowledge of physical therapy and the care of geriatric patients with colleagues around the world. Educating and mentoring local providers in Peru, Ethiopia, St. Lucia, Vietnam, China, and Sri Lanka. Dr. Billek-Sawhney has started what she believes to be a ripple effect that extends far beyond the individuals trained on a single assignment. “Those physios treat so many future patients and mentor future PTs! We have the potential to make an impact!”

According to the United Nations 2015 *World Population Ageing Report*, “virtually every country in the world is experiencing growth in the number and proportion of older persons in their population.” Between 2015 and 2050, the number of individuals aged 60 and older is expected to more than double, with the number of persons aged 80 and older rising at the fastest rate.<sup>1</sup> To meet the needs of their growing older adult populations, societies across the globe will need to adapt, including increasing the quality and availability of specialized geriatric health services. Physical therapists specializing in older adult patients, in particular, will play a pivotal role in ensuring as many individuals as possible are able to maintain their mobility and independence as they reach age 60 and beyond, and regain their quality of life after experiencing age-related catastrophic health events.

Because beliefs about aging and the care of older adults vary across cultures, local health care providers are best qualified to care for aging members of their communities. With this in mind, it is essential to invest in the education and professional development of the health workforce in resource-scarce countries

to ensure an adequate number of trained health care providers can meet the local need for services.

Understanding the essential role of an educated workforce, Dr. Billek-Sawhney has been making an impact on the global practice of physical therapy since 1988, when she completed her first international volunteer assignment through [Health Volunteers Overseas](#) (HVO). The HVO is a Washington, DC-based nonprofit that facilitates short-term volunteer assignments for qualified health care professionals to support their colleagues in resource-scarce countries through education and professional development opportunities.

“In 1988, my friend and colleague Karen Maloney Backstrom PT, DPT, MS and I were investigating opportunities to serve internationally,” she recalled. “We investigated short-term volunteer opportunities and, despite no internet, we found Health Volunteers Overseas or they found us.”

That same year, the two women traveled to Addis Ababa, Ethiopia. They were among the first volunteers to serve in HVO’s [physical therapy program](#). Dr. Billek-Sawhney returned to Ethiopia through HVO in 2012 and, although HVO’s project in Addis Ababa closed in 2013, she was able to return again in October 2017 to deliver a continuing education course in geriatric physical therapy.

“I was fortunate to teach what I think were the first geriatric physical therapy courses in Beijing, China; Addis Ababa, Ethiopia; and Kandy, Sri Lanka,” she said.

In addition to delivering these courses, Dr. Billek-Sawhney has continued to volunteer her services as an educator at multiple HVO projects sites, including St. Jude’s Hospital in St. Lucia and Da Nang Orthopedic and Rehabilitation Hospital in Vietnam. During these assignments, she has mentored providers and students in the care of patients ranging in age from babies to

older adults. However, she noted, “Since 1988, there has been a huge growth in the older adult population.”

During a 2013 trip to St. Lucia, Dr. Billek-Sawhney had the opportunity to direct her teaching efforts toward the needs of this population when she delivered a one-day course on the care of older adult patients to 21 nurses and nurse aides at Comfort Bay—the country’s only government-owned nursing home. The topics covered during this course included the importance of maintaining mobility, as well as proper technique for positioning and transferring non-ambulatory patients. At the conclusion of the training, Dr. Billek-Sawhney and her fellow volunteers provided the nursing home staff with written guidelines they could refer to when implementing the newly learned techniques.

“Unfortunately, I have seen patients who have been immobilized for too long; this negatively impacts the patients’ rehabilitation and predisposes the patients to a multitude of other problems,” Dr. Billek-Sawhney reflected.

In addition to increasing the implementation of tertiary prevention strategies, such as performing mobility and strengthening exercises with mobility impaired older adult patients, Dr. Billek-Sawhney hopes to see an increase in the use of primary and secondary prevention strategies among physical therapists and other health care providers in resource-scarce countries.

“Prevention is a new concept, especially primary and secondary prevention in [low-resource countries]!”

Encouraging older adults to remain physically active and maintain a healthy weight will prevent loss of mobility and other problems of physical functioning from occurring with age. As a result, more individuals will enjoy good health and well-being in older adulthood, reducing the strain on local health systems. Dr. Billek-Sawhney and her fellow global health volunteers empower health workers in resource-scarce countries by

sharing their knowledge of primary, secondary, and tertiary prevention strategies. In turn, these health workers are able to apply their understanding of local cultural, social, and environmental factors to help patients implement these strategies in a way that is realistic and sustainable.

Dr. Billek-Sawhney encourages physical therapists interested in international volunteer work not to discount the value of their overseas colleagues' expertise.

"Be open. Listening, asking questions, and demonstrating interest is a great way to learn and gain insight into the views of people whether a patient, a colleague, a student," she advises. "Be willing to learn, talk, grow."

Lessons learned from international colleagues have the potential to improve

volunteers' effectiveness as educators while on assignment and to enhance their clinical practice with geriatric patients from other countries after they return home. The result is an improved capacity to care for older adults on a global scale. As Dr. Billek-Sawhney summarized, "Although, we go to volunteer and serve, we get so much more than we give!"

Do you want to join Dr. Billek-Sawhney and others in helping to improve global access to physical therapy? The HVO has short-term volunteer opportunities for physical therapists in Bhutan, India, Malawi, Rwanda, St. Lucia, and Vietnam. Assignments generally last 2 to 4 weeks and volunteers are placed throughout the year. For more information visit [www.hvousing.org](http://www.hvousing.org).

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Guest author, Nora Daly joined Health Volunteers Overseas in 2015. She is a dual degree master's candidate in public health and social work at Virginia Commonwealth University where she is also completing a certificate in nonprofit management. Prior to joining HVO, Nora worked for the PBS NewsHour.

# CALL FOR NOMINATIONS

## Academy of Geriatric Physical Therapy AWARDS 2019

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November 15, 2018 and all awards  
will be presented at the Academy  
Awards Ceremony at CSM in  
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For additional information on the criteria and selection process for academy awards, please visit the Academy of Geriatric Physical Therapy website at [www.geriaticspst.org](http://www.geriaticspst.org) or contact the office by email at [karen.curran@geriaticspst.org](mailto:karen.curran@geriaticspst.org) or by phone at 866/586-8247

# Development of an International Geriatric-focused Clinical Experience

Becca Reisch, PT, DPT, PhD; Talina Corvus, PT, DPT

## INTRODUCTION

Clinical education plays a vital role in the development of future clinicians, with physical therapy (PT) students spending, on average, 20% of their program time in clinical experiences.<sup>1</sup> To provide this resource, both classroom and clinical educators must balance ways to meet a diverse set of academic and student needs, including exposure to different patient populations, clinical settings, geographical regions, and innovative clinical teams. Additionally, PT students are increasingly seeking opportunities for international clinical experiences.<sup>2-4</sup> With a growing number of PT schools and students seeking to establish clinical relationships, there has been a paucity of sites to meet demand.<sup>5,6</sup>

International clinical experiences can have many benefits for students and educators. International study improves cultural sensitivity and has a positive impact on future career choices for students.<sup>7,8</sup> International study also allows educators to introduce concepts of interprofessional education (IPE) and global health in a practical manner. Interprofessional education is seen as a vital way to educate students about collaborative health care and improve health outcomes.<sup>9-11</sup> Adding a global scale approach to health care provision and outcomes, as both a concept and a practice, is becoming prominent among health care educators as they are increasingly aware of the importance of preparing new practitioners to be effective clinicians in an ever-intersecting world. A global health approach recognizes that there are health issues, determinants of health, and health solutions that cross borders, either directly or indirectly.<sup>12</sup> Physical therapists may look to address health with attention to global perspectives because they recognize that the profession has a role to play, not only in musculoskeletal disorders, but in physical and mental health over the life span and throughout the life course.<sup>13</sup>

Principle to this paper is the interest in aging from a global perspective and in a global society. With a global population of people over the age of 65 expected to reach 16% by 2050<sup>14</sup> the role of PT in addressing the health needs of older adults worldwide is growing. This paper briefly outlines the development of an international internship in a geriatric setting that strived to achieve the goals of integrating IPE and global health education while creating an innovative clinical experience to inspire a broader understanding of aging, health, and health care.

## PROGRAM DEVELOPMENT AND IMPLEMENTATION

Pacific University College of Health Professions (PU) (Hillsboro, OR) and the Jessie F. Richardson Foundation (JFRF) (Portland, OR) began collaboration on a pilot PT clinical experience in 2015. The original partnership between PU and JFRF began in 2007, when the organizations initiated a service learning partnership in Nicaragua wherein interdisciplinary teams of health profession students executed 10-day service learning trips to Nicaraguan *asilos para ancianos* (elder-care homes). The goals of this partnership was to provide practical interprofessional learning experiences, exposure to geriatric patient populations, and exposure to global concepts in health and aging while increasing the capacity of Nicaraguans to provide geriatric care. The same *asilos* were visited repeatedly over the years in order to demonstrate dedication and accountability and establish relationships upon which trust and productive communication could be developed. Overall the service learning program was viewed as successful in its ability to guide students toward greater interprofessional understanding and cooperation and increase student awareness of the multifarious nature of aging. Student professionals involved in this program included any combination

of individuals from the schools of audiology, dental hygiene, health administration, occupational therapy, pharmacy, physical therapy, physician assistant, and psychology, being placed in an environment where effective service provision relied on their developing strategies for navigation and communication around clinical problems. Team building under such circumstances was rapid and effective. Capacity building, by nature, however, does not happen rapidly. At the close of the service learning program the decision was made to trial a focus on longer clinical experiences to better serve the needs of the caregivers and residents of the *asilos*. A pilot PT clinical experience was planned for the summer of 2016 with the goals of (1) determining the viability and feasibility of a split domestic/international PT clinical experience; (2) making recommendations for future clinical experiences, if deemed viable and feasible; (3) providing PT services, with collaboration from *asilo* administrators to identify areas of priority; and (4) providing services in a way that would be easily transferable to a caregiver or local therapist upon the departure of the supervisor and student(s).

Two 2nd-year PT students from PU applied for and were chosen to participate in a 3-week clinical experience in Nicaragua. This was supervised by one US-trained and licensed PT who had previously traveled to Nicaragua 6 times for the above-mentioned service learning project. The 3-week experience was preceded by a 3-week internship in a US skilled nursing facility (SNF). Students were selected based on Spanish language proficiency, interest in international practice, interest in geriatric practice, and perceived ability to thrive in a foreign culture and health care system. One student dropped out prior to travel due to health concerns, leaving a 1 student:1 clinical instructor (CI) model.

Prior to the trip, the CI and student had several meetings to discuss

internship expectations, student goals, and cultural issues. The student and CI traveled separately to Nicaragua, with the student attending a 1-week language training program prior to the internship. The CI and student then met up two days prior to the internship to move into their homestays and participate in an orientation for the *asilo* and city. This was conducted by an in-country representative from JFRF.

The *asilo* in which the internship occurred was located in Jinotepe, Nicaragua, and housed 26 residents (mean age: 73 years). During the first week the CI:student team met with the administrators, who developed a list of residents they wanted the team to address, as well as with a local PT who proved weekly services in the *asilo*. The team visited with all residents to establish rapport, then performed 8 full examinations and 4 follow-up treatments, with the more challenging cases led by the CI and the more straight-forward cases led by the student. In the second week, the student began to set the day's schedule and lead all exams and treatments. The student also created and implemented several group activities (eg, group exercise class). The team also made multiple modifications to assistive devices (canes, walkers, wheelchairs) as requested by caregivers and residents. The second week resulted in 4 full examinations and 18 follow-up treatments. The focus of the third week was to create a large visual representation of the care recommendations, including listing each resident, their primary rehabilitation objectives, and instructions for several activities or exercises, including pictures. The team reviewed the document with the *asilo* administrator, head caregiver, and head nurse; the administrators then created a plan to schedule each resident for "therapy" with a caregiver 2 to 3 times per week, based on the recommendations. The CI and student met at the end of each day to review the day and make plans for the next day, as well as at the end of each week to prepare for the following week. All documentation was performed in Spanish directly into the residents' paper charts.

## OUTCOMES

The first goal of the pilot clinical experience was to determine viability and feasibility. Overall, the pilot was

successful, and the split domestic/international clinical experience model was deemed feasible and viable. The student had ample opportunity to practice examination skills, a variety of interventions, long-term treatment planning, and communication with administrators and caregivers, and *asilo* administrators' and caregivers' schedules were minimally impacted by the presence of the student and CI.

Goal 2 was to make recommendations for future clinical experiences. The experience was originally scheduled in a 2 students:1 CI model, with schedule overlap with occupational therapy (OT) students. Due to student attrition, there was no PT/OT overlap and the internship was done with a 1:1 model. This worked well for a pilot internship; however, this ratio is not financially sustainable. Two to 3 PT students could easily be accommodated in this setting, but there might be logistical challenges if multiple students from various programs are all in the *asilo* at the same time. Moderating the number of students present with the preference for interprofessional interaction will be an ongoing factor to consider and respond to as variables in the *asilos* and between schools and professions shift each year. Three weeks in one *asilo* was an ideal duration, allowing adequate time for orientation, examinations, follow-ups, training, and recommendations. A two-week format could be accommodated if the supervisor is already familiar with the *hogar* and the student(s) are advanced or fluent in Spanish. A longer format is also feasible, especially if student-supervisor teams travel to additional *asilos*.

Goals 3 and 4 were regarding service provision. The supervisor/student team was able to provide many direct services to residents, but perhaps more importantly, the team was able to collaborate with local PTs and *asilo* administrators and caregivers to create feasible and sustainable plans of care for most of the *asilo* residents. Moving to a clinical experience model from a service learning model was intended to better aid in building the capacity of these communities to make and sustain their own health care decisions for their own aging populations. This outcome was particularly welcomed.

Inherent in these goals was the consideration from the student perspec-

tive. It was important to examine how the student perceived her work, valued the site and the experience as it fit into the overall PT education, and engaged and challenged the understanding of aging and the PT role in working with older adults. Over the course of the service learning program, students from all involved professions expressed some degree of an expanding awareness of how culture and environment impact aging and expectations of aging. Often these findings were tied to the evaluative lenses these student professionals were cultivating. This made the interprofessional component so vital to creating opportunities for students to grow in recognizing global health issues, broadly, and in recognizing ways different professions can complement each other when meeting the unique and individual needs of older adults where they are. The student from this pilot reported similar reactions to the experience, stating that "completing a clinical internship in Nicaragua gave me a broader perspective of how health conditions are experienced by older adults in a different part of the world." And as this model allows for much more one-on-one time between students and residents of the *asilo*, relationship building, and personal sharing can occur in greater depth. This student also reported, "during my physical therapy sessions with the residents, I was struck by the realization that we all have much more in common than we have differences." Again, this was an observed outcome from the service learning model as well. Students finding enjoyment and value in the process is key to the long-term viability of an international geriatric clinical experience. The pilot program provided encouraging feedback towards the possible long-term benefits for students, educators, and clinical coordinators of this type of clinical education experience.

## CONCLUSION

The Nicaragua clinical experience pilot demonstrated that this model can contribute to the quality and value of geriatric clinical education at PU in a variety of ways. The viability of the internship allows for the opening of new, and more varied, avenues for clinical site development, diversifies clinical and cultural experiences with a global perspective on aging, and adds unique value to



student clinical education. International clinical sites reduce the strain to find a sufficient number of placements within the United States, where clinics are already in high demand, and have the potential to provide future practitioners with the tools and insights to become global thinkers and innovators in geriatric PT. Pacific University was fortunate when launching this pilot to have had 10 years of experience and program development already established to support such an endeavor. Challenges to making this program sustainable, such as knowledgeable and dedicated faculty and CI on campus and a willingness to travel in country, partnerships with local organizations, government, health officials, and individuals that can inform and guide the work as based on the needs and desires of those Nicaraguans involved, and foresight surrounding setting and meeting student expectations were more easily navigated during this trial. Addressing each one of these components is understood by this team to be vital to the long-term success of an international clinical relationship. Thus far, though, the outcomes seem worth the effort.

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Becca Reisch, PT, DPT, PhD, is Associate Professor of Physical Therapy at Pacific University. She is in her 12th year of participating in rehabilitation projects in Nicaragua. Her other interests include women's health physical therapy and evidence-based practice.



Talina Corvus, PT, DPT, GCS, CEEAA, LMT, is adjunct faculty to the School of Physical Therapy at Pacific University and a practicing PT in multiple geriatric settings. She spent 6 years working with the Nicaragua service learning program and is a member of the AGPT Global Health for Aging Adults SIG.

# Global Health for Aging Adults SIG Report

Lisa Dehner, PT, PhD

The new Global Health for Aging Adults (GHAA) SIG met at CSM this year to finalize our purpose and objectives and to start moving forward towards meeting them.

## PURPOSE

To bring together physical therapists from across the world to share ideas and collaborate to improve the health and participation of aging adults.

## OBJECTIVES

1. To support the goals of the International Association of Physical Therapists Working with Older People (IPTOP).
2. To support the goals of the WHO Rehab 2030 Initiative.
3. To facilitate networking and collaboration between geriatric Physical Therapists of various countries.
4. To encourage awareness of the education and practice of geriatric physical therapy in other countries.
5. To develop and implement projects to enhance the global health and well-being of older adults everywhere.
6. Facilitate collaborations among clinicians and researchers to address current significant health care issues from a scientific perspective in the United States and abroad.

7. Provide global rehabilitation opportunities for clinicians in the United States and abroad to eliminate disparity of health care and social condition in elderly people in developing countries.

The GHAA SIG is an independent group within the AGPT but also maintains a link with our partner group, the International association of Physical Therapists working with Older People (IPTOP), a subgroup of the World Confederation for Physical Therapy (WCPT). By having the Chair of GHAA be the AGPT liaison to IPTOP allows seamless communication regarding the practice of geriatric physical therapy internationally. However, both groups are independent of each other, and AGPT members are welcome and encouraged to participate in either group (or both!). The AGPT pays dues to IPTOP so that all members can benefit from the work of IPTOP.

### **The other GHAA SIG officers are:**

#### Vice Chair:

Rick Black, PT, DPT, MS

#### Secretary:

Manjula Ramachandran, PT, MSPT

#### Nominating Committee:

Soshi Samejima, DPT, MS

Ka-Chun (Joseph) Siu, PhD

Any AGPT member with interest in our GHAA SIG, please visit the AGPT website at <https://geriatricspt.org/special-interest-groups/> to join us.

Anyone with interest in IPTOP can contact me at [lisa.dehner@msj.edu](mailto:lisa.dehner@msj.edu).

In addition to working toward our objectives, the GHAA is also looking for anyone with interest in writing about their international/global health experiences for *GeriNotes* as well as members who are interested in helping to facilitate a GHAA journal club.



Lisa R. Dehner, PT, PhD, CEEAA, is the Chair of the GHAA SIG and the AGPT liaison to IPTOP. Her “day job” is Professor of Physical

Therapy at Mount St. Joseph University in Cincinnati, Ohio. She teaches Neuroscience, Pathology and Pharmacology, and Geriatric Evaluation and Treatment. She practices clinically in long-term care. She can be reached at [lisa.dehner@msj.edu](mailto:lisa.dehner@msj.edu).

**Do YOU have 10-15 minutes a month to share with the AGPT membership committee?**

*Looking for members to fill 3 different jobs:*

New member welcome (emails)

Coordinator (match volunteers to short and long term needs)

Video (2-3 people to assist in creating a video highlighting AGPT for new members)

**Contact Rania Karim: [karim@marshall.edu](mailto:karim@marshall.edu)**

# Ignite Your Culture of Wellness: International Council on Active Aging Annual Conference

*Lori A. Schrodtt, PT, MS, PhD*

The International Council on Active Aging (ICAA) Annual Conference in October of each year continues to be an interactive opportunity to network and learn more about active aging and wellness. This year's conference will be held October 18-20, 2018, at the Hyatt Regency Long Beach and Long Beach Convention & Entertainment Center in Long Beach, California. You can find out more at: <http://icaa.cc>.

Historically, the ICAA Annual Conference promises to promote forward-thinking concepts and discussion. The most recent conference keynote addresses provided by Dr. Andrew Weil (founder and director, University of Arizona Center for Integrative Medicine, Clinical Professor of Medicine and Professor of Public Health, Lovell-Jones Professor of Integrative Rheumatology) and Dr. Richard Carmona (Chief of Health Innovations of the Canyon Ranch Institute, Distinguished Professor, Zuckerman College of Public Health, University of Arizona, and the 17th Surgeon General of the United States) certainly lived up to this precedent. Dr. Weil's address focused on an integrative approach to embrace healthy aging and wellness, and most notably, his thoughts on trying to shift the US health care system from a disease-management system to one that better promotes and supports healthy lifestyles and wellness. His focus on holistic, lifestyle medicine includes examples and research supporting compression of morbidity through diet (largely plant-based and anti-inflammatory), daily activity and exercise, social and intergenerational activities, and intellectual engagement. He also touched on the potential of lifestyle to influence genes, in particular nutrigenomics, as having an emerging role in healthy aging. Dr. Carmona's address traveled in time to the year 2035, posing what an older adult in the future

might look like. He introduced where we are with our knowledge of genomics and the possible, more specific roles of pharmacogenomics, nutrigenomics, and psychogenomics. He posed that the future older adult would have the advantage of knowing how to individually tailor their lifestyle and health care based on this knowledge. Dr. Carmona also posed a future health care system where epigenetic factors are embedded in health records to optimize health and care. Like Dr. Weil, he provided research and illustrations of the benefits of various lifestyle and behavioral strategies for enhancing health. In particular, he noted the benefits of mindfulness and meditation for decreasing narcotic medication use. The older adult Dr. Carmona pictures in 2035, will realize that all life factors are inter-connected; that physical, cognitive, and social aspects of life are not separate. The future older adult will also realize the power of physical activity and view food as "high octane fuel." Older adults in 2035 will be working longer, but also leverage technology to remain in their homes and be active longer. In summary, Dr. Carmona posed that the older adult of the future will not just be adding years to their life, but life to their years.

In addition to the keynote addresses, the 2017 conference also offered over two days of programming aimed at energizing implementation. There were interactive panel sessions on the physical therapy/wellness connection, as well as sessions on fall prevention, retaining dignity through technology, cognitive health, marketing, and innovative trends in technology and wellness. There was also a special opportunity for attendees to engage with product and service developers through an interactive design forum and lab.

The 2018 conference promises to continue engaging professionals from

across disciplines and sectors in interactive discussions and problem solving. Preconference programs on exercises for fall-risk reduction and water-based exercises for medically challenged individuals are offered for those who want a more in-depth learning experience. General conference sessions across several tracks (including cognitive & emotional health, physical activity, research, trends & innovations, and wellness for health) offer a breadth of content. As usual, a variety of sessions focused on exercise will be available, some of which include interactive opportunities. Two keynote addresses by Dr. Ken Dychtwald, CEO of Age Wave, and Dr. Joseph F. Coughlin, founder and director of the Massachusetts Institute of Technology's AgeLab promise to be informative and thought-provoking.

Consider joining the other dedicated and enthusiastic participants this year. Programming and conference details can be found at: <http://www.icaa.cc/conferenceandevents/overview.htm>.



Lori Schrodtt, PT, MS, PhD, currently serves as Chair of the Health Promotion and Wellness SIG and as the AGPT Liaison to the International Council on Active Aging. She specializes in community-based healthy aging and fall prevention programs. She is a professor in the Department of Physical Therapy at Western Carolina University where she teaches geriatric and neuromuscular rehabilitation courses and treats clients in a balance and fall prevention specialty clinic. She can be contacted at [lschrodtt@email.wcu.edu](mailto:lschrodtt@email.wcu.edu).

# GET LITerature

## The Latest Examinations and Interventions for the Older Adult Examination for Parkinson's Disease: Do We Have it Backwards?

Carole Lewis, PT, DPT; Valerie Carter, PT, DPT

Today begins a new column with new ideas that I hope will inspire you. My deepest thanks go to the Board of the AGPT for asking me to do this. Early on in my career, I was challenged and questioned by my mentor Dr. Rene Calliet to find the latest and best evidence for intervening to assist my patients in their recovery process. That challenge has turned into a passion. I love getting up at 4:00 or 5:00 o'clock in the morning and gathering articles from all over the world on geriatric rehabilitation. I find it irresistible to read, ponder, digest, and then synthesize the research that our talented peers conduct. My favorite part is to condense the results in a practical format that I can use with my patients. I also enjoy sharing this information with my fellow physical therapists as I do when I teach across the country. Now, in addition, I get to do this quarterly with you.

The first two articles in the GET LIT series will be co-authored with Dr. Valerie Carter, who I believe is the most experienced and talented clinician in the area of Parkinson's disease (PD). She is the real deal. She owns her own clinic, specializes in PD, and she teaches and conducts research. I am honored to be writing with her on examination for this article and intervention in the next article.

We hope you enjoy our column and we welcome your comments and questions. Again, thank you AGPT.

Examination for Parkinson's Disease: Do We Have it Backwards?

One of the greatest concerns for older adults, particularly for those with PD, is falling. In 2018, Parashos et al published a study in *Neurology Clinical*

*Practice* entitled "What predicts falls in Parkinson Disease?"<sup>1</sup> They reviewed data from the National Parkinson Foundation of 3,798 participants and found that 86% reported no or rare falls. Twelve percent reported at least monthly falls. The predictors of these falls include:

1. Less than 90% diagnostic certainty
2. Female gender
3. Motor fluctuations
4. Levodopa treatments
5. Anti-depressant treatments
6. Prior deep brain stimulations
7. Worse quality of life
8. Hoehn & Yahr stage 2 or 3
9. Worse semantic fluency
10. Addition of amantadine
11. Referral to OT and social services
12. New diagnosis of cancer or osteoarthritis
13. Increased emergency visits

This is quite a list but it gives us areas to look for as we work with our patients.

What is new for predicting falls in our patients with PD? In 2018, Dr. Valerie Carter published an article in the *Journal of Geriatric Physical Therapy* entitled "The 3-m Backwards Walk (3MBW) and Retrospective Falls: Diagnostic Accuracy of a Novel Clinical Measure."<sup>2</sup> The study consisted of 59 older adults whose average age was 71 years. The sample did not have neurological deficits, so norms for community dwelling older adults could be set. This was a retrospective study that looked at demographics, medical history, falls in the past year as well as several balance tests: Timed Up and Go, five times sit to stand,

fours square step test, and the 3MBW. The researchers found that the 3MBW tool had better diagnostic accuracy than these commonly used measures and that people walking backward faster than 3 seconds on the 3MBW were unlikely to report falling whereas those who completed the test at a speed slower than 4.5 seconds were likely to report falls.

The 3MBW is simple and easy to do and takes seconds of our time. To conduct the test, you must have an area at least 3 meters in length that is wood or tile flooring. The 3-meter area should be marked off with black/contrasting tape. To begin the test, participants place their heels on the tape. They are then instructed to walk backwards as quickly and safely as possible on the signal "go." They are then instructed to stop once they have gone 3 meters. Participants may look behind but are not allowed to run. The examiner walks along with the person but does not touch him or her. The test should be done 3 times and an average of the 3 tests is recorded.

Dr. Carter is currently collecting data on patients with PD to see if the norms are different for fallers, but until then, we can use the 3MBW as an evidence-based, predictive functional assessment tool for our PD patients who are community dwellers.

There are many choices we can use in examining our older patients with PD and other patients who may be at risk of falls. It is critical to perform test and measures that will accurately assess the full picture of fall risk among our elderly patients, as well as those patients who are neurologically impaired. The 3MBW test is one you may want to include. Not only does it provide good information on falls risk, it provides the beginning of an intervention strategy. We will



look at backward walking as well as many other treatment ideas in our next GET LITerature article on interventions for PD.

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# A New Role in Physical Therapy, Serving as Community Health Providers in a Super-Aged Society

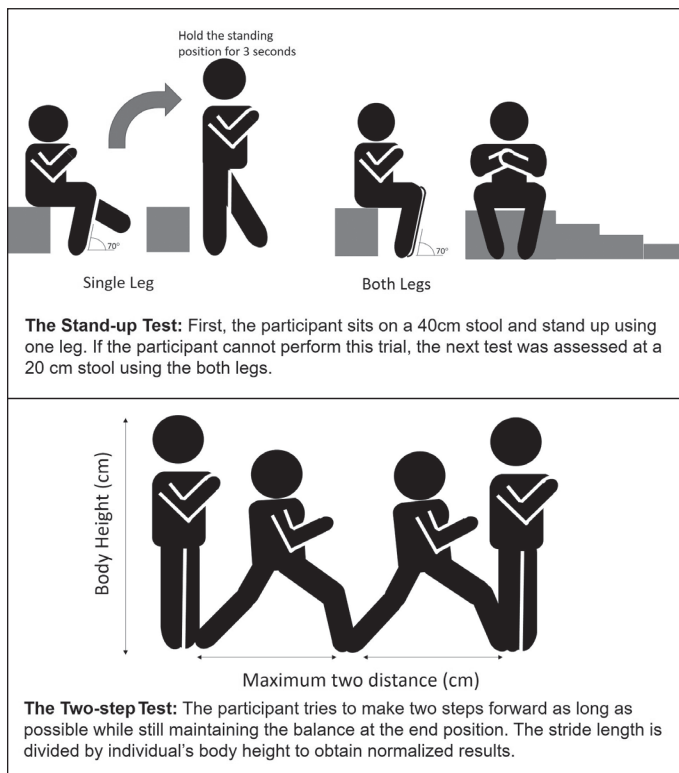
Yuri Yoshida, PT, PhD; Motohiro Matsukawa, PT;  
Yahiko Takeuchi, PT, PhD; Kaiwi Chung-Hoon, PT, PhD

A rapidly aging society is a global health issue. An estimated increase in the numbers of older adults create what is referred to as 'super-aged societies,' defined as populations whose demographics of adults over the age of 65 exceeds 20% of the total population.<sup>1</sup> One of the leading countries for this trend is Japan, reported population of 127 million (2015) includes 26.7% considered to be super-aged; this is estimated to exceed 33% by 2036.<sup>2</sup> This is also occurring in the United States where the number of adults 65 years of age and older currently exceeds 35 million and is anticipated to increase two-fold by 2030, and projected to reach 89 million by 2050.<sup>3</sup> The steadily increasing numbers of super-aged citizens has caused government agencies to develop programs to accommodate the higher medical and assistive care demands of this aging population.<sup>4</sup> One option explored in Japan has been the collaboration of physical therapist (PT) and other health care professionals with national and local government agencies to provide health services for the super-aged. This report will intro-

duce the unique role of PTs collaborating with national and local government agencies in Japan.

A community-based Integrated Care System and 'Healthy Japan 21' were introduced in 2012.<sup>5</sup> The community-based Integrated Care System encourages local government entities and health care professionals to use an interdisciplinary approach when providing medical, assistive, and welfare care to reduce costs while sustaining the ability of older adults to live within their respective homes. Healthy Japan 21<sup>5</sup> is a preventative program designed to promote overall health and well-being within the country. Collectively, these programs were implemented by local governments who employ health care professionals such as medical doctors (MD), nurses, social workers, PTs, and occupational therapists (OTs) to address the medical, welfare, and assistive care needs of disabled and older adults via community center and health care institutions. This comprehensive health care approach aims to reduce 63.8 trillion yen (\$57.5 billion U.S.) for health care and assistive

costs of the elderly population within 16 years.<sup>6</sup> Additionally, these health care workers have been instrumental in assisting local governments develop databases to monitor changes in population demographics, socio-economic needs, birth rates, general health status, and culture influences of caring for the disabled and elderly. The databases are then used to develop and establish networks between government-funded hospitals, schools, community centers, assistive living facilities, and other community care centers. Subsequently, this collaborative health care approach has been effective not only in reducing health care costs but improving the quality of care provided to super-aged societies.<sup>4,6</sup> This program has been expanded to include other medical screenings including body mass index, metabolic syndrome, cancer, osteoporosis, and EKG testing. Standardized mobility screenings are used to identify those who may benefit from preventative physical therapy or other services. For example, older adults who performed well on mobility screening tests (Figure 1) were identified as indi-



**Figure 1.** Mobility screening tests.



**Figure 2.** Silver rehabilitation exercise program.

viduals who may benefit from preventative interventions such as nutrition education and community-based exercises.<sup>4</sup> Collaborative efforts between the government, PTs, and other health care professionals have established a role in using clinicians to minimize health care costs and to develop normative data bases of mobility levels. This information may be used to facilitate standardized care protocols with normative levels of mobility for older adults established to facilitate standardize health care regimes at a community-based level.

An added feature contained within these programs includes health care professionals recruiting, enlisting, and training community volunteers to assist with providing community-based

activities to care for the needs of older adults within their respective communities. Volunteers receive instruction from health care providers over a 6-day period in basic anatomy, physiology, exercise physiology, kinesiology, and gerontology. They are then mentored by PTs and OTs to learn mobility skills with consideration given to the volunteer's current mobility levels. Once trained,

these volunteers lead and instruct community-based exercise classes; these are sometimes called 'Silver Rehabilitation Exercise Programs.'<sup>7</sup> Reported benefits of this program include improved volunteer quality of life, as well as improvement in participant overall health (Figure 2).

Similar programs such as Senior Corps in the United States have been implemented to train older adults to assist in serving in various capacities within their respective local community. Some of the reported benefits of these US programs include improved quality of life for individuals within local communities by providing evidence-based exercise routines that reduce mobility declines in both the volunteer instructors and the exercise-participants. Though these types of programs are beneficial, they are often under-represented within the United States. The experience of lowered health care costs from Japanese innovations may provide unique opportunities for American physical therapists to develop collaborative community-based health care programs for disabled and older adults.<sup>7</sup> Strategies to reduce costs, such as those used in Japan, may prove beneficial within the United State. For example; "Stepping On," an evidence-based falls prevention program

has been challenged to find clinicians to assist and lead this program because of high clinic demand and productivity standards placed on physical therapists. Physical therapy students and faculty may be a viable option in meeting the needs of community-based programs.<sup>8-10</sup> The challenge remains regarding how to best implement and support community-based programs within the United States.

Some of the benefits that Japan has experienced with government initiated community-based health care programs include (1) the collection of nationwide normative values for general health conditions, (2) robust collaboration between local health and medical care systems to support older adults, and (3) opportunities for implementing evidence-based exercise programs. Similar strategies may be a viable option in the United States to maximize resources and reduce health care costs of older adults.

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## Press Release

# The Academy of Geriatric Physical Therapy Endorses “Global Call to Action on Fragility Fractures”

A Global Call to Action (CtA) on Fragility Fractures, an initiative led by the Fragility Fracture Network (FFN) of the Bone and Joint Decade, has been published in *Injury*, the International Journal of the Care of the Injured. The Academy of Geriatric Physical Therapy is proud to be among the 80+ international organizations endorsing the CtA. The full text of this publication is available here: [https://www.injuryjournal.com/article/S0020-1383\(18\)30325-5/fulltext](https://www.injuryjournal.com/article/S0020-1383(18)30325-5/fulltext).

The global population is currently undergoing the greatest demographic shift in the history of humankind. A direct consequence of this “longevity miracle” – if left unchecked – will be an explosion in the incidence of chronic diseases afflicting older people. In the absence of systematic and system-wide interventions, this tsunami of need is poised to engulf health and social care systems throughout the world. Osteoporosis, falls and the fragility fractures that follow will be at the vanguard of this battle which is set to rage between quantity and quality of life.

By 2010, the global incidence of one of the most common and debilitating fragility fractures, hip fracture, was estimated to be 2.7 million cases per year. Conservative projections suggest that this will increase to 4.5 million cases per year by 2050. While all countries will be impacted, in absolute terms, Asia will bear the brunt of this growing burden of disease, with around half of hip fractures occurring in this region by the middle of the century. And the associated costs are staggering: in Europe in 2010, osteoporosis cost Euro 37 billion, while in the United States estimates for fracture costs for 2020 are US \$22 billion.

If our health and social care systems are to withstand this assault, a robust strategy must be devised, and an army of health professionals amassed to deliver it. This strategy must transform how we currently treat and rehabilitate people who have sustained fragility fractures, in combination with preventing as many fractures from occurring as possible. The latter can be achieved in part by ensuring that health systems always respond to

the first fracture to prevent second and subsequent fractures. In short, let the first fracture be the last.

A major step toward making this aspiration a reality has occurred today with publication of a Global CtA to improve the care of people with fragility fractures. Endorsed by 81 leading organizations from around the world, covering the fields of medicine and nursing for older people, orthopaedic surgery, osteoporosis and metabolic bone disease, physiotherapy, rehabilitation medicine, and rheumatology, the case for transformation of the following aspects of care has been made:

- The surgical and medical care provided to a person hospitalized with a hip fracture, a painful fracture of the spine and other major fragility fractures.
- Prevention of second and subsequent fractures for people who have sustained their first fragility fracture.
- Rehabilitation of people whose ability to function is impaired by hip fractures and other major fragility fractures, to restore their mobility and independence.

The CtA was conceived at an annual congress of the FFN, when 6 leading organizations came together to determine how they could most effectively collaborate to improve fracture care globally. Lead author of the publication, Professor Karsten E. Dreinhöfer said “Fragility fractures can devastate the quality of life of people who suffer them and are pushing our already overstretched health systems to breaking point.” Dreinhöfer added, “As the first of the baby boomers are now into their seventies, we must take control of this problem immediately before it is too late.”

The Global CtA illustrates that for the first time, all the leading organizations in the world have recognized the need for collaboration on an entirely new scale. “The Academy of Geriatric Physical Therapy has a long history of promoting bone health to improve population health and we are proud to be among the charter group of global endorsers. The publication of this CtA along with the

unprecedented level of consensus shared by societies across the world provides an opportunity to drive widespread implementation of best practice in the United States and globally,” Dr. Greg Hartley, President of the Academy of Geriatric Physical Therapy.

The Global CtA proposes specific priorities for people with fragility fractures and their advocacy organizations, individual health workers, health care professional organizations, governmental organizations and nations as such, insurers, health systems and health care practices, and the life sciences industry. The World Health Organisation (WHO) has declared the years 2020-2030 to be the “Decade of Healthy Aging” and later this year the United Nations (UN) will hold its Third High-level Meeting on Non-communicable Diseases. The authors highlight the opportunity for WHO and UN to consider the recommendations made in the Global Call to Action as an enabler for their global initiatives.

### Read more at:

<http://fragilityfracturenetwork.org/cta/>  
Fragility Fracture Network  
Central Office  
c/o MCI Schweiz AG  
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# Drink Water: Prevent Falls

Lise McCarthy, PT, DPT

It is summer in California as I write this article for the fall issue of *GeriNotes*. I am focused now on gardening while trying to conserve water – a daily thought because I live in a parched state where large areas are being consumed by wild fires. My concepts of watering the yard or washing anything have had to drastically change over the past several years. By the time you read this, it is likely that fires will have further ravaged my state and we will be in high water conservation mode. Health care literacy discussions about water regulation and falls occur daily in my geriatric house calls practice for other reasons: “You should drink more water because your blood pressure (BP) is too low. Low BP can affect your brain and increase your risk of falling. I can’t start you on your Otago exercise program to reduce your fall risk until your BP is higher and in safe ranges for you to exercise while standing.”

I work in San Francisco, surrounded by 5 hospitals. I treat a lot of retired physicians and nurses. I am surprised: 18 years of clinical practice leads to observations that most of my patients and/or their caregivers do not properly take or interpret BP readings. Is this a skill? Yes, but it is one that I think we should be teaching clients. Poor arm positioning is the most common error that I find.

I recently experienced this in the emergency room with one of my parents. I watched as the medical team demonstrated that they were relying on seated and standing BP measures taken with the arm hanging down at the side. It was awkward, but necessary, to assert my physical therapy knowledge in such a personal situation and to educate in variances of BP with arm positioning. The need for doing this is an example that our health care system is beyond overwhelmed. Our profession can be instrumental in effecting positive change by educating our patients about the impact that inadequate water intake has on BP and fall risk.

Clients and caregivers may have limited understanding of BP measure-

ments; this can promote fear, anxiety, and poor compliance with medication and diet. I have learned by participating in Medicare’s PQRS program and preparing for the MACRA and MIPS programs, that I can significantly reduce costs to Medicare by helping my patients develop their self-care skills (eg, accurately measure their BP, drink adequate amounts of water, and do their Otago exercises). ProPublica reports my average number of services and average Medicare payment per patient as around 50% lower than my peers. If you are interested, you can type in your name and state to see how your treatment stats compare with your peers by going here: <https://projects.propublica.org/treatment/doctors>.

Understanding the dynamics of BP is a part of the essential competencies of our profession.<sup>1</sup> So, every one of my patients (and/or their family/caregivers when indicated) receives some level of health literacy training (CPT billing code 97535) from me about BP, especially in the first few visits as we get to know each other. I help them formulate basic BP self-care questions, and then I help them understand the answers. By building their BP health literacy and skills, we develop trust in each other and have confidence the information we share is reliable.

- What do the first and second BP numbers mean?
- What are healthy BP ranges for my patients?
- When should they measure their own BP?
- Why does BP change with position and activity?
- What medications are they taking that impact their BP?
- Are they taking their BP medications as prescribed?
- How much water are they drinking every day?

I also have them practice with me how to properly take their BP. I compare their digital readings with my manual readings to make sure their technique

is correct, their cuff is the correct size, and their machine is properly working. Nearly without exception, my patients and/or their caregivers think they are taking their BP correctly, often they are not. Commonly, they sit and show me they take their BP with their arm supported but somewhat dependent, or alternatively actively held up horizontally in the air.

If, when lying, sitting or standing, my patients have a systolic BP that is abnormally low, we have a conversation about what may be going on and how they can correct it. When a patient has a low BP at rest that is not due to medication, I highly suspect this “wilted-flower” phenomenon may be due to inadequate hydration. To rule this hypothesis in or out, I engage my patients or their caregivers in a BP/water drinking test demonstration, when appropriate. If I am right and they are not drinking adequate amounts of water, then – just like a wilted flower will rise and become straighter when given water – their second systolic BP measure will be comparatively higher, often rising close to 10 mmHg.

The protocol that I use for those people who have a low seated resting BP and do not have fluid intake or swallowing restrictions:

- Step 1: Patient/caregiver correctly measures seated resting BP.
- Step 2: Patient drinks 1 to 2, 8-ounce glasses of water in 5-10 minutes.
- Step 3: Patient/caregiver correctly re-measures seated resting BP.
- Step 4: Compare the 2 BP measures. [NOTE: If the 2nd systolic measure is higher, then this patient may be a candidate for a hydration program.]

You would think getting people to drink water is a simple task. It isn’t! It’s been over 20 years since the medical community started a campaign to increase awareness of dehydration in older adults.<sup>2</sup> Yet in 2018, I still actually show many of my patients what a standard 8 oz glass of water looks like and teach

those who are interested to re-learn how and why to drink water. Some patients are in the habit of sipping their preferred coffee, soda, or alcohol. Some have a hard time with the “taste” of water. This may explain why the physical aspects of drinking water quickly and in larger amounts seems so difficult for so many clients even though they do not have significant oral sensorimotor deficits or dysphagia. I have found many people seem to have an impaired ability to move a larger bolus of water through their mouth mainly through lack of practice.

Patients living with amnesic or non-amnesic cognitive impairment or dementia require strength-based communication approaches to help them engage in clinically important interventions, such as consistently drinking enough water every day to reduce their risk of dehydration, delirium, and falling. Research supports the selective use of reality orientation,<sup>3</sup> spatial orientation cues,<sup>4</sup> and validation techniques<sup>5</sup> to reduce confusion and modify behavior in people living with cognitive deficits on the dementia spectrum.

I use a 4-step communication technique that combines clinically directed orientation cues and validation techniques with much-needed patience and non-verbal language. This type of complex cuing technique is particularly effective when the patient's emotional state, level of awareness, and degree of disorientation are considered along with their increased processing time and need for environments that are minimally distracting. I coined this style of communication as “OREO” cuing because:

- OREO is an acronym for Orient, Reorient, Encourage, and Observe; and
- OREO cues can be effective communication “cookies” that are structured to help people living with mild cognitive impairment (MCI)/dementia digest and respond to verbal requests (eg, drink water, stand up, perform an exercise).

Using orientation cues, providing validation/positive feedback especially during task initiation, demonstrating body language and facial expressions that convey a sense of attentiveness in completing the task, and ensuring sufficient processing time in a quiet environment collectively represent an effective method for enhancing task engagement in a confused person. An example of how an OREO cue can be used to help people living with MCI/dementia drink more water is found in Table 1.

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## Delirium Poster:

If you are planning a health literacy campaign about falls this year, please consider including information about water intake, BP, and fall risk. To help you lead this campaign in your community, the Cognitive and Mental Health SIG has created a 2-page poster about delirium, included on page 31 of this issue, that is designed to share with colleagues and patients.

**Acknowledgements:** Contributors of ideas, edits, and support for the development of this handout on delirium: **Barbara Billek-Swabney, Cindi Cathey, Michelle Criss, Greg Hartley, Jill Heitzman, Jennifer Howanitz, Grace Knott, Lise McCarthy, Jean Miles, Christine Ross, Michele Stanley, and Sue Wenker.**

**Table 1.**

OREO cues for drinking water		Rationale
O = Orient	Example: Laura, please drink this water because your blood pressure is too low.	People living with MCI/dementia are adults. Almost all people respond to good manners and respectful requests. Almost all people tend to comply with requests when given a rationale that they can understand.
R = Reorient	Example: Laura, your blood pressure is too low, so please drink this water.	People living with MCI/dementia may have significant disorientation and sensory processing deficits. Reorientation via repeating a request and associated rationale is important for improving everyone's comprehension and compliance.
E = Encourage (positively)	Example: “That’s right. Laura. Drink some more water, please. It’s good for you.”	People living with MCI/dementia often get side-tracked in a multi-sequence task. Telling people they are doing something right promotes confidence and encourages them to continue doing it.
O = Observe (attentively and expectantly in silence)	Demonstrate via body language and facial expressions that you are focused on her completing this important task of drinking water.	People living with MCI/dementia can become easily distracted. If you look away, the person may look at what you are looking at and become distracted from engaging in and completing the task at hand. Quiet time helps people focus and remain on task.

# Increase Awareness of Delirium-Induced Fall Risk Across All Settings

## DID YOU KNOW?

- Delirium is a multifactorial syndrome that causes acute changes in mental status, with effects lasting weeks to months, and resulting in short-term and long-term negative outcomes.<sup>1</sup>
- Negative outcomes from delirium include: falling, declines in function and cognition, longer hospital stays, and institutionalization.<sup>2</sup>
- Delirium is prevalent across all settings ranging from 13-89%, and yet prevention programs are still not being consistently implemented in all settings.<sup>2</sup>

## WHAT CAN YOU START TO DO RIGHT NOW?

- Any physical therapist, physical therapist assistant, and student can help lead the way to reduce falls related to delirium by educating themselves on this topic.<sup>1,3</sup>
- Identify people with risk factors for delirium: ask about their history for recent hospitalizations, review their medications, and use tests and measures to help you link potential signs and symptoms to evidence-based interventions.<sup>1</sup>
- Incorporate evidence-based nonpharmacological interventions for delirium that address and include, but are not limited to: cognition or orientation, early mobility, hearing, sleep-wake cycle preservation, vision, and hydration.<sup>2</sup>
- Provide patients and their care partners with information on delirium and dehydration prevention, such as the handouts referenced below.

### COMMON DELIRIUM RISK FACTORS<sup>1</sup>

Immobility, serious illness (eg, infection, metabolic disturbance, hip fracture and cardiac surgery, depression), vision and/or hearing impairment, sleep-wake cycle disturbance, certain drugs (eg, narcotics, opioids, and benzodiazepines), alcohol misuse, old age, and MCI/dementia.

**CASE STUDY:** Levi is a 65-year-old retired carpenter. He is starting outpatient physical therapy today because he feels unsteady when walking. Knowing that Levi was in the hospital for hip fracture surgery 2 months ago and experienced delirium, his physical therapist screens him for delirium risk factors as part of her fall risk assessment. She asks him questions about his daily hydration regimen, reviews his medications with him, and performs a targeted hypotension screen that includes measuring and comparing his blood pressure (BP) response to different positions before and after he drinks some water.

Orthostatic/Hydration Test	Supine	Immediate Standing	3 mins Standing
Baseline	108/60	88/56	100/50
After Levi drinks 16 oz. water	112/60	98/56	Not tested

She finds his systolic BP response to position changes is abnormally low and slow, but improves after a hydration intervention. Levi's clinical presentation suggests he is inadequately hydrated and has increased risks for delirium and falling. In addition to teaching Levi exercises to help him fully recover his strength and balance after his recent surgery, she provides him with health literacy handouts not just about falls but also about hydration and delirium. She reviews the literature with him to answer his questions and to help him establish a self-care home hydration program. She makes plans to recheck his blood pressure responses during his next visit as a means to give him feedback about his hydration home program and risks for delirium and falling.

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## HANDOUTS

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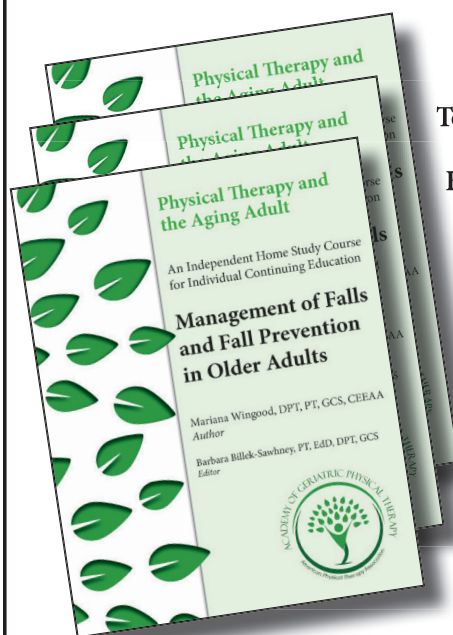


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