

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



Partnerships and collaboration. These two words come up a lot in our strategic plan. I am happy to say that our members have gone above and beyond in

helping to forge two important partnerships in recent months, and as a result, we are truly living our vision.

First, our partnership with the National Senior Games Association (NSGA) resulted in a hugely successful collaborative event at the National Senior Games in Albuquerque, NM in June. The AGPT/NSGA Partnership Task Force, led by Task Force Chair, Dr. Becca Jordre PT, DPT, Board Certified Geriatric Clinical Specialist and Certified Exercise Expert for Aging Adults, began their work in January 2019 shortly after CSM in Washington, DC. Objectives of this Task Force included creating co-branded educational materials for older adult athletes and the surrounding community of physical therapists who work with these athletes. The Games took place June 14-25, 2019, and many PTs, PTAs, and PT/PTA students from the NM Chapter and other parts of the country volunteered by administering the Senior Athlete Fitness Exam (SAFE) screening and providing athlete education. The handouts and educational materials developed by the Task Force are available for download on the AGPT website (<http://geriatricspt.org/?ms1ze1>). The collaboration was a big success and we are already planning for the next National Senior Games in 2021 in South Florida. Visit NSGA's website for local, regional, and state games that occur year-round (<https://nsga.com/>).

Second, our partnership with the National Council on Aging (NCOA) has been very busy as well. A Task Force, led by Dr. Tiffany Shubert, PT, PhD, has worked diligently to develop a variety of co-branded resources for members and the public. [EDITOR'S

NOTE: Read CHAMPS article in the July GeriNotes; Part 2 of their series in this issue.] Some of these resources are still in development and will be available soon. Watch for educational materials targeting PT/PTAs in outpatient and home health settings on (1) the benefits of community evidence-based programs/aging service organizations and physical therapist partnerships; (2) how to create effective partnerships; and (3) the business case for these partnerships by December 2019. Since NCOA is the sponsor of the National Falls Prevention Awareness Day (September 23, 2019), not surprisingly, we are gearing up for a busy month in September. In addition to Task Force resources, our Balance and Falls SIG, chaired by Dr. Jennifer Vincenzo, PT, MPH, PhD, has developed a National Falls Prevention Toolkit that includes multiple resources, including PowerPoint presentations, patient education materials, screening tools, and more. These resources are available on the AGPT website for download.

Thanks to diligent work by our SIGs, the AGPT has been able to collaborate with the Centers for Disease Control (CDC) on several fall prevention initiatives. We hosted a webinar presented by the CDC on the STEADI Toolkit (<https://www.cdc.gov/steady/index.html>) and a future webinar, hosted by AGPT and presented by the CDC, on the CDC's "My Mobility Plan," targeting motor vehicular safety in aging adults (https://www.cdc.gov/motorvehiclesafety/older_adult_drivers/mymobility/index.html), is planned. Also, watch for programming at CSM 2020 that will include speakers from the AGPT and the CDC on health promotion, population health, safety, and injury prevention in aging adults. This session is sure to be very popular.

These partnerships are a visible way AGPT is making a societal impact. Even so, a study published in June in the medical journal, *JAMA* found that for people over 75, the rate of mortality from falls more than doubled from 2000 to 2016 (*JAMA*. 2019;321(21):2131-2133). This disturbing fact has gotten

the attention of the United States Senate Special Committee on Aging. The Special Committee on Aging, works to examine issues that are particularly relevant to the needs of older Americans. One outcome of these examinations is an annual report that informs policymaking in Congress. This year, the Committee's report will focus on the prevention and management of falls and fall-related injuries. The Academy, with input from members of the AGPT's Evidence-Based Documents (EBD) Committee and the EBD Editorial Board, the Balance and Falls Special Interest Group, the AGPT/NCOA Partnership Task Force, and the Payment and Legislative Committee, put forth a detailed response that includes specific recommendations that would expand access to physical therapist services among older Americans. The response is posted in its entirety on AGPT's website (<http://geriatricspt.org/?sxpq3h>). I hope that you will take the time to read it. I believe it is perhaps one of the more significant advocacy efforts we have put forth in the past couple of years. With the US Senate paying close attention to falls and fall prevention, the likelihood of policy change in the future is increased. The Academy will keep a watchful eye on their actions and plans to be present for any Congressional hearings.

I hope that all members will take advantage of the tremendous resources our partnership task forces and SIGs have developed. And I hope that you have planned to participate in the National Falls Prevention Awareness Day on or around September 23, 2019 (the first day of Fall). More info about that can be found here: <https://www.ncoa.org/healthy-aging/falls-prevention/falls-prevention-awareness-day/>.

Our friends at the NSGA, the NCOA, and the CDC have been wonderful partners. The fruits of these collaborative efforts are just beginning to be realized. I am looking forward to even more ways our amazing organization can collaborate to live our vision: "Embracing aging and empowering adults to move, engage, and live well."

Editor's Note

Michele Stanley, PT, DPT



Fall! Changes everywhere that you look. The next issue of *GeriNotes* is our Focus issue: filled with themed “read for 4 CEU credits” content.

This year’s issue theme is “After the Fall” and looks at some of the consequences that *befall* (pun points for me!) people as they age. The reason for this teaser is that, in honor and celebration of PTAs in their anniversary year, every PTA that is now a member OR joins the Academy of Geriatrics before the end of October will be able to “take” 3 of these CEU courses from prior years that are still accessible on the web **FREE**. And, if they are ambitious, they will be able to avail themselves of the 2019 November issue **FREE** also – potential to get 16 credits as well as all the other goodies that come with APTA Geriatrics membership. So, tell all of your friends and colleagues – no better time as we transition of payor systems to also offer additional supports to our PTA work partners.

I am plenty excited about *this issue* of *GeriNotes* as well! Part 2 of the collaborative work of the Academy of Geriatrics with the National Council of Aging is unrolled; it is long but worth the read. Educate yourself on all the free or low-cost resources to offer your clients as they transition off of caseload. This is also published on our website for easy reference. *Journal of Geriatric Physical Therapy* Editor, Leslie Allison, and *GeriNotes* continue to collaborate on the best way to translate research knowledge into clinical relevance. The dream of these two editors is to establish a direct and easily digestible link from research to “news you can use” in the clinic.

Several more colleagues share with us in this issue how they have added dimension to their physical therapy careers (developing software, starting a private practice, finding a niche in the ICU, remembering the value of empathy).

Finding your....bliss? OK, so maybe that 1:1 time with my treadmill or walking poles and the dusty road are not... blissful. But they are very helpful at keeping all my moving parts, moving. I model practice of that which I preach whenever I can but this is not necessarily exciting and, since I moved recently, I have not done a good job of balancing work vs travel vs obligations to end up in more rigorous classes or to learn Tai Chi (a bucket list thing). I have never been a fan of watching a screen while on the treadmill and, in fact, I am not a regular TV watcher with the exception of the occasional binge watch of *Grace and Frankie* or *Downton Abbey* or... *Grey's Anatomy*. Recently I have discovered podcasts to make the walk go faster though: The APTA website features a number of free podcasts of interest to geriatric physical therapists: (also available on iTunes, Spotify, or Google Play). Visit <http://www.apta.org/Podcasts/> for many options; these are among my recent favorites:

Studies indicate that muscle power correlates, to a high degree, with functional status-maybe even more so than the correlation of muscle strength or muscle mass to functional status. In other words, in the aging process, muscle power declines earlier and faster than does muscle strength. High velocity training (HVT) or power walking is safe and effective. <https://www.moveforwardpt.com/Radio/Detail/older-adults-benefits-of-high-velocity-training>

The physical effects of Alzheimer's disease can be addressed-with major positive impacts on the quality of life of people who have the disease and their caregivers. Plus, research shows that regular exercise actually can improve memory in people with Alzheimer's, and that it can delay symptoms in those who have the disease but have not yet shown signs of it. <https://www.moveforwardpt.com/Radio/Detail/benefits-of-physical-therapy-people-with-alzheimer>

Who doesn't have an older patient with complaints about their feet? Chris Neville, PT, PhD, discusses what the latest science reveals about the state of

foot and ankle health, the importance of choosing proper footwear, and what you can be doing right now to ensure your feet and ankles are strong, healthy, and equipped to continue moving you through life. <https://www.moveforwardpt.com/Radio/Detail/foot-health-avoiding-pain-injury>

The Joys of Gardening and Eldercare by Cheryl Till, PT https://www.blubrry.com/apta_podcasts/44322639/achieving-peak-bloom-defining-moment/

WHAT IS A LISTSERV?

A listserv is a wonderful communication tool that offers its members the opportunity to post suggestions or questions to a large number of people at the same time. When you submit a question or something that you want to share to the listserv, your submission is distributed to all of the other people on that list.

Why should I join the AGPT listserv?

Our listserv was created to provide rapid communication with and among the membership. Here staff and leadership can post “hot topics” that members need to stay up-to-date, and members can ask other members questions related to geriatric physical therapy. Members have even sought out clinical specialists for family members and friends who live in other areas of the country.

How do I join the listserv?

There are several ways to subscribe to the listserv:

1. Send an e-mail to geriatricspt-subscribe@yahoogroups.com
2. Visit the AGPT (www.geriatricspt.org) website and use the link to the yahoo groups website
3. Visit the yahoo groups website (<http://groups.yahoo.com/group/geriatricspt/>) directly and click “join this group”

So join the Academy of Geriatric Physical Therapy listserv today!

PART 2

Evidence-based Programs and Your Practice

A Foundation for Value-Based Care

The AGPT-NCOA Task Force

Lori Schrodt, PT, PhD; Tiffany E. Shubert, PT, PhD; Jennifer C. Sidelinker, PT, DPT;
Colleen Hergott, PT, MEd, DPT; Kathy Shirley, PT, DPT; Beth Rohrer, PT, DPT; Jennifer Tripken, EdD, CHES;
Jennifer Vincenzo, PT, MPH, PhD; Jennifer Brach, PhD, PT; Patrice Hazan, PT, DPT, MA

Article 1 of this series: “What are evidence-based programs (EBPs) and why should I care?” highlighted the CHAMP innovative academic-community partnership.^{1,2} In this article, we continue our conversation. Our goal is to provide physical therapy professionals practical guidance to answer the question: “How do I find and refer patients to appropriate EBPs?” We highlight how a clinician can use clinical-community partnerships to build an effective continuum of care to achieve sustainable patient outcomes.

EVIDENCE-BASED PROGRAMS

The National Council on Aging (NCOA) is often our best source for learning more about evidence-based programs (EBPs). Numerous EBPs are approved and included in the NCOA list. For the purposes of this article, we will focus on the most commonly available EBPs for chronic disease self-management, physical activity, and falls prevention. Brief explanations of the purpose of these programs is below or access a more detailed table format of descriptions, appropriate participants, and potential offering locations for common EBPs [here](#).



Chronic Disease Self-Management Education (CDSME): This suite of programs, developed from

the original Chronic Disease Self-Management Program, focuses on self-management education for anyone with a chronic condition, of any age. Spanish programs and programs designed for specific conditions (eg, arthritis, diabetes) are also available, as are programs for caregivers. Many states that offer the CDSME programs have re-named them to focus on healthier living rather than chronic disease (eg, Living Healthy, Live Well, etc). The NCOA summary of CDSME programs can be found here (<https://www.ncoa.org/healthy-aging/chronic-disease/>)

Enhance[®]Fitness and approved tai chi programs: Several physical activity group EBPs are available for general strengthening and balance, arthritis management, and fall prevention. Enhance[®]Fitness is a group-based exercise program for individuals with a wide range of functional abilities (exercises can be done sitting and/or standing). Several evidence-based tai chi programs are also approved for fall prevention (Tai Chi for Arthritis, Tai Ji Quan: Moving for Better Balance, and YMCA Moving for Better Balance).

Falls Prevention Programs such as A Matter of Balance and Stepping On are two programs specific to fall prevention education, fall risk management, and behavior change. A Matter of Balance is designed to specifically reduce fear of falling, whereas Stepping On includes a focus on risk factor management and maintenance of an active lifestyle. Both programs are provided in a group-based, participatory format.

Otago Exercise Program (OEP): The OEP is a progressive strengthening, balance, and walking program to improve mobility and reduce fall risk. The OEP is most often delivered by, or under the direction of, a physical therapist. Training information and a therapist locator can be found: (<https://www.med.unc.edu/aging/cgec/exercise-program/>).

Other approved programs available for fall prevention, disease management, depression management, and social isolation can be found at the evidence-based fall prevention program page on the NCOA website <https://www.ncoa.org/healthy-aging/falls-prevention/falls-prevention-programs-for-older-adults-2/>.

This table provides a series of case studies that illustrate how to integrate these types of programs into your practice for patients with a variety of diagnoses.

HOW TO FIND EBPS IN YOUR COMMUNITY

Community-based organizations (CBOs), such as Area Agencies on Aging, senior centers, YMCAs, and faith-based organizations have assumed key roles in promoting wellness and prevention through offering EBPs in local communities.

Area Agencies on Aging (AAAs, <https://www.n4a.org/>) were established under the Older Americans Act (OAA) to address the local needs of older adults. The AAAs provide a variety of services, with evidence-based health and wellness being part of their mission. In fact, 93% of AAAs offer some type of EBP.³ Each AAA web-

Table 1. Case Studies Demonstrating Examples of Integration of EBPS into a Plan of Care

Scenario	Challenge	Recommended EBP	Progression	Outcome
65-year-old female with rotator cuff injury and significant knee and shoulder DJD. The injury was due to a fall but the referral is for shoulder pain. Healing slowed by poor control of diabetes. She wants to do a better job managing her diabetes but does not really know where to start.	To meet her goals and sustain her progress after discharge, the patient would benefit from increased self-efficacy in managing her diabetes.	Diabetes Self-Management Program (DSMP) Program is offered face-to-face monthly at the local senior center.	Starts DSMP during PT episode of care with increased adherence and compliance with HEP after 2 sessions; more confident and engaged in PT sessions. Discharged from PT before she finishes DSMP.	Patient recommended to start EnhanceFitness upon finishing DSMP. Discussed this option with both the patient and the lay leader of the DSMP program. -Patient enrolls in EnhanceFitness program. -6 months later: blood sugars so well controlled she no longer takes Metformin. -Patient walking 3 miles a day and now attending a Zumba class at the senior center.
83-year-old deconditioned female discharged from hospital due to pneumonia. She was advised she was at high fall-risk due to significant balance and strength impairments and fear of falling. Patient does not drive, but is not considered homebound. Her spouse drives and is an enthusiastic caregiver. Receiving PT in the home under Medicare Part B.	Patient has significant fear of falling. Is willing to do HEP with her spouse but experiences anxiety that she might fall while exercising.	Initiate and progress Otago Exercise Program (OEP) as part of physical therapy program in the home -A Matter of Balance at local Parks and Recreation Department. Recommend patient take MOB concurrent with therapy. Husband will accompany patient to the class to reinforce patient comfort and confidence.	Patient completes 8-week MOB program. She is also doing the OEP as her home exercise program. -Therapist keeps patient on Med B caseload for 12 weeks, with gradual decrease in frequency of visits over time. -Patient told to continue with OEP progression and check in with therapist at 6 months.	Patient understands value of exercises after MOB class. Completes her OEP exercises 3 times a week and is now walking 45 minutes 3 times a week. At a 6-month follow-up phone call, therapist recommends patient to go to tai chi class offered at local YMCA. Patient agrees.
73-year-old male who slipped and fell on ice in February fracturing scaphoid. Limited activity after fall. STEADI falls screen: <ul style="list-style-type: none"> • TUG = 12.2 seconds • Chair stands = unable to do 1 • Single leg stance = 4 seconds • Believes that increased risk of falls is a normal part of aging 	Patient loss of strength, conditioning will continue unless he understands he can manage his fall risk. He requires significant behavior change. He loves to learn and is feeling some social isolation.	Stepping On - offered through the AAA. You recommend to put therapy on hold until he completes Stepping On, and he should contact you if interested in continuing after program completion.	After completing Stepping On, patient is ready for greater balance challenges. Works with physical therapy for 6 sessions over 2 months while using Medicare Advantage benefit to attend EnhanceFitness class at his local YMCA.	Patient understands he can manage his fall risk through regular balance and strength exercise, monitoring his medications, and also safely navigating challenging environments such as ice and snow. -He goes to the gym 3-5 times a week for his exercise class and is excited to continue his progression. He just learned about another program at the YMCA: Tai Chi: Moving for Better Balance. His new buddy from EnhanceFitness told him about that, and he feels ready to sign up when it is next offered.

Abbreviations: DJD, degenerative joint disease; DSMP, Diabetes Self-Management Program; HEP, home exercise program; PT, physical therapy; OEP, Otago Exercise Program; MOB, Matter of Balance; STEADI, Stopping Elderly Accidents, Deaths, and Injuries; TUG, Timed Up and Go

site is constructed differently; AAAs are often housed within councils of government and can be searched within the appropriate government council. Many AAAs describe programs offered under health promotion and disease prevention, healthy living, and/or fall prevention. A detailed schedule of times and offering locations may not be included on the website and may require you to call your local AAA for more information.

The Evidence-Based Leadership Council (<http://www.eblcprograms.org/>) offers information about specific EBPs (chronic disease and medication management, physical activity, falls management, and depression) and the opportunity to search for local EBP licensed organizations. From their home page, you can use the drop down to learn more about specific programs and also click on “Map of Licensed Organizations” for a local search. Search results provide a list of organizations and the specific programs they provide, as well as a website link and contact information.

Many YMCA branches also offer EBPs (most commonly: *YMCA Moving for Better Balance*, *Enhance®Fitness*, and *A Matter of Balance*) in addition to their other active adult programming. The EBPs at the YMCA are often available to non-members with a reduced fee and program scholarships may be available. Contact your local YMCA for more information. The YMCA also partners with many health insurance plans (eg, *Silver Sneakers*, *Silver & Fit*, AARP Medicare Supplement Program, and more) to provide low or no cost access to specific programs. If you need to locate YMCA branches nearest your patient, enter the location zip code at <http://www.ymca.net/>. Once at the local branch site, search for active and/or older adult programs and contact the local branch for more information.

You may find some duplication in the above search strategies, but using various approaches may also uncover different CBOs offering

EBPs. For instance, independent CBOs, such as faith-based organizations or some fitness or recreational centers, may appear in the searches through the Evidence-Based Leadership Council website, but not through the AAAs or YMCA. Also, directly contacting each CBO can reveal helpful information about their EBP offerings, as some CBOs may not post regular schedules to their website.

Bridging Across the Continuum - Best Practice Strategies

Now that you know which programs are most appropriate and available in your community, how can you help ensure that your patient engages in the recommended program? There are a variety of things that the physical therapy provider can do to facilitate patient success in transitioning to and benefiting from the recommended EBP. Consider how you might evolve your practice to incorporate some of the following best practice strategies:

- Set the expectation with patients early on; partnering to execute a plan for sustained activity after physical therapy is key to successful outcomes.
- Start the conversation about participation in EBP as early as possible, during the active physical therapy course of care.
- Encourage patients to help identify feasible options in the community (history of participation by self or loved one?, etc).
- Attend one or more EBP sessions with patients as part of the skilled PT treatment program. Medicare Part B will allow patients to be treated outside of a brick and mortar clinic. However, you should check with your Part B provider and insurance company to insure your liability insurance covers off-site treatments.
 - Ensure patient ability to tolerate full participation, and prescribe adapted strategies for certain components as needed.
 - Increase patient confidence in

the ability to be successful, especially if they have not participated in such a program, format, or venue in the past.

- Increase patient confidence in EBP instructor, illustrating the close communication and partnership between the PT provider and EBP provider.
- Increase mutual respect and understanding of scope and role of PT and EBP provider, which helps facilitate appropriate referrals in both directions.
- Facilitate connections with a peer champion.
 - Previous patients who have attended, or are currently attending, the program you are recommending for the patient.
 - Connect with previous or current participants who are identified by the EBP instructor.
- When a program is not available or appropriate until after completion of the active course of physical therapy, support successful transition by:
 - signing the patient up for the program prior to transition from active physical therapy course of care,
 - contacting EBP provider to determine if patient can be contacted directly when the next program is offered and provide additional details about the program as needed, and/or
 - providing a courtesy support “check-in” call to patient after the completion of the active physical therapy treatment program, to encourage EBP participation and address any gaps to successful participation.

WHAT’S NEXT

“What happens if I can’t find these programs near me?” The next article in this series (available in January 2020 issue) will address this question in detail, provide decision-making guidance to choose the best

currently available option, and offer strategies to support development and advocate for additional options in the future. We will discuss partnering with community organizations as well as offering both wellness and evidence-based programs in house.

However, if you are eager to get started and you treat a population that is more frail, you can immediately implement the Otago Exercise Program into your practice by following these steps:

1. Go to <https://www.med.unc.edu/aging/cgec/exercise-program/> and complete the online training, "The Otago Exercise Program: Fall Prevention Training" (\$35).

2. Purchase a few sets of adjustable ankle weights (ideally up to 10#).

3. Print out the exercises or download the exercise instruction videos from <https://www.med.unc.edu/aging/cgec/exercise-program/> to distribute to your patients.

4. Prescribe the appropriate exercises from the OEP as a HEP specifically to improve lower extremity strength and balance for appropriate patients.

5. If appropriate, see patients at the recommended OEP frequency prior to discharge to insure adherence and compliance.

6. Set an appropriate progression goal for the patient to keep working toward after discharge and have fun!

Article 4 in this series will focus on the return on investment for your practice when you integrate EBPs into your offering. We will illustrate the business case for an effective continuum of care, demonstrating 2 successful models: building a continuum of care within your own practice, and leveraging clinical-community partnerships for practice success.

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Lori Schrodt, PT, PhD, is a Professor the Department of Physical Therapy at Western Carolina University (WCU; Cullowhee, NC) and is the lead physical therapist of the WCU Balance and Fall Prevention Clinic. Dr. Schrodt also participates in research and other initiatives to strengthen clinical-community partnerships for healthy aging and fall prevention. She has presented numerous educational, platform, and poster sessions at CSM and other professional conferences.

Tiffany E. Shubert, PT, PhD, is Founder & Clinical Architect at Shubert Consulting in Chapel Hill, NC. Dr. Shubert has provided over 10 presentations at CSM since 2012. She has also presented platform, poster, and teaching sessions at several national and international conferences.

Jennifer C. Sidelinker PT, DPT, GCS, is Vice President of Clinical Services and Director of Physical Therapy - Genesis Rehab Services in Kennett Square, PA; experience includes several national speaking engagements, including APTA CSM, Aging in America, ACRM, and ICAA.

Colleen Hergott PT, MEd, DPT, is an Assistant Professor in the Department of Physical Therapy at Augusta University. She is a Geriatric Clinical Specialist, CEEAA, and NDT certified, as well as an ACSM Certified Clinical Exercise Physiologist. She currently practices in skilled nursing.

Kathleen D. Shirley PT, DPT, GCS, is a clinical Physical Therapist and former Clinical Assistant Professor at Texas Woman's University in Dallas. She specializes in Geriatric Physical Therapy and Vestibular Rehabilitation. She is a coach for the A Matter of Balance, evidenced-based program and certified in Tai Chi for Rehabilitation. She has presented nationally and internationally including APTA CSM.

Beth Rohrer, PT, DPT, is a Senior Medical Director – PT/OT Services at Tivity Health. She is a board-certified Orthopaedic Clinical Specialist (OCS) and a Certified Exercise Expert for the Aging Adult (CEEAA). She has a Master of Science - Physical Therapy degree and a Doctor of Physical Therapy degree from Duke University. Her experience includes over 20 years in various leadership positions in the health care industry.

Jennifer Tripken, EdD, CHES, is the Associate Director of the Center for Healthy Aging at the National Council on Aging. Dr. Tripken has been involved in the provision of evidence-based services for older adults for over 8 years and has presented at various national and international conferences. Dr. Tripken also has over 7 publications in peer-reviewed journals in the field of public health.

Jennifer Vincenzo, PT, MPH, PhD, is an Assistant Professor with the Department of Physical Therapy at the University of Arkansas for Medical Sciences. She is a board-certified geriatric clinical specialist in physical therapy with over 20 years of clinical experience treating older adults. Dr. Vincenzo also has her Masters in Public Health and is a Certified Health Education Specialist. She has presented 4 platform presentations and 1 symposium at the Combined Sections Meeting, and chaired a symposium at the Gerontological Society of America yearly meeting. She has also presented numerous posters and educational sessions at other state, regional, and national conferences.

Jennifer Brach, PhD, PT, is a Professor in the Department of Physical Therapy at the University of Pittsburgh, Pittsburgh, PA. Dr. Brach has over 20 years of research experience in the areas of aging, mobility, and exercise and has presented at various local, national, and international conferences.

Patrice Hazan, PT, DPT, MA, is founder and CEO of GroupHab,*

an innovative PT clinic pioneering an alternative model of PT care including PT designed and supervised group exercise classes, an alternative model of PT care with long-term solutions to keep patients well. She has a Doctorate in Physical Therapy from Des Moines University and a Master's degree in Gerontology from Roosevelt University. In addition, she is a GCS, a member of the Academy of Geriatrics, a member of

PPS, and a member of ACSM. She has presented this model at CSM, SCAPTA, and PPS annual conventions. Patrice has been published in numerous publications, including the American Physical Therapy Association's *PT in Motion* for her ground-breaking work.

How I Built A Geriatric Physical Therapy and Wellness Center: The HouseFit Story

Beth Templin, PT, DPT

I was never, I mean **never ever** going to start my own practice. I had no dreams of being a business owner. In fact, I felt the exact opposite. I loved the idea of working for a large company with great benefits and lots of job security. I thought people in my graduating class who were excited about the possibility of owning their own clinic were a little crazy. I had no interest in it whatsoever.

What I did know was I wanted to work with older adults. I was part of that small percent of physical therapy students that knew they wanted to work in geriatrics. After graduation, I spent the first two years of my career in the hospital setting before transitioning to home health. Being able to treat older adults in the comfort and convenience of their own home was my dream job. It was the perfect combination of being both a challenging and rewarding environment. I loved it so much, I worked for the same company for 11+ years.

The longer I stayed in the home health setting, the more I began to notice that there was a gap. I was discharging patients who no longer qualified for home health because they were not homebound. They were not always transitioning successfully to outpatient therapy even though I knew they would benefit from additional services. They

would go for a few visits and then stop. I found there were several reasons for this, ranging from poor motivation and unreliable transportation to not liking the typical outpatient clinic experience. I began to wonder if there was a way to fill that gap: a way to catch those that were falling through the cracks; a way to help keep these people from having a decline after they were discharged from home health services only to end up right back on service a few months later? Was this even a thing? Could I continue to see patients at home under Medicare Part B?

That is when I started looking into building a mobile physical therapy practice. I thought it would be the perfect way to keep seeing the geriatric population that I loved to treat, but not be tied down by homebound status. Plus, I really believe that the home is one of the best places to treat our geriatric patients. After months of planning and preparation, I opened a mobile practice in April 2017. I focused on my strengths, working with older adults and people with Parkinson's disease, focusing on independence, balance training and fall prevention. I loved it!!

An amazing benefit of starting my own practice was it allowed me the time to get out and become more involved in the community. I became a certified Rock Steady Boxing Coach and I also

started teaching group exercise classes for the local American Parkinson Disease Association. At first, I was nervous about teaching group classes; it is not something I thought of as a traditional PT role. I found that not only did I love the challenge of teaching group classes, I did it well. I received such positive feedback about my classes; they grew quickly. People kept asking if I had DVDs or a YouTube Channel so they could exercise with me more often.

What I found out was that clients really loved that I was driving intensity, that they actually felt like they got a work out, that they were sweating, that they were short of breath. They told me their balance was getting better, they had more energy. I realized there was a need for more aggressive and intense group exercise classes. I was beginning to see the role of a physical therapist for health and wellness. I started thinking about getting my own gym space. It could be a dedicated place for older adults to exercise with other people that look and move just like them, that have stiff joints, that were worried about losing their balance, that had blood pressure issues, that got short of breath easily.

The New York Times published an article in January 2018 about a really unique fall program developed in the Netherlands.¹ Several people sent

it to me saying “you need space so you can do this.” When I read the article, I got really excited about the prospect of recreating a similar program. I searched to see if there was anything like it in the United States; I could not find anything. That was my personal call-to-action. I knew that there was a huge need to bring programming like this to my area. I felt I had the skills needed to build a comprehensive, therapy-driven, and evidence-based fall prevention program that stepped outside the standard therapy mindset. I had already considered getting a physical location to hold more classes. I wanted space to be able to offer advanced balance training and fall prevention programming. I had a mission.

I kept researching other models to see what was already out there and found articles about the ActiveStep Treadmill². This piece of equipment allows for perturbation training at high intensity in a safe and controlled environment. Participants are secured in a harness over a treadmill. The treadmill belt reproduces “slips” and “trips” by quickly changing directions. I decided that this equipment was the final piece I needed to be 100% committed to move forward with securing a space.

I knew I could do so much to help serve my community by not offering just physical therapy, but by creating high quality group exercise classes geared specifically toward seniors and also being able to provide falling boot-camps, educational workshops, and advanced perturbation training. In my mind, my future practice was taking shape. I looked at several different spaces throughout the Saint Louis area over a period of several months before making my decision. I chose a 5000 square foot location in a strip mall very close to my home. I knew from coaching at Rock Steady Boxing that I wanted more than 3000 square feet so that I could conduct both therapy sessions and group exercise classes simultaneously. The location also had to have several other “must haves” on my list including handicapped accessible bathrooms, abundant and flat parking, and easy access for anyone with a wheelchair or a walker. Even though this space was originally a little larger than I had planned for, it had everything I wanted. Plus, the floorplan was wide open, which meant I would have very few modifications or buildout. It was perfect!

The next steps to move forward included creating a business plan, securing a bank loan, finalizing the lease, working with a contractor on the buildout, hiring and training staff, and developing a marketing plan. It was a busy and hectic few months. We maintained the mobile practice and successfully opened the gym space for business on October 1st. Since opening, we have been able to refine our marketing message. We are primarily focusing on education-based marketing. This means we are speaking directly to our patients and educating them on how physical therapy may be the solution to their problem. We do this through regular articles in the local newspaper, a monthly newsletter, offering free workshops at our location, and through our presence on FaceBook. Once they express interest, we move forward with obtaining physician orders to begin treatment.

This whole process has been a huge learning curve for me. I have made some mistakes along the way, but I have done more right than wrong. I have been able to build my dream practice and build an amazing team to help me serve the aging community in a new and exciting way. The response from the community has been amazing. Everybody loves our space. They like exercising next to people dealing with similar issues. We play music from the 60s the majority of the day and our clients sing and dance along during their therapy sessions. It is a very happy place, which makes for a better overall experience for our clients.

There are so many benefits and rewards to being a business owner. There are also many challenges, especially when you are new and trying to grow. Once I knew I was going to expand my practice from a one-person mobile practice to having a physical location with staff, one of the best things I did was commit to joining a coaching group. They give me an immense amount of support and guidance.

By the time we have become a licensed therapist, many of us have 7 years of school or more under our belts just to become an entry-level therapist. Then all of the additional years of practice and education we go through to really master our practice. Unless you were a business major or minor for your undergraduate degree, there is so much to learn about running a business. You need to invest time and energy to learn how to become

a good business owner to be successful.

As our population continues to age, there are not enough physical therapists available to continue treating our geriatric patients one-on-one. We need to think of better ways to serve aging adults. One way of accomplishing this is to offer group classes specifically designed to meet their needs. The benefits of the group setting go way beyond the physical for these individuals. The social, emotional, and mental well-being of older adults also improves with this kind of model. Another important shift we need to make as professionals is to emphasize wellness and prevention. Consider offering an annual check-up or other type of screening for those of Medicare age so you can identify small issues before they become a big problem. Educate seniors to be proactive about managing their physical health and fitness by providing educational workshops. Keep them on the “exercise wagon” after they discharge from rehabilitation physical therapy services by offering group classes to prevent decline that sends them back on your caseload a few months later.

I think this is an exciting time to be working with our older adults. The potential to make a big and lasting impact is huge. That is what motivates me. I cannot wait to see how my practice continues to grow and serve my aging community. I invite your questions. Please send correspondence to beth@housefitstl.com

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Beth Templin, PT, DPT, GCS, is the Owner of HouseFit, a Geriatric Physical Therapy & Wellness Clinic in Saint Louis, MO.

Policy Talk: PDPM Resources

Ellen R. Strunk, PT, MS

By the time you are reading this issue of *GeriNotes*, we will be less than 30 days away from the implementation of the Patient Driven Payment Model (PDPM) for the Skilled Nursing Facility

Part A benefit. This represents the biggest change to the SNF setting in 20 years. If you are a regular reader of *GeriNotes*, you may be tired of hearing about it for so long and just want it to begin.

This page is intended to be a quick guide to resources as you implement PDPM in your world.

Table 1. Academy of Geriatric Physical Therapy Resources. They can be found at: <https://geriatricspt.org/practice/payment-policy-and-advocacy.cfm?>

Title	Media Type	Brief Description
Busting the Myths Associated with PDPM and PDGM	Webinar recorded 11/15/18; On Demand Replay	FREE resource busting common myths associated with PDPM implementation.
Post-Acute Care Update	Webinar recorded 2/20/19; You Tube	FREE resource discussing the overall goals for post-acute care reform.
Functional Outcome Measures	Webinar recorded 4/24/18	FREE to members; The CMS Functional Outcome Measures using Section GG are described.
The Patient Driven Payment Model	Recorded Webinar with 2 recorded live Q&A sessions on 3/12/19 and 3/14/19	FREE resource describing the PDPM Model and answering questions posed from members ranging from operational to clinical.
SNF PDPM FAQs	Downloadable Document	FREE providing answers to frequently asked questions in 9 areas.
Therapist Readiness Tool	Downloadable Document	FREE self-assessment competency tool developed by PTs for PTs/PTAs.
Group Therapy Resources and Tools	Downloadable Documents	FREE resources to help you get started developing clinically appropriate Group Therapy treatments.
Managing Change While Succeeding	Webinar recorded 8/1/2019	FREE resource for managers and clinicians working in SNF.
Medicare Payment and Policies for Skilled Nursing Facilities	Webpage: http://www.apta.org/Payment/Medicare/CodingBilling/SNF/	Information and resources on payment and policy; check back for updates.
What You Need to Know About the New SNF Payment Model	Webpage: http://www.apta.org/Payment/Medicare/NewPaymentModels/	

Table 2. Centers for Medicare and Medicaid Services PDPM Resources. All the resources are free, and can be found at: <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFFPS/PDPM.html>

Title and Brief Description	Media Type
Fact Sheets on: Concurrent and Group Therapy, Functional and Cognitive Scoring, Interrupted Stay Policy, PDPM Patient Classification, Variable Per Diem Adjustment.	Downloadable Documents
PDPM Frequently Asked Questions: CMS answers a range of questions posted by SNF providers.	Downloadable Documents
PDPM Training Presentation: A slide deck used by CMS in one of its educational webinars; providers can use it for reference and/or to train their own staff.	Downloadable Documents
PDPM ICD-10 Mappings: An Excel workbook containing 3 important worksheets: (1) A crosswalk showing the clinical categories each ICD-10 code is mapped to; (2) A list of ICD-10 codes qualifying as SLP co-morbidities; (3) A list of ICD-10 codes qualifying as Non-Therapy Ancillaries	Downloadable Zip File which contains the Excel Workbook

The Art of Empathy: A Physical Therapist's Voice

Annei Rose Banzon, PT, DPT

Patients come to us so they can walk again and return to their prior level of function. Most of them get better and return home in hopes of spending time with their loved ones, enjoy their hobbies, have the ability to play with their grandchildren, to travel again, etc. Physical therapists are motivators, cheerleaders in their own right, and a shoulder to cry on when the going gets tough. When we provide therapy, do we explore the idea that we are more than just physical therapists? Is it inherent in us to care for our patients beyond the exercises?

According to the World Health Organization,¹ satisfied patients are more likely to complete treatment regimens and tend to be compliant and cooperative. Are we in tune to our patient experience? In school, our professors taught us to be empathic; parents try to teach this trait as well. Some people appear to be born with it; some may have learned it through clinical experience. Empathy means our capacity to understand other people's feelings and be able to share those feelings with them. It is a way of placing your feet in their shoes or just imagining yourself in their situation.

Does a good patient experience equate to effective patient-centered care? The Department of Health and Human Services² defines quantifying patient experience as the ability of the health care provider to give to the patients what is expected from them, ie, as clear communication. Studies have shown that a good patient experience brings positive results: patients are more likely to follow medical advice, show improved clinical outcomes, decrease usage of unnecessary health care, and results in effective and safe patient practice.

I am a foreign graduate from the Philippines (circa 2001) who came to New York in 2005 in hope of fulfilling my dreams. I started in outpatient physical therapy, moved to home care, and am

currently working in a hospital setting. I have seen everything from the terminally ill and comatose to people more agile than I am. What is common to all of my experiences is the way that patients light up when I am genuinely interested with their lives (hobbies, pets, mundane thoughts, their witty remarks, love lives, or a loved one lost). Non-verbal gestures provide comfort as well. A gentle touch to painful areas, holding their hands while resting, or sometimes while they are struggling with their exercise have improved patient-therapist relationships. I see the patient's high motivation and receive frequent phone calls from family members (in Homecare) asking me to come back. Families offer to adopt me or say, "Annei, I would like to clone you." Of course, I politely decline both adoption and cloning. However, I call most of them back just to check their health status and continuing progress. I still keep in touch with patient Y, who migrated to another state, from time to time. I feel wistful knowing I had to let her spread her wings and enjoy her own life. It is hard when I know that a patient has expired. Ending each patient session with this question, "Is there anything else I can do for you today?" goes a long way personally and therapeutically. Do not get me wrong, I am no saint and I am still learning our craft. I firmly believe a dash of tender loving care and good rapport are major keys to successful patient functional outcomes.

The choice of our words, our facial expression, our pause and silence in between questions, and our tone and demeanor can also have an effect on the relationship with patients beginning at day one.³ Patients somehow learn how to gauge if they can trust you to treat their body part from a mere wrinkle on your forehead or based upon a deep gratifying smile plastered on your face. Do you portray yourself as a cold, robotic, humorless, impatient physical therapist? Picture this classic scenario: you may

walk in your patient's room with a million thoughts racing in your head. You may be thinking about your caseload, your appointments, your errands or chores, and the list goes on. This may manifest as either you are absent-minded or simply rash. So, before you perform your initial evaluation, shake all those thoughts away, take a deep breath, and smile. Your relaxing and comforting smile will be a welcome presence to your ailing patients.

There are also other factors to consider that affects motivation in attending therapy. Financial burden, lack of family support, unsafe living situations, depression, anxiety, cognitive impairment, language barrier, side effects of polypharmacy,⁴ socioeconomic status, and self-reported health status⁵ are among these factors. A meta-analysis conducted by Hughes et al stated that patient adherence to exercise can be greatly influenced, although there is no single conclusive factor influencing the whole.⁶ Do you adjust your treatment regimen just to accommodate these factors?

Throughout my practice, I have also noticed how physical therapists provide patient care and if I may, I would like to categorize them based on the 4 Personality Types⁷:

(1) Sanguine/The Overachiever PT:

This type of physical therapist is on top of their schedule, reports back to the manager, advocates for their patients, is critical about their treatment in hopes to achieve a better outcome, still thinks of their patients once they are at home, and replays the scenes of the day. They could be overpowering in their patients' and co-workers' eyes.

(2) Phlegmatic/The Skilled PT:

This type of physical therapist is manually gifted, and makes sure documentations are of good quality. They have good communication skills with their patients and encourage them a lot when things

get rough, very jovial and good-natured. Does not make a fuss nor complain about their caseload. Good mentor to fellow therapists and to students. The best role model for everyone.

(3) Choleric/Ruminating PT:

This type of physical therapist goes by the saying “still water runs deep.” They dislike small talk and may appear cold and aloof. They like brutal honesty and tough love. They will treat their patient’s condition like boot camp and may treat patients as if they are inanimate objects unknowingly. However, they love deep conversations and will warm up once they get to know their patients well. They are viewed as the hidden gem in their patient’s lives.

(4) Melancholic/Traditional PT:

This type of physical therapist is the foundation of our profession: think of professors, mentors, directors, and managers. They like to teach and show other therapists the proven and effective way of a treatment protocol. Their guidance and wise words are much sought after. Reading and researching about the best treatment for their patients are their key focus daily and they would tend to stick to basic foundational skills. Some may view dry needling, new equipment, and new electronic medical records with a wary eye.

Now the question: are you a Type 1? Or are you a mix of a couple traits or the sum of all 4 types? For me, I believe that we are not strictly just one type. I consider a lot of our traits in dealing with our patients as a combination or an overlap of a couple of traits. I believe that is what makes a good physical therapist become the best of him or herself. A Personality Study conducted by Morelli et al (2017) suggested that empathic people help others in dealing with stressful and difficult situations. They also bring out positive vibes and experiences. This in turn will affect others in the community in a healthy, good way.

Being a Clinical Coordinator at my current job, we have a tool called My Rounding.⁸ It is a tool designed to cater to patients’ satisfaction during their stay in rehabilitation. It helps to address any issue or any concern that a patient has while receiving rehabilitation. It is also

designed to make our therapists become better and be the brightest of stars. As I make my rounds, I spend time with patients asking them basic questions such as, are you satisfied with your therapist? I encourage them to mention their therapist’s name and say grateful things about them if warranted. Some of these patients would knock on my office door personally and tell me about their great patient experience. They convey endearing words about how their therapists made them better by treating their ailments and making them feel special at the same time. On the other end, I encourage therapists to make that connection with their patients within and outside their treatment timeframe. Physical therapists may find it corny and may not admit it but I believe it helps boost morale and prevent burn out from the demands of the daily routine. In general, patient satisfaction has been deemed necessary in playing a role in the quality of health care provision.⁴

I spend less time now with direct patient care and spend more time behind the scenes. I must admit that I do miss the interaction with patients. It makes me feel full-hearted to see them smile when I walk in, to laugh at my self-deprecating jokes, and for them to ask me back about my weekend. What I am saying is: empathy goes both ways and this makes being a physical therapist all worth my while.

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Annei Rose Banzon, PT, DPT, GCS, graduated from San Pedro College in Davao City, Philippines in 2001. She came to New York

and started working as a Physical Therapist in various settings since 2006. In 2012, she earned her transitional tDPT from Boston University. In 2018, she became a Board Certified Geriatric Clinical Specialist. Currently, she works at Kingsbrook Jewish Medical Center in Brooklyn as an Assistant Director of Rehab in LTC. She is also a New York State Advocate for the Academy of Geriatric Physical Therapy. Her hobbies include baking, photography, reading, movies, and traveling. She loves the beach and inner peace mantras. You may reach her at annei.banzon@gmail.com.

2019 Academy of Geriatric Physical Therapy Election

Those elected will take office at the AGPT Member Meeting in February of 2020 at CSM in Denver, CO. Online voting will begin on October 1, 2019 and continue thru October 31, 2019. Please watch your email and www.geriaticsppt.org for more details. Contact geriaticsppt.org to request a paper ballot. Per bylaws, only PTs and PTAs are eligible to vote.

SECRETARY (VOTE FOR 1)

Anne Coffman, PT, MS

*Board Certified Geriatric Clinical Specialist
Certified Exercise Expert for Aging Adults*



Employer/Position: Miracle Home Care, Lead Physical Therapist

Education: UW-La Crosse BS in PT 1992, UW-Milwaukee MS in Educational Psychology, 1995

What experiences would you bring to the position of Academy secretary that makes you a strong candidate?

I have 15 years of experience being on the Board for the Academy as Director, Treasurer, Vice President, and Nominating Committee/Chair. This has provided years of experience, historical perspective as well as understanding the current focus and vision for the Academy. In addition, serving 9 years on the WI Chapter Board and 11 years as a delegate for the WI Chapter has given me insight and solid understanding of the role of components within the APTA structure. These experiences position me well for participating on the Board and on the Executive Committee.

I am detail oriented, organized, and able to manage the minutes while attending to the ongoing discussion. The Secretary also assists with bylaw revisions, management of the archives, and oversees the website/listserv and PR/marketing committee. I am confident in my abilities to assist with all those tasks in addition to the Board responsibilities and look forward to getting involved in a new area within the Academy, as these were not my primary responsibilities in past positions.

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

The Secretary is very involved in communication by overseeing the listserv, website, and social media. Maintaining active leadership and participation within these committees is the primary Board liaison role that I would fulfill. These committees have the potential to reach younger/newer PTs just joining the profession and to identify opportunities for their involvement. The Academy already has plans in place to promote a mentor program for the GCS exam and it would be beneficial to expand that to mentoring newer practitioners as well. Responsiveness to members is the responsibility of the entire Board and ensuring adequate office staff, paid and volunteer resources, publications, and communication are the means to respond to, as well as anticipate, member needs. Being part of the Board to allocate resources of time and funding will ensure that the Academy is pro-active in meeting members' needs.

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

A primary challenge for both PTs and PTAs is balancing constant change with payment methodology, demand for increased productivity, and providing cost effective, evidenced-based physical therapy services. The Academy has addressed this with the new Advanced CEEAA course that teaches clinicians how to manage care using patient scenarios. Expanding offerings like this as well as continuing existing CEEAA courses will provide effective strategies to our members. Other APTA member services such as *GeriNotes* and listserv can teach skills on being effective, efficient practitioners, which will reach the broader membership.

Partnering with the APTA to address the changes in payment is critical to have an advocate for appropriate reimbursement and educator of these changes. Currently the Academy is involved with APTA yet with many payment system changes continually occurring we need to better mobilize our members to be advocates in support of our positions.

Thank you for your nomination for Secretary and to my trusted colleagues for their support. I ask for your vote and allow me to serve the Academy and its' members.

Myla "Myles" Quiben, PT, PhD, DPT, MS

*Board Certified Geriatric Clinical Specialist
Board Certified Neurologic Clinical Specialist*



Employer/Position:

Associate Professor and Interim Chair, University of North Texas Health Science Center, Department of Physical Therapy

Education: Master of Science in Clinical Investigation: University of Texas Health Science Center at San Antonio, 2014; PhD in Physical Therapy: University of Central Arkansas, 2009; Doctor of Physical Therapy: University of Central Arkansas, 2003; Bachelor of Science in Physical Therapy, University of the Philippines, 1995; Fellow, Education Leadership Institute (ELI) Program: APTA, 2016; Fellow, Tom Waugh Leadership Program: Texas Physical Therapy Association, 2016; Fellow of the Castella Faculty Geriatric Research Fellowship: University of Texas Health Science Center at San Antonio, TX, 2011-2014

What experiences would you bring to the position of Academy secretary that

makes you a strong candidate? With a depth and breadth of clinical, academic teaching and administration experiences, and prior service at different levels of the APTA and the Academy, I bring to the Board a broad knowledge of geriatric physical therapy practice issues and strong leadership skills critical to advancing geriatric physical therapy practice and education.

I engage closely with a dynamic group of professionals within and external to our profession who support the PT geriatric practitioner, educator, and older adults; these interactions provide me with rich insights I bring to the Academy. More importantly, as a clinician, I have a passion for geriatric care for optimizing the function and quality of life of older adults, and for promoting physical therapists as the geriatric practitioner of choice.

I have been part of the work, organization, and dedication that fuels the Academy in my past service as Director of Education and collaborated with many dedicated leaders for CSM and regional programming, home study courses, and the CEEAA course. I was intimately engaged in the Academy's last strategic plans; I intend to support the executive team in moving the strategic plan forward while providing fair and honest feedback to its leadership.

My colleagues will attest that I am collaborative, enthusiastic, quality-driven, and function well under pressure. I bring a strong desire to contribute and bring a fresh perspective with administrative skills honed by a history of service to the profession, serving in the American Board of Physical Therapy Specialties, Geriatric Specialty Council, Credentialed Clinical Instructor Program, Federation of State Board of Physical Therapy Specialties, and in my home state as Delegate. These experiences allow me to have a holistic insight from varying points of view. This viewpoint coupled with my commitment to excellence, work ethics, and enthusiasm to move the Academy forward, make me a strong candidate for the position. I would be honored to have your support and have the opportunity to serve the profession and the Academy as your Secretary.

How would you promote communication to enhance participation of and

responsiveness to members? In the current era of multiple communication tools, I would utilize as many on hand – efficiently and succinctly. While many tools abound, many of us are not on the same platforms and/or use these tools in different ways. As such, casting a wide net, promoting communication via traditional email and mailouts (as appropriate), AGPT and partner organization websites, *GeriNotes*, *Journal of Geriatric Physical Therapy*, webinars, podcasts, and social media including Twitter, Instagram, and Facebook, is not only a necessity, but a way to reach as many members AND non-members.

To work on efficiency, I would work closely with the leaders in membership and practice to investigate membership demographic and communication preferences. When preferred communication channels are identified, we need to explore avenues to meet those preferences or at the very least, target as many platforms as our financial and our human resource pool allows, to promote participation in Academy affairs and increase their engagement.

People engage when leadership is visible, accessible, and connectable. I envision the leadership to utilize more means of connecting with the membership and being more visible on social media. It may be through a podcast, a live webinar or two, or a simple blast email from leadership updating the members on current issues tackled by the BOD or minutes posted online. Website updates have improved over the years; we can further streamline the organization, links, and content for ease of navigation.

What is the greatest challenge facing the geriatric practitioner and how can the Academy help? Geriatric practice is complex and is further complicated by the dynamic nature of health care and reimbursement. I bring forward two great challenges to the geriatric practitioner that are closely entwined. To say that reimbursement is one of these challenges is an understatement; I would be amiss to not include the lack of recognition for the identity of PT as the geriatric practitioner of choice as a secondary challenge.

While we have the opportunity to be the primary health care provider in the prevention of age-related mul-

tisystem decline, yet we have not fully promoted or established ourselves in the public and in the medical profession to fulfill this role. Crucial to this conversation of promoting physical therapists as geriatric practitioners is acknowledging the need for vigorous geriatrics education at the entry- and at the post-professional levels. Closely tied to education is bringing the research evidence into the hands of clinicians and students for a true evidence-informed practice.

How to help? The Academy has started on this path as a source of information to members on current events impacting the care of older adults. The Academy should be a provider of current resources and content experts for members. Multiple communication avenues should be tapped to provide upcoming changes AND current payment policy and advocacy resources, similar dialogues and resources on the Patient Driven Payment and Patient Driven Grouper Models.

On the education forefront, the Academy has also invested in post-professional education that calls attention to the appropriate interventions for older clients and patients, clinical practice guidelines, recurrent efforts towards policy and reimbursement issues, essential competencies for inclusion of geriatric content into entry-level curricula, and with increasing presence with outside partners to advance geriatric issues. The Academy has also begun to develop advanced courses to continue the growth of PTs who have a passion for caring for older adults.

But there is much more to be done. We need to develop stronger curricula on geriatrics and advocate for all programs to have essential geriatric competencies embedded in the curricula. We need to continue to have a strong voice in external entities that shape public policy. We need to contribute to the critical dialogues at the national level about issues that impact care for the older adult, in a timely manner. We need to have conversations with other health care professionals and organizations about our key role in an aging society.

It would be an honor to work on these challenges and to continue to build a strong infrastructure for future geriatric practitioners and put our stamp as the experts in the care, management, and health promotion of older adults.

DIRECTOR (VOTE FOR 1)

Tamara N. Gravano, PT, EdD, DPT

Board Certified Geriatric Clinical Specialist
Certified Exercise Expert for Aging Adults



Employer/Position:

Associate Professor of Physical Therapy, Rocky Mountain University of Health Professions

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

Greetings to the members of the Academy of Geriatric Physical Therapy. I enthusiastically welcome the opportunity to continue to serve as one of your Directors. I am deeply honored to be considered for this important work within the Academy to advance our new mission: *"Building a community that advances the profession of physical therapy to optimize the experience of aging."* The role of Director allows me to collaborate with the AGPT leadership and other voluntary Directors and work with our six SIGs, 18 committees, and all the stakeholders of the Academy. This is an exciting time to serve my profession, as the AGPT continues to grow, and there are several exciting initiatives we have planned to help us achieve our new vision: *"Embracing aging and empowering adults to move, engage, and live well."*

I earned my Bachelor of Health Sciences, Master of Science in Physical Therapy, and transitional Doctor of Physical Therapy from the University of Miami in Coral Gables, Florida. I completed my EdD in Leadership Studies with an emphasis in Higher Education Administration from Marshall University. Over the last 19 years of APTA membership and service, I have had the privilege of serving on several committees in the AGPT: as Founding Chair of the Residency and Fellowship Special Interest Group (RFSIG), Chair of the Residency & Fellowship Subcommittee of the AGPT Practice Committee, and as Chair of the AGPT Membership Committee. Currently, I am on the Editorial

Board of the *Journal of Geriatric Physical Therapy* and am the Co-Coordinator of the Certified Exercise Expert for Aging Adults (CEEAA) course series. I was thrilled to be recognized for my service to the AGPT with the President's Award in 2016, the APTA Lucy Blair Service Award in 2017, and the Joan M. Mills Award in 2018.

Besides my leadership roles in the AGPT, I have served my profession in other APTA sections, especially in the areas of post-professional education. As one of the initial graduates of the first geriatric physical therapy residency program (2004), my interest in promoting geriatric patient care is evident in the service roles I have chosen. I have recertified as a Board-Certified Clinical Specialist in Geriatric Physical Therapy, and since earning the APTA Emerging Leader Award in 2007, I have sought after and enjoyed many opportunities to align my interests in geriatric education and practice. Recently, I completed 2 terms on the Board of Directors of the American Board of Physical Therapy Residency and Fellowship Education (ABPTRFE) where I reviewed and accredited residency and fellowship programs. I have participated on the Specialty Council on Geriatric Physical Therapy of the American Board of Physical Therapy Specialties (ABPTS), culminating as Chair in 2012. During this period, I was privileged to co-author the 2010 Geriatric Physical Therapy Description of Specialty Practice, and currently am assisting with the 2020 edition. Previously, I was an item writer for the Geriatric Specialty Board Exam as a member of the ABPTS Geriatric Specialization Academy of Content Experts (SACE). Joining SACE allowed me to participate in the creation and management of the Geriatric Specialty board examination, which is the ultimate goal of most, if not all, geriatric residency programs, and afforded me the opportunity to collaborate with related APTA committees.

My interest in promotion of geriatric patient care is not limited to post-professional specialty educational development; as I am also a trainer for the Credentialed Clinical Instructor Program of the APTA and have been an item writer for the Federation of State

Boards of Physical Therapy (FSBPT), which helps me to close the loop from entry-level to advanced clinical practice education in geriatrics. In my role as Associate Professor at Rocky Mountain University of Health Professions in Provo, Utah, I teach Geriatrics and Wound Care in the DPT curriculum and I practice per diem in a skilled nursing facility. My research interests are Fall Prevention, Generational Differences, Healthcare Literacy, and Best Practices in Adult Education. Together, my experiences across the many facets of APTA and Geriatrics allow me a unique point of view when addressing the needs of our Academy.

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?

I seek to carry on serving the section that has provided me with so much inspiration to serve my profession. Recently, the Academy of Geriatric Physical Therapy has renewed our strategic plan. The new Mission emphasizes *"Building a community that advances the profession of physical therapy to optimize the experience of aging."* My experiences in the ABPTRFE, ABPTS, and AGPT focus on promotion of geriatric education and practice. I see my role as Director as one that aligns the educational committees together to work toward the common goals to pursue best physical therapy practice for optimal aging. To this end, I support geriatric-specific continuing education like the CEEAA and other continuing education forums to help clinicians learn the skills necessary to provide the best patient care. I would like to see the CEEAA course expand and increase our regional course offerings. In addition, continued recognition of Advanced Proficiency of PTAs in geriatrics and other specialty areas is important to encourage more PTAs to seek quality geriatric continuing education. As the former Membership Chair, collaboration with other professional associations that serve the geriatric community such as the National Council on Aging and the American Geriatrics Society should be expanded to improve not only our own patient outcomes, but also to promote the profession of physi-

cal therapy among the greater healthcare community.

After years of service to the Academy, I understand the needs of the Academy as it grows as well as the challenges each member faces as we move forward together to embrace our common interests. I support the sharing of resources between committees and establishing clear lines of communication between academies to allow us to work together to meet our mutual goals. I plan to maximize efficiency through communication with the rest of the BOD and leadership. Our profession as a whole has an unprecedented opportunity to engage an aging population, represented as an increase in the complexity of our client/patient population. Our clients are no longer pegged into a single box, but instead are becoming more diverse in ability, experience, and goals. The AGPT is working to increase student and new professional membership to help prepare current and new geriatric practitioners with the best evidence for treatment of this growing area of practice.

What is the greatest challenge facing the geriatric practitioner and how can the Academy help? The AGPT has identified several challenges facing today's geriatric practitioner, and it will take a coordinated effort from all stakeholders to continue to move forward. The Academy is a valuable source of information to help clinicians navigate the recent healthcare changes and its current and future impact on practice. The AGPT can help the geriatric practitioner by promoting educational resources for clinicians to elevate their practice to keep up with the changing needs of our patients. Providing increased access to resources to support patient advocacy, interdisciplinary practice teams, increase reimbursement, improve documentation, and explore professional community partnerships would go a long way toward better serving our patients and clients. It is more important than ever to promote and to provide evidence-based practice specific to the geriatric population. To that end, the Academy needs to continue to educate the consumer as well as other healthcare professionals that the physical therapist is the practitioner of choice for the aging

adult's health and wellness needs. The new Vision of "*Embracing aging and empowering adults to move, engage, and live well*" is a veritable call to arms for our profession to challenge aging bias and not see age as a limiting factor. Our aging population is changing, and we need to do more to promote potential over achieving minimal functional goals as a standard of practice. Underdosing of exercise is still a real problem, and the AGPT is one of the best resources available for providing information to the consumer and other healthcare professionals to enhance aging for all.

DELEGATE (VOTE FOR 1)

Patricia Brick, PT, MS

Certified Exercise Expert for Aging Adults



Employment / Current position: TLC Rehab and Wellness: President and Owner, TLC Rehab and Wellness provides home based physical therapy and post rehab

exercise consultation services, home assessment for safety and modification recommendation and long-term needs assessments.

Education: AAS Physical Therapy; Atlantic Cape Community College 1981; BA Psychology; Richard Stockton University 1988; MS Physical Therapy; Neumann University 1998

Geriatric Clinical Specialist 2006, 2016, CMC 2010, Certified Exercise Expert for Aging Adults 2017

What skills and experiences qualify you to serve as the Academy's Delegate? I have been a member of AGPT for 20 years serving at the committee, task force and Director level and as alternate delegate. That service has given me a good understanding of AGPT's initiatives and priorities as well as the processes that help the Academy function. I have also served my state of New Jersey as a delegate, Chief Delegate, and President. I have attended 16 houses, 10 Northeast Caucuses, learned Roberts

Rules and how to use them, and been involved in development and passing of several RCs. I served on the new Vision task force that brought that work to the BOD to present to the HOD in 2013. I believe that my long and diverse experience will serve me well to represent the AGPT in the House of Delegates.

How do you envision the role of Delegate? I see the role of delegate as multidimensional. The AGPT delegate has to be able to connect with members and other delegates; state and component, to express the needs of the Academy's members and those we serve. The delegate must have a command of Roberts Rules to be able to function effectively in the House. And the delegate must demonstrate leadership on behalf of the Academy while supporting or rejecting RCs as they are developed and presented. I believe that those qualities and as well as being a good negotiator are critical to the role as delegate, as you will be called on to enlighten others and encourage them to consider the impact of policies and practice that are the result of motions past in the House.

What are the issues facing the profession that will require leadership by the Delegate for the Academy of Geriatric Physical Therapy? We are in very uncertain times; payment policy and processes are changing, coverage is changing, practice models are changing. We must be prepared to identify and demonstrate our ability to be risk managers, money savers, and movement system specialists. We must recognize the evolving needs of aging adults to optimize their movement and improve their quality of life and that of those around them. We have to educate patients, other providers, payers, and the public that aging is a verb and is not defined by poor health, impaired mobility, and forgetfulness. Aging is an active process that is unique to every person. We as PTs and PTAs are best qualified and ready to optimize aging for the vast numbers of people we serve now and will serve in the future. The AGPT Delegate must look for opportunities to advocate by supporting RCs, opposing RCs and developing and presenting RCs that represent the Academy's mission, vision, and strategic goals, as well for the people we serve.

Tiffany Hilton, PT, PhD



Education: BS: Wake Forest University; MPT: University of St. Augustine for Health Sciences; PhD: University of Florida; Post Doctoral Fellowship:

Washington University in St. Louis

Employer/Position: Duke University School of Medicine, Doctor of Physical Therapy Division, Assistant Program Director/Director of Curriculum, Associate Professor

What skills and experiences qualify you to serve as the Academy's Delegate? My passion, organization, and attention to detail are important qualities that will help me to be successful in this role. Prior to becoming a CSM steering group member, I served as program co-chair for the Academy of Geriatric Physical Therapy (AGPT) from 2012-2016. In this role, I developed an appreciation the needs of our members and the programming priorities of the Academy and how they related to the broader APTA organization. I am also the Assistant Program Director for the Doctor of Physical Therapy Program at Duke University. In this role, I have gained valuable experience with strategic planning, improved my communication, and learned to navigate the delicate balance between the big picture and the details of our program. I also oversee the policy review process for the Doctoral Division of Physical Therapy. This skill set will serve me well as delegate as I work to build bridges, represent the needs of our Academy, and consider the impacts of association policy on AGPT and its members.

How do you envision the role of Delegate? The role of delegate requires a commitment to understanding the APTA's bylaws, policies, positions, and guidelines and to determine those documents' impact on the vision and mission of the association. This must be accomplished while keeping the needs of society and our patients in mind. As delegate I will effectively communicate with our Academy leadership and

membership to accurately represent the Academy and advocate our positions to APTA's House of Delegates.

What are the issues facing the profession that will require leadership by the Delegate for the Academy of Geriatric Physical Therapy? The APTA is engaging in a bylaws review process that may provide an opportunity to change how Sections and Academies are represented at the House of Delegates. Sections and Academies provide a strong voice for the specialty interests of our profession and it will be important as APTA considers the changing needs of a modern association to find effective ways for the Academies to be presented. Additionally, the APTA Board of Directors recently adopted a new strategic plan for the association. One pillar of that plan is to elevate the quality of care provided by PTs and PTAs. AGPT can align with APTA in these initiatives to ensure the needs of our older adult patients/clients are considered as APTA seeks to expand services in prevention and wellness.

David Taylor, PT, DPT



Employer/Position: Director of Clinical Education, Clinical Associate Professor, Department of Physical Therapy, Mercer University

Education: Transitional-Doctor of Physical Therapy, Emory University School of Medicine, 2004; Master of Physical Therapy, Emory University School of Medicine, 1992; Bachelor of Science, Emory University, Emory College, 1988

Certifications: University of Alabama at Birmingham, Department of Physical Therapy, Certificate in Health Focused Patient/Client Management for Physical and Occupational Therapists, 2015

What skills and experiences qualify you to serve as the Academy's Delegate? I am well qualified to serve as the Academy of Geriatric Physical Therapy (AGPT) Delegate to the APTA House of Delegates (HOD) based on

my skills and experiences. My service as a Georgia Delegate (2013-2015) and Chief Delegate (2017-2019) gives me a strong working knowledge of delegate's roles in year-round Association governance. As a Chief Delegate, I successfully brought forward and contributed to the development of motions, and lead a nine-member delegation. I have strong relationships with Chapter and Component delegates, House Officers, the Reference Committee, Board of Directors, and APTA staff. As a member of the Southern Regional Caucus, I worked alongside the AGPT Delegate. Serving as a Chief Delegate in the last three, consecutive HOD's has made me aware of current and pending motions coming before the 2020 House. As for my skills, I am a collaborator and advocate for our profession and academy. My service within the Physical Therapy Association of Georgia (PTAG) as a member of the Board of Directors (BOD) and Executive Committee have helped me develop skills that support success in this role. In PTAG, I had multiple roles including liaison to PTAG committees, fiduciary BOD responsibilities, strategic planning, and Chief Delegate. My role on the BOD, as Chief Delegate, was to keep the BOD and PTAG members apprised of national and regional issues influencing practice, education, and governance.

How do you envision the role of Delegate? The primary role of the AGPT Delegate is to represent members in the APTA House of Delegates. The AGPT Delegate must keep the AGPT board and members up-to-date on practice, education, and governance issues coming before the House, in addition to bringing forth motion positions, charges, or bylaws on their behalf. The Delegate should be able to collaborate with AGPT members, other delegations and components, the APTA and AGPT Board. In year-round governance, AGPT delegates must represent the Academy over themselves. Delegates should also understand the strategic plan and operations of the Academy. Lastly, Delegates should advocate for older adults in year-round governance and consistently ask the question, "How will this influence geriatric physical therapist practice and support optimal aging?"

What are the issues facing the profession that will require leadership by the Delegate for the Academy of Geriatric Physical Therapy? The AGPT Delegate will face multiple issues influencing the profession involving practice and payment, governance, and social issues. I expect practice and payment issues related to scope of practice, practitioner status, prevention and wellness, and geriatric workforce needs would be addressed. Opportunities exist for geriatric physical therapists to contribute more in areas of prevention for Medicare beneficiaries, including the Annual Wellness Visit. Physical therapists, able to manage the complex issues of aging, need to be prepared to meet the needs of the growing older adult population. Student debt must also be a component of geriatric workforce development initiatives. Through the House, the Association will continue to address governance issues. In 2020, the House will address Association bylaws and I expect robust debate on the Section vote. I am in favor of section delegates having a vote and believe the House can determine the process and number of votes. I support section delegates voting in both elections and governance matters and will advocate for this to occur in 2020. The HOD has been associated with the Associations summer meeting (NEXT); this will be changing after the 2020 House. The AGPT needs to have both a seat and a voice at the table in determining the future format of APTA governance. Lastly, AGPT must be prepared to take a stance on social issues. For example, in 2020, the House adopted positions on diversity, equity, and inclusion, firearm injuries and deaths, and vaccinations. I believe we will continue to address social issues in the House and should do so in the context of the Associations Vision and Mission.

NOMINATING COMMITTEE (VOTE FOR 1)

Jason DeCesari, PT, DPT
Board Certified Geriatric Clinical Specialist
Board Certified Orthopaedic Clinical Specialist



Education: Richard Stockton University
DPT class of 2012

What skills and experiences qualify you to serve on the Nominating Committee? In my role as the clinical coordinator for the quality assurance and professional development department at Fox, I am heavily involved in the identification and development of new and established members of the leadership team. I assist in interviewing, selecting, and mentoring geriatric residents and fellows. I am also involved in the development of mentors for our student and new graduate programs. Through these experiences, I have gained skills in behavioral interviewing, education, and conflict resolution that would serve me well in a role on the nominating committee. I also serve as an adjunct professor at Rutgers and have the opportunity to interface with students yearly. This allows me to continually build on my abilities as an educator and refine my communication skills.

How would you identify and mentor new leaders within the Academy? My interest in participation in the Nominating Committee and the Academy more broadly stems from a feeling that the professional organization and its sections can feel daunting from the outside. I have spent the early part of my career with a desire to do more and limited knowledge of where to start. My goal for participation would be to help to break down this barrier and engage current and prospective members. I would seek to engage with a variety of clinicians at professional meetings, my teaching engagements, and within my own practice. Given my broad experience in a relatively short time, I feel that I can relate to a wide variety of professionals and can offer assistance. As my own experience within the academy grows, I will seek to pass on any lessons I learn.

Employer/Position:
Fox Rehabilitation:
Clinical Coordinator
for Quality Assurance and Professional Development;
Rutgers University:
Adjunct Instructor

**Arvie Vitente,
PT, DPT, MPH, PhD(c)**
*Board Certified Geriatric Clinical Specialist
Graduate, APTA Education
Leadership Institute
Certified Dementia Practitioner*



Employer/Position:
Academic Coordinator of Clinical Education, Asst. Professor, DPT Program, University of St. Augustine for Health Sciences

Education: Doctor of Philosophy (Candidate), Angeles University Foundation, Educational Management, February 2020; APTA Education Leadership Institute Fellowship, American Board of Physical Therapy Residency and Fellowship Education, Education Leadership, July 2019; Doctor of Physical Therapy, Dominican College of Blauvelt, 2017; Master of Public Health, Angeles University Foundation, 2006; Bachelor of Science in Physical Therapy, Angeles University Foundation, 2003

What skills and experiences qualify you to serve on the Nominating Committee? One of the most significant skills which makes a committee effective is the ability to work as a group by drawing on the skills and talents of each member. I feel that my teamwork and coordination skills are best suited and well-aligned towards the common agenda of the Nominating Committee. I have 16-years' experience, serving in both academic and clinical institutions. A period of 16 years in academic and clinical institutions gave me the opportunity to develop my organizational, teaching, and clinical skills. Recently, I graduated from the APTA Education Leadership Institute (ELI) class of 2018-2019. My experiences in this fellowship not only enhanced my leadership skills but also advanced my ability to work with other leaders in the profession. I was also a PTA program director at Pensacola State College before joining the ranks as a Core Faculty/Academic Coordinator of Clinical Education at the University of St. Augustine for Health Sciences. I also represent the minority in our field, and hence, the topic of diversity, inclusion, and equality is my huge

advocacy. The above are the reasons why I believe that I am best suited to be one of the members of the Nominating Committee. Given a chance to serve as a member, I will make sure that both PT and PTA educators, and the minority are well represented in the academy in support of the objectives of our association.

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

To identify and mentor new leaders, I

believe that one must know them personally. I will hence attend meetings and other interactive activities hosted by the Academy and APTA to personally meet our active members. Active membership is very important in accomplishing good leadership. Mentoring new leaders should be aligned with the mission, vision, and objectives of the Academy. I strongly believe that our leaders will benefit and learn more through an interactive framework built on experiential

learning. I understand the importance of learning through hands-on experience, and reflection. These are key factors to consider in mentoring upcoming leaders. I believe that I am well suited for this role, and hence being a part of the Nominating Committee is important to me. If given the chance to serve, I will make it a point to dedicate my time to mentor new leaders and prepare them to assume their offices.

Working in an ICU and Tips for Taking the Fear and Apprehension Out of Mobilizing Critically Ill Patients

Devayani K. Kurlekar, PT, DPT, MS

INTRODUCTION

Bed rest or immobilization is frequently part of treatment for patients in the intensive care unit (ICU) with critical illness and the effects of prolonged immobility can be devastating.¹ Despite knowledge of the deleterious effects of bed rest on multiple body systems, the ICU is a complicated and difficult environment to mobilize the critically ill.² Multiple life-sustaining catheters and monitors, sedative medications used to calm agitation or reduce energy expenditure, impaired levels of alertness from medications, sleep disturbances, electrolyte imbalances, and tenuous hemodynamic status all are contributing factors that limit mobilization.²

Early mobilization of ICU patients has been associated with improved muscle strength and functional independence, as well as a shorter duration of delirium, mechanical ventilation, and ICU length of stay.³ Despite the potential concerns about mobilizing critical patients in the ICU, many studies have repeatedly demonstrated that early mobilization and rehabilitation in the ICU appears safe, feasible, and beneficial.⁴⁻⁷

A systematic review and meta-analysis synthesized data from over 7,546 patients and over 22,351 mobilization/rehabilitation sessions in the ICU, demonstrated that early mobilization and

rehabilitation in the ICU appears safe, feasible, and beneficial with an overall cumulative incidence of potential safety events of 2.6% and rare (0.6%) medical consequences with the occurrence of events.⁸

Owing to critical illness, the hemodynamics can rapidly change. Therefore monitoring patients' safety before and during mobilization is of vital importance.⁹ This article will focus on tips for taking fear and apprehension out of mobilizing critically ill patients in the ICU.

The basics:

It is vital to have the knowledge of the following:

- The knowledge of cardiovascular and pulmonary anatomy and physiology, pathophysiology, oxygen transport, and pharmacology is necessary for any clinician who wishes to work in the ICU.¹⁰
- It is essential to have the knowledge of telemetry monitors, basic EKG rhythms. It is necessary to understand the basics of mechanical ventilation, artificial airways such as an endotracheal tube and tracheostomy tube, respiratory care and supplemental oxygen delivery systems, and equipment. The type and intricacy of respiratory care equipment can change with ad-

vances in technology. It is necessary to know about the equipment that will be used when working with the patient. A knowledge and comfort level with respiratory care modalities and equipment will relieve anxiety and promote effective and safe interventions.¹⁰

- It is essential to know location, purpose and precautions of lines, catheters, and tubes that are attached to the patient so they can be managed by the way of either disconnecting or securing them safely during mobility. Some of the lines that are most commonly encountered in the ICU are the arterial line, the central venous pressure line, the Swan-Ganz catheter, the intracranial pressure line, temporary pacemaker, PICC line, hemodialysis catheter, chest tube, surgical drains, nasogastric feeding tube (Dobhoff tube), nasogastric feeding tube (NG tube), percutaneous endoscopic gastrostomy tube (PEG tube), etc.
- Lab values provide physiological basis for monitoring the patient's symptoms, provide a way to predict response to therapy interventions and/or indicate precautions and/or contraindications to therapy interventions. Some of the essential laboratory values to pay attention to the ICU setting are hemoglobin, hematocrit,

white blood cell count, platelets, the international normalization ratio (INR), blood glucose level, potassium, sodium, magnesium, and calcium. Some of the other important lab values that a therapist needs to pay attention to are troponin, serum creatinine, blood urea nitrogen (BUN), and brain natriuretic peptide (BNP). The Academy of Acute Care Physical Therapy distributed a laboratory values interpretation resource to all physical therapy practitioners in 2017, to better reflect current trends in practice. The resource is available at <https://cdn.ymaws.com/www.acutept.org/resource/resmgr/docs/2017-Lab-Values-Resource.pdf>¹¹

- The patient in ICU can be on multiple medications at one time. It is necessary to be aware of side effects of these medications, especially when mobilizing a critically ill patient. Some of the commonly used medications in the ICU are pressors, B-blockers, ionotropes, chronotrops, calcium channel blockers, diuretics, and sedatives. Monitoring patient's vital signs before, during, and after a physical therapy session is necessary.
- It is necessary to be aware of emergency procedures, protocols, and policies in the ICU where you practice.¹²

A daily assessment of patients in the ICU regarding their suitability for mobilization is necessary⁷ and the input of the multidisciplinary team including the intensivists, RNs, and respiratory therapists is necessary along with PTs, OTs, and SLPs. Working in an ICU setting often involves coordinating with not just intensivist but with internists and specialists such as surgeons, cardiologists, nephrologists, gastroenterologists, etc. When taking care of a patient with multiple medical issues, it may be necessary to communicate with one or all. A collaboration with respiratory therapy during mobility is essential especially when mobilizing a patient on a ventilator. The respiratory therapists can assist with ventilator settings and management of respiratory equipment. The nurses can assist by managing line and tubes that can be disconnected for ease of mobility. Once a consult is received for physical therapy, a comprehensive physical therapy evaluation needs to be

performed and appropriate goals and plan of care need to be developed.¹²

The evaluation of physical functioning is valuable in the intensive care unit to help enhance patient recovery after critical illness, to identify patients who may require rehabilitation interventions, and to monitor responsiveness to such interventions. The International Classification of Function (ICF) framework explicitly recognizes that functioning is affected by the interplay between an individual's health condition and contextual factors, which may include personal (eg, education) and environmental/social (eg, home set-up, family support) factors.¹³

Important considerations:

- Once orders are received for a physical therapy consult in the ICU, it is important to find out when the order was written and who wrote the order. It is possible to have an order that was originated in the emergency room or when the patient was admitted to the floor and the patient has since transferred to the ICU due to a change in status for higher level of care due to a medical event. It is essential to obtain valid orders prior to initiating a therapy session in the ICU.
- It is important to communicate with the patient's nurse to find out about any changes in the patient's medical status that may not have been entered in the medical chart. The nurse can also assist with disconnecting lines and feeding tubes as needed for ease of mobility.
- The respiratory therapist can provide information on type of respiratory support the patient may be on. The respiratory therapist is also able to change the ventilator settings for ease of mobility with patient. The respiratory therapist is also able to provide assistance with managing respiratory care equipment while mobilizing a patient on a ventilator. The guide to physical therapy practice provides a thorough patient management model. It identifies key components necessary for a thorough patient examination and evaluation of the patient, test and measures, identification of impairments, and intervention and outcomes that help the therapist in providing a multisystem examina-

tion and evaluation that will lead to appropriate treatment and achievement of optimal function and goals.¹¹

- A thorough chart review can provide information on past and present medical, surgical history,¹¹ hospital course, tests, and procedures that have been done or will be done. Special attention needs to be paid to tests like VQ scans and venous doppler that rule out diagnosis such as pulmonary embolism, deep vein thrombosis, and CT and MRI results, as well as x-ray results to rule out presence of fractures. A mobility session may need to be postponed until the results of these tests are available.
- Patient's prior level of function and social history¹¹— the information about prior level of mobility and independence in activities of daily living, history of falls, assistive device use, home oxygen use, family support, and co-morbidities can be obtained from chart review as well as family interview.
- The ICU environment is intimidating to patients and families, so it is essential to explain the role and importance of the plan of care. Patients and their families are part of the interdisciplinary team and need to be educated about their role in the plan of care.
- It is necessary to understand the patient's goals for therapy and providing information on the physical therapy role and plan of care.
- It is important to perform a pain assessment and manage the patient's pain before, during, and after mobility. A patient may need to be pre-medicated before a mobility session, as needed.
- Assessment of mental status is necessary and consciousness as well as ability to follow commands needs to be assessed. The Richmond Agitation-Sedation Scale (RASS) is used to measure the agitation or sedation level of a patient. ICU mobility may have to be tailored to a patient's RASS level.^{9,14}
- Cardiac and pulmonary status—it is necessary to assess vital signs such as heart rate (HR), respiratory rate (RR), blood pressure (BP), and oxygen saturation readings before, during, and after session. The ratings of perceived exertion scale can be used to measure the intensity of exercise during a physical therapy session. The mobility

session may have to be modified depending upon the patient's response to mobility.

- Neuromuscular status-the presence of fractures, range of motion limitations, presence of significant muscle weakness, and neurological limitations need to be taken into consideration. The society of critical care medicine recommends considering certain factors with each ICU mobility session¹⁵
 - Determining whether the level of activity is therapeutic.
 - Identifying the available equipment.
 - Scheduling a time to work on physical activity with the patient, family, nurse, and respiratory therapist. Ascertain whether sedation should be suspended.
 - Assessing and managing the patient's pain before, during, and after mobility activity.
 - Optimizing the work of breathing and patient level of alertness to make treatment beneficial.
 - Creating activities that are goal-oriented for the patient.
 - Not delaying or deferring physical activity and rehabilitation even if the patient is to be extubated that day.
 - Not delaying or deferring physical activity because of agitation if it can be safely managed by the nurse and therapist. For patients who are agitated or experiencing disorganized thinking and delirium, a focused task provides an opportunity for reorienting conversation.

Certain conditions need to be taken into consideration, while making decisions regarding whether to stop or limit activity with a critically ill patient. They are as follows:

Absolute contraindications:¹⁶

- Unstable angina.
- Resting systolic BP >200 mmHg or resting diastolic BP >110 mmHg (evaluated case by case basis).
- Comatose, unresponsive patients.
- Significant and symptomatic changes in resting EKG such as multifocal PVCs, more than 10 PVCs per minute at rest.
- New onset atrial fibrillation with RVR.
- Uncontrolled heart failure.

- Hemodynamic instability requiring high doses or multiple vasopressor drugs.
- Suspected or known dissecting aneurysm.
- 3rd degree atrioventricular block without pacemaker.
- Acute pulmonary emboli with unstable medical condition.
- Significant oxygenation dysfunction requiring high levels of supplemental oxygen, usually more than 0.7 FiO₂, unless specified by the physician.
- Cerebral edema with uncontrolled ICP significant neurological and/or musculoskeletal dysfunction.
- Uncontrolled diabetes mellitus.
- Severe orthopedic conditions that would prohibit exercise.
- Acute systemic illness or fever.

Guidelines to terminate a physical therapy session in the ICU:²

- Severe chest pain associated with EKG changes, dysrhythmias.
- Heart rate above predicted maximum heart rate (>70% of age predicted max. HR) or more than 20% decrease in resting HR.
- >20% decrease in systolic/ diastolic BP, MAP <60.
- Intolerable dyspnea associated with increased use of accessory muscles, paradoxical breathing pattern, low oxygen saturation, nasal flaring, and cyanosis.
- Severe pain or fatigue.

Mobility intervention

While mobilizing critically ill patients, it is recommended to keep a close watch on vital signs and to monitor them frequently along with monitoring patient's response to activities. It is safe to increase the intensity and progression of activities slowly.

DISCUSSION

Despite barriers to mobility, critically ill patients can be safely mobilized for much of their ICU stay.¹⁷⁻²¹ Early mobilization is a complex intervention that requires careful patient assessment and management, as well as interdisciplinary team cooperation and training.^{17,18} It is essential to obtain clinically sound and relevant information prior to safely mobilizing a critically ill patient in the ICU. Physical therapists are equipped to address this matter and

can recognize that in a complex ICU environment, inter-professional collaboration is required to deliver beneficial interventions to patients in a timely, consistent manner.²² This article was an attempt to provide generalized basic guidelines to safely mobilize a critically ill patient in the ICU. The early mobility interventions for critically ill patients need to be tailored to their specific needs taking into account their hospital course, co-morbidities, medical status and last but not the least their goals.

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It Takes Two to Tango: Knowledge Translation Depends on Both Authors and Readers

Part II

Leslie Allison, PT, PhD, Editor-in-Chief, Journal of Geriatric Physical Therapy

Welcome to Part II of this 3-part series written for practicing clinicians who read to seek evidence that will positively impact their clinical practice and improve outcomes for their cli-

ents. The purpose of these short articles is to support evidence-based clinical decision-making by helping clinicians better comprehend clinical intervention research results. In Part I, [*GeriNotes*.

2019;26(3):13-15] we covered the difference between statistical significance and clinical significance, specifically, the limitations of reporting only statistical significance (p values) and the benefits of

reporting, in addition to *p* values, metrics that represent clinical significance such as the minimal detectable change (MDC) and minimally important clinical difference (MCID). In Part II, we will cover the importance of *statistical power* and 4 more metrics that represent the degree of clinical significance: *effect size*, *relative risk or risk ratio* (RR) and *odds ratio* (OR), and the *number needed to treat* (NNT).

FINDING THAT NEEDLE IN A HAYSTACK: STATISTICAL POWER

An example provided in Part I demonstrated that when client outcomes in a treatment group are actually and truly statistically significantly better than client outcomes in a control group, it is possible for one study to find this true difference ($p \leq .05$) while another study does not find this true difference ($p > .05$). Often, the explanation for this sort of discrepancy is the amount of *statistical power* that a study brings to bear to find the between-group difference, assuming it truly does exist. Statistical power is the ability of a study to find a statistically significant difference if it actually exists. Studies with high statistical power may find a difference (even if it is a small difference), while studies with low statistical power may not find a difference or may find a difference only if it is very large. [The size of the post-treatment between-group difference is the *effect size*, which we will address later in this article.]

Study authors should report their statistical power so that readers know how confident they can be that a finding of “no statistically significant difference” is correct or not. Statistical power is reported as a number between 0 and 1, or a percentage between 0% and 100%. Higher numbers/percentages indicate a greater chance of finding a true difference. The ability to detect a true difference should be at a minimum of 0.80 (80%), although higher is better. For example, if an author reports that their statistical power was 0.85, that means: If there actually was a true between-group difference, there was an 85% chance it would have been found, and a 15% chance it would have been missed. If study A with reported statistical power of 0.92 reports there was no statistically significant difference between the treatment group and the control group,

it is likely there was no difference. Consequently, a clinician might reasonably consider foregoing use of that treatment with their clients, as it is unlikely to make any difference (see Part I for other factors to consider in this decision). If study B with statistical power of 0.42 reports there was no statistically significant difference, the reader doesn't know whether (1) there wasn't a difference or (2) the difference exists but the study was underpowered and couldn't find it. These equivocal findings are clearly far less valuable for clinical purposes.

Several factors influence statistical power, but the primary factor that is under the control of the researcher is the number of participants (sample size). A study with a small sample size in which the scores are quite variable (large standard deviation [SD] or standard error [SE]) will have low statistical power, while a study with a large sample size in which the scores are more consistent will have high statistical power. Obviously, the more participants in the study, the more likely the statistical power will be sufficient to find a true between-group difference. Study authors should report that they determined in advance (*a priori*) how many participants they would need to achieve adequate statistical power of 0.80 or greater. Because the degree of variability in the outcome scores (expressed as SD or SE) also affects statistical power, authors should also report that they calculated what their actual statistical power was after their data were analyzed (*post hoc*). Readers should look for the *a priori* determination in the Methods section of the article, and for the *post hoc* calculation in the Results section. Here are two examples:

“An *a priori* power analysis estimated that a total sample size of 29 participants would detect a correlation of 0.50, with a statistical power of at least 0.80 at an α level of .05.”¹

“According to the *post hoc* power analysis, the statistical power in the logistic analysis was 0.89.”²

BIGGER IS BETTER: EFFECT SIZE

If the probable outcome of a time-consuming, effortful, and expensive

treatment is not considered to be especially meaningful or valuable, why choose that treatment? To judge whether an intervention is worth doing or not, clinicians who read intervention research want to know not only *if* there was any real difference at all between the treatment and control group, but *how large* that difference was. The treatment *effect size* is simply the size of the difference in outcomes between groups, taking into account the amount of variability in the scores (SD) from each group.

Effect size is expressed as a number between -1 and 1, where negative numbers indicate a negative effect, and positive numbers, a positive effect. An effect size of zero means there was no between-group difference in post-treatment scores. Numbers further away from zero, in either direction, represent a larger between-group difference in post-treatment scores. Effect sizes are typically categorized as *large* if they are > 0.8 , *moderate* if between 0.5 – 0.8, *small* if between 0.2 – 0.5, and *trivial* if < 0.2 .^{3,4,5}

Intervention studies frequently measure more than one outcome variable, e.g., the effect of an intervention on measures of strength, balance, gait, fear-of falling, and quality of life. Because variability in outcome scores (SD or SE) affects both statistical power and effect size, authors should report the statistical power and effect size (or other estimate of impact magnitude, eg, relative risk ratio (RR) or odds ratio (OR), see below) for each outcome variable. It is not uncommon to find that effect sizes differ from measure to measure, eg, a large effect size for strength, moderate effects sizes for balance and gait, a small effect size for fear-of-falling, and a trivial effect size for quality of life. This information is highly clinically relevant, as the reader can then understand which outcomes are likely to be improved by an intervention, and by how much.

Sample size, outcome score variability, statistical power, and effect size are all related.⁶ If either the sample or effect sizes are small, and/or outcome score variability is high, then statistical power will be low, and the study may fail to find a between-group difference that really does exist. If the effect size is large, even an under-powered study may find the between-group difference. If the statistical power is high, the study may

find a between-group difference even if the effect size is small.

WAYS TO ASSESS THE INTERVENTION IMPACT MAGNITUDE WHEN THE OUTCOME VARIABLES ARE CATEGORICAL OR DICHOTOMOUS: RELATIVE RISK/ RISK RATIO AND ODDS RATIO

Many clinical intervention studies include outcomes measured by categorical or dichotomous variables. For example, an outcome might be recorded as 'no falls, one fall, or recurrent falls' (categorical) or 'discharged to home versus discharged to long-term care' (dichotomous). In these studies, one of two alternative metrics may be used to express the degree to which the treatment group differed from the control group: the relative risk or risk ratio (RR), or the odds ratio (OR). These metrics are similar but not identical; the type of study will determine which one is used.⁷ If the study is a randomized controlled trial (RCT) or a cohort study, results reporting may include the RR. The RR is a ratio of the *probability* that a certain outcome will occur in the treatment group to the *probability* that that outcome will occur in the control group.⁸ If the study is a case-control or logistic regression study, results reporting may include the OR. The OR is a ratio of the *proportion* of people in the treatment group who achieve a certain outcome to the *proportion* of people in the control group who achieve that outcome.⁸

Because both metrics are ratios, if the ratio is equal to 1, then no difference was found between the treatment and control groups. When the desired outcome is an *increase* of some sort (eg, increase in those categorized as community ambulators, increase in those remaining alive after one year, etc), if the ratio is greater than 1, the treatment group did better than the control group, and the treatment was beneficial. If the ratio is less than 1, the control group did better than the treatment group, and the treatment was not beneficial and may even have been harmful. Conversely, when the desired outcome is a *decrease* of some sort (eg, decrease in those who fall, decrease in those classified as frail), if the ratio is less than 1, the treatment group did better than the control group, and the treatment was beneficial. If the ratio is greater than 1, the control group

did better than the treatment group, and the treatment was not beneficial and may even have been harmful. Just as a larger effect size indicates a greater between-group difference, RR and OR values further from 1 indicate greater differences between the treatment and control groups.

The main problem with the interpretation of both ratio metrics is that they only tell you about the *relationship* between the two group outcomes. Other factors must be considered when interpreting RR and OR values. First, what was the *baseline* risk in the population being studied? Let's use the example of falls in community-dwelling older adults, where it is known that nearly 30%, will fall at least once per year (while 70% will not fall).⁹ This is the baseline risk, before any intervention is provided. Because the desired outcome is a *decrease* in the number of people who fall, we hope to see a RR value that is less than 1. If the study results report the RR = 0.80, that represents a 20% reduction in relative risk. Given the original baseline risk of 30%, 20% of 30 = 6, and the reduction in actual fall risk after the intervention is 6%.

Second, the RR or OR value may be the same whether the number of people in each group is very large or very small, but the perceived value of the intervention would not be the same. For example, let's say that we are reading the results of a study of pre-frail older adults who lived alone and were undergoing rehabilitation in a skilled nursing facility after a fall. The treatment group with 100 participants received a substantially larger dose of physical and occupational therapy, plus fall-prevention education, and 20 of them were discharged to a long-term care facility (LTC). The control group with 100 participants received 'usual care', and 40 of them were discharged to LTC. Because the desired outcome is a *decrease* in the number of people discharged to LTC, we hope to see a RR value that is less than 1. In this case, the relative risk of being discharged to LTC was 20/40, or RR = 0.50, in favor of the treatment group. Given the human and financial costs of LTC, a 50% reduction in the number of people discharged to LTC would seem to be a worthwhile intervention. But what if there were 1000 participants in each group, and 20/1000

in the treatment group versus 40/1000 in the control group were discharged to LTC. The RR would remain the same, 20/40 = 0.50, but the perceived value of the intervention would change. In the first study, 20/100 people (20% of treatment participants) were able to go home instead of to LTC. In the second study, this improved outcome was realized by only 20/1000 people (2% of treatment participants).

SHOULD THIS INTERVENTION BE WIDELY ADOPTED: NUMBER NEEDED TO TREAT

When researchers report RR or OR values by themselves, they are reporting for the sample they investigated. It is difficult for readers to know how to judge the value of the intervention in relation to any given client population as a whole. A 'client population' could be "older adults with osteoarthritis," or "older adults who fall"; these groups can be very large! Before an intervention could be recommended for widespread adoption, clinicians would like to know how big an impact that intervention might have on the larger client population. To understand this, it is very helpful if researchers also calculate and report the *number needed to treat* (NNT).

The NNT represent the number of clients that would need to be treated before one treated client improves who would otherwise not have improved (without the treatment). For example, "How many clients would I have to treat to avoid discharging one person to LTC?" In the first study example above, 100 people received the intervention and 20 people who otherwise would have been discharged to LTC were discharged home instead. If we divide 100 by 20, that equals 5; we needed to treat 5 people for every one for whom we were able to improve the outcome. In the second study example above, 1000 people received the intervention and 20 people who otherwise would have been discharged to LTC were discharged home instead. If we divide 1000 by 20, that equals 500; we needed to treat 500 people for every one for whom the outcome was improved. In both study examples the RR value was 0.05, but if we also consider the NNT value, we have a much better understanding of the impact of the intervention on the client population as a whole. A high NNT

indicates that the intervention was less effective and more costly; a low NNT indicates the reverse.

Coming up in Part III: Confidence Intervals, Series Summary, Clinical Research Interpretation & Application Examples, & Quick Quiz. Stay tuned!

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WCPT Congress – Go International!

Lisa R. Dehner, PT, PhD, AGPT Liaison to IPTOP (USA)

Did you know there is an international physical therapy conference held every 2 years? I did not, in 2010, when I saw a call for presentations for a conference in Amsterdam. I made the fateful decision to develop a proposal (the worst they could say was no). This has developed into new treasured colleagues, broadened my view on physical therapy, and taught me more about being a physical therapist than really anything else (and that is coming from an academic). I hope this article gives those of you who have never heard of WCPT and its Congress the information you need to take a step (or leap!) into the World of Physical Therapy.

WCPT stands for World Confederation for Physical Therapy. WCPT was founded in 1951 and now represents over 450,000 physical therapists from 120 member countries.¹ The American Physical Therapy Association (APTA), representing therapists from the USA was a founding member of WCPT. All APTA members are WCPT members. WCPT has sub-groups for areas of specialty just like the sections of APTA. The

geriatric sub-group is the International association of Physical Therapists working with Older People (IPTOP).² All Academy of Geriatric Physical Therapy (AGPT) members are members of IPTOP. That's a lot of alphabet soup but the message is, you are already a member of 2 international organizations and may not have had a clue! I hope you take some time to visit the websites for WCPT and IPTOP listed in the references to learn more about your membership.

WCPT holds a Congress (conference) every 2 years. In the words of WCPT, "as the profession's leading global meeting" it is where the world of physical therapy meets.³ Past locations include Vancouver, Amsterdam, Cape Town, and Congress 2019 was held in Geneva this past May. President of WCPT, Emma Stokes, said "one of the joys of the Congress was the fact that, in one room, you could have physiotherapists from all over the world."⁴ The diversity of people and programming is really unparalleled. For me, and I hope a few of you in future,

it's incredibly exciting, challenging, and paradigm-changing. I love that the Congress has such different ways of presenting programming from what I'm used to in the US including discussion sessions, networking sessions and Indaba. A panel of experts *and* the audience discuss a particular topic in discussion sessions. Networking sessions are held on a huge range of topics (>30 at this Congress) that facilitate valuable connections with physical therapists across the world. "Over 80% of delegates report networking as one of the main benefits of attending a WCPT Congress."⁵ Indaba "is a meeting and inspiration zone within the exhibition hall...delegates may wander in and out of the Indaba space at any time, or gather on the perimeter, to listen to what is happening."⁶ The goal of Indaba is to bring people together and deemphasize the traditional speaker and audience format. One Indaba I attended had a lively discussion on promoting physical activity.

Other examples of great programming for a geriatric physical therapist were the focused symposia *Falls Around*

the World and *Physical Activity*. A team of speakers from different countries presented information around these topics over 1.5 hours. In the *Falls* session, the speakers highlighted that falls intervention needed to take into account local, geographical, and cultural differences to be effective. How do older adults really function in your area? For example, many older adults that I treat don't have good sidewalks or access to transportation for fitness. This lack of ready chances for physical activity would have to be taken into account along with the knowledge of effective evidence-based programs. The speakers emphasized it is important to get a broader scope from older adults living in different areas to better serve the health of all older adults, globally. From *Physical Activity*, I learned a lot about the successes of physiotherapists trying to increase physical activity in older adults around the world. The speakers were passionate that physiotherapists needed to go beyond treatment and be a force for change in policy, practice, and research.

Poster sessions are great at WCPT. I get a lot out of seeing what's up and coming, much like I do at CSM. I especially like the Rapid 5 format: each presenter has only 5 slides and 5 minutes to present their research. After the first 5 presenters finish, they move to a station where the audience can ask direct questions for about 25 minutes. Though the audience is often hesitant at first to get up and ask a question, after a few minutes people are milling around and there is a lot of great discussion. In one session, I had a great conversation with

a speaker about how older adults define physical self-sufficiency for themselves.

It has been 8 years since I tentatively called the powerhouse that is Jennifer Bottomley PT, MS PhD, former President of IPTOP, to inquire about the liaison position. I did not even know what IPTOP was. She drew me in, as she does everyone, with her passion for older adults. I knew I wanted to get involved internationally and so I took that doozy of a first step. I encourage anyone that thinks they may be interested in international connections, learning about how physical therapy (physiotherapy) is practiced in other countries, and improving the global health of older adults to take that tentative first step. There are so many places to begin your journey: Global Health for Aging Adults (GHAA) special interest group of AGPT⁷, IPTOP, reading resources on your interests from WCPT, and of course, attending the next Congress which will be April 8-10, 2021 in Dubai, UAE hosted by Emirates Physiotherapy Society.⁸

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2019 House of Delegates Update

Ellen R. Strunk, PT, MS

The 2019 session of the House of Delegates was held June 10-12, 2019, in Chicago, IL. I thought last year's agenda was packed with 58 main motions, but 2019 surpassed 2018 with 70! 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. As the AGPT's Delegate, I am serving on a subcommittee appointed to review the minutes, which will be done during the month of August. 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 on a House of Delegates "hub" that facilitates important and constructive conversations between all the component Delegates throughout the year. This process allows for informative deliberations about the merits of each motion. As delegate, I also participate in "Virtual Town Halls," a meeting of the Southern Caucus (determined by my home state) and collaborate with other Component delegates. Although the Sections do not have a vote in the House of Delegates, we do participate in both debate and discussions.

The 2019 House of Delegates began with an inspiring message from President, Sharon Dunn. She proposed that one of the biggest issues our profession needs to tackle is the cost of physical therapy education, calling it a *"crisis that is plaguing our present and threatening our future."* She pointed out the cost of a DPT degree is *"an almost insurmountable barrier that challenges the ability of recent graduates to achieve basic financial stability.....to participation in our association.....to increasing our*

profession's diversity." She challenged all members to use their individual voices – not just to advocate for better payment – but also to find ways to make education more affordable in our institutions, and at the state and federal levels.

This year, The Special Committee to Review House Documents (SCOHD) was again a busy group, finishing their charge to recommend consolidation, amendment, and/or repeal of House Documents that have been in existence for many years. In fact, over half of the RC's discussed in this year's House came from the SCOHD. All members of the Association owe a debt of gratitude to these individuals for volunteering so much of their time. Next time you see them, thank them! They were Alan Crothers, Babette Sanders, Blair Packard, Janet Bezner, Karl Gibson, Katherine Harris, and Kyle Covington.

The AGPT collaborated with the SCOHD on two motions to revise position documents to more contemporary language. They were RC13: The Role of Physical Therapy in Safe Patient Handling and RC18: Physical Therapy for Older Adults. Both motions passed the 2019 House of Delegates. I was also pleased to speak on behalf of all AGPT members on the floor of the House in support of RC65: Physical Therapy Inclusion in Medicare's Annual Wellness Visits. This motion charges the APTA to explore how physical therapists could be included in the Medicare Annual Wellness Visit (AMV). The AMV is a yearly appointment with a primary care provider to create or update a personalized prevention plan. The plan is not a head-to-toe physical, but it could help prevent illness based on the individual's current health and risk factors. There were other motions that garnered lively discussion on the floor and included RC6: Levels of Supervision, RC9:

Opposition to Physician Ownership of PT services, RC11: To Amend Principles and Objectives for the United States Health Care System, RC56: Position on Public Health Crisis of Firearms-Related Injuries and Deaths in The United States, RC 62: To Adopt a Position for Naloxone Availability Where Physical Therapist Services are Provided, and RC67: To Charge the APTA to provide Resources and Materials on Cannabis or Cannabis-Based Products for Health Related Conditions. More information about these and all the motions can be found on the AGPT website at: <https://geriatricspt.org/members/index.cfm?>.

A new area of specialization was approved! The creation of a sound management specialty area for certification by the American Board of Physical Therapy Specialties was proposed by the APTA Academy of Clinical Electrophysiology and Wound Management. It becomes the 10th area of physical therapist clinical specialization.

The APTA also elected new officers who took office at the close of the House. Kip Schick was elected as Secretary. Kyle Covington was elected Vice-Speaker of the House of Delegates. Carmen Cooper-Oguz, Deirdre "Dee" Daley, and Heather Jennings were all elected as new Directors. Two new Nominating Committee Members were elected as well, Carole "Carrie" Cunningham and V. "Kai" Kennedy.

As stated earlier, the official minutes of the House of Delegates's proceedings will be posted on the APTA's website in September. The 2020 House of Delegates is scheduled for June 1-3, 2020 in Phoenix, AZ. As your state begins to develop concepts for new motions in 2020, please feel free to share those issues with me, so the Academy can continue to engage all members.

GET LITerature

Bed Mobility: Interventions Take Skill!

Linda McAllister, PT, DPT; Carole Lewis, PT, DPT

How can we improve our patients' ability to move easily in bed? The ability to do so is an essential activity of daily living and requires skilled assessment and possibly intervention. Our previous article identified Alexander's taxonomy of movement patterns people use to roll from the supine to the sitting position. The patterns listed first in each category are the ones most commonly used.^{1,2}

Upper extremity categories

- Lift and reach below shoulder level
- Lift and reach above shoulder level
- Upper extremity push and reach
- Upper extremity push

Head and trunk categories

- Right pelvis aligned with right shoulder girdle
- Right pelvis leads
- Relationship between pelvis and shoulder girdle changes
- Right shoulder girdle leads

Lower extremity categories

- Bilateral lift
- Unilateral lift without a push
- Unilateral push
- Bilateral push

Rehabilitation specialists may use these categories to help identify a patient's movement pattern. A combination of therapeutic techniques can be used to enhance the patient's rolling pattern or even to adapt the patient's pattern to one that he or she can tolerate more easily.

In addition to determining causes contributing to limitations, such as range of motion, strength, or tone impairments, and working on these, there are several techniques that therapists can use at the level of activity identified by Alexander.^{1,2}

Perform:

1. Isolated trunk rotation to help initiate rotation on to the side for rolling in bed.
2. Multiple repetitions of supine neck rotation to initiate the phase of rolling over to the side of the bed.
3. Repetitions of supine arm reach to initiate the phase of rolling over to the side of the bed.
4. Repetitions of supine pelvic rotation to initiate the phase of rolling over to the side of the bed.
5. Combined neck rotation with trunk rotation to facilitate rolling on to the side.
6. Combined pelvic rotation with trunk rotation to facilitate rolling on to the side.

In another study by Alexander et al, participants demonstrated improvement at 12 weeks in bed mobility tasks with targeted resistance training that were based on the movement tasks. Nine tasks (arm reaching with trunk lift, lateral leg movement, unilateral heel raise, roll to side lying, side lying to sit, weight on hip and hold, trunk elevation by upper extremity extension, bridging, and supine to sit) were performed. Participants performed the tasks 3 times at a comfortable speed. If the task was too difficult, the therapist provided facilitation; if the task was too easy, the therapist provided resistance. Resistance was provided by either a weighted vest, ankle cuff weights, or weights on the abdomen. Weights by the end of the trial period progressed from 5 to 14 pounds.³

A progressive program for motor relearning, developed by Carr and Shepard, includes interesting strategies to enhance movement in bed.⁴⁻⁶ The program first identifies the essential movement components of specific

activities such as rolling in bed and then breaks up each activity into smaller tasks. Any component that is missing is then performed in isolation and once mastered is put into the entire movement pattern. To illustrate, the task of sitting up over the side of the bed has 3 essential components.

1. Lateralization of the head
2. Lateralization of the trunk
3. Getting the legs over the side of the bed

A therapist asks a patient to attempt to get up over the side of the bed and notices which of these activities is missing or inadequate. If for example, the patient attempts to get up but his or her the head stays in neutral, the therapist would prescribe an activity in which the patient lifts the head off of a pillow many times, for a few days in and out of therapy sessions. Once the patient had mastered the head component, one would be asked to attempt the task of sitting up over the side of the bed, but this time the patient would lateralize the head and complete the movement pattern.

A comprehensive bed mobility program includes stretching, strengthening, working on bed activities (eg, rocking, rolling, scooting), and progressing through movement patterns as noted in both techniques above. With comprehensive examination and intervention, this skilled approach can yield excellent outcomes.

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Global PT Day of Service October 2019

Lucy Jones, PT, DPT, MHA
Board Certified Geriatric Clinical Specialist
Certified Exercise Expert for Aging Adults
APTANJ Geri SIG Chair

There are many ways to make an impact in your local community.

Every year Global PT Day of Service (PTDOS) brings together thousands of volunteers from over 50 countries. Since its inception in 2012, Global PTDOS has grown exponentially with service projects occurring each year in countries all over the world, and in all 50 states across the United States. It gives us, the physical therapy community, the chance to lead and serve at the same time. Global PTDOS empowers local lead-

ers with a platform to serve, providing mentorship to those interested in creating sustainable service projects in their area, and the opportunity to financially contribute through sponsorship.

Whether we call ourselves "Physical Therapists" or "Physiotherapists," service embodies who we are, what we do, and how we act. Become a part of Global PT Day of Service as we join to make a positive difference in our world. Participation includes any community service activity. No mat-

ter where or how, we can positively impact change. It is a great way to engage your component membership, build a positive awareness of physical therapy presence in your local area.

In New Jersey, the GeriSIG of APTA New Jersey will participate at food banks at 3 locations throughout the state. The PTs, PTAs, students, and NJ AGPT State Advocates will be present to assist organizations with food distribution in low resource areas as seasons transition. Think about what your state can do! <http://ptdayofservice/signup>

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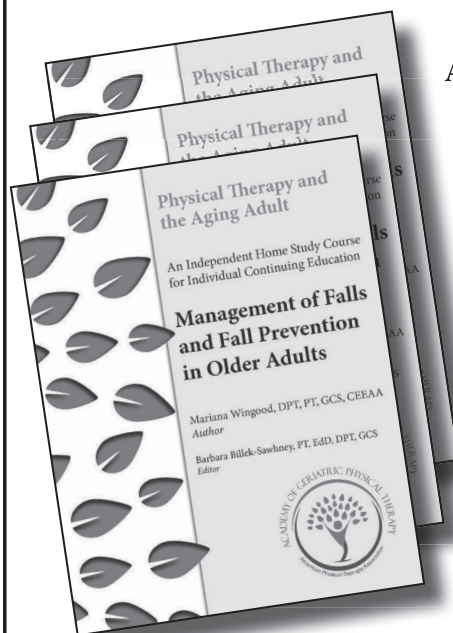
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