

GERI NOTES

SECTION ON GERIATRICS, AMERICAN PHYSICAL THERAPY ASSOCIATION

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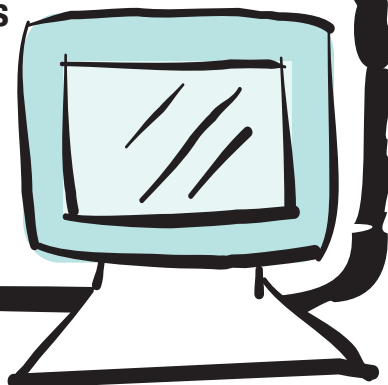
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PRESIDENT'S PERSPECTIVE: REVISED VIEW OF STUDENT CONCLAVE

John O. Barr, PT, PhD



Some of my closest and most progressive colleagues in the Section on Geriatrics will confirm that, at times, I can be a proverbial wet blanket to their creativity and enthusiasm. During the Christmas season, my family refers to this as the Barr-humbug affect...

Since the early 1990s, I had regarded APTA's National Student Conclave (NSC) as nothing more than a superficial commercial message for APTA membership. After all, since the mid-1980s I had been organizing and participating in affordable intrastate and inter-institutional regional annual 'conclaves' for PT students that featured national PT leaders, discussion of 'hot' contemporary professional topics, and healthy outdoor recreation.

So it was with a mixture of amusement and wonder that I regarded APTA's invitation to participate in the 2006 National Student Conclave in Dallas, Texas. Through a process of parallel invitations, I was paired with a Section member and State Advocate from the region to give three 90-minute presentations concerned with physical therapy in geriatrics. Since no one else had volunteered, I stepped forward to set-up, staff over 2 days, and tear-down the Section booth. This event was absolutely destined to fulfill my preconceptions.... However, almost from the instant of my arrival at the InterContinental Dallas Hotel, site of the Conclave, I came to realize that I'd never had a more inaccurate perspective about an APTA event...

This year's NSC attracted an impressive 1,707 registrants, including 1,366 student physical therapists and 195 student physical therapist assistants. Among 81 booths in the Exhibit Hall were a large number of employers, 10 component sections, and the Student

Assembly. The Conference Program booklet rivaled those for APTA's Annual Conference and the Combined Sections Meeting.

With good advanced planning, co-presenter Stella Bakarich, PT, MS, Rehabilitation Director at Alta Vista Regional Hospital in Las Vegas, New Mexico, and I crafted our talk "Maximizing Physical Therapy Services for Older Persons." This presentation is available in PDF format on our website (www.geriatricspt.org, then click on Education and National/APTA Section Meetings). We were both pleasantly surprised at the wonderful attendance at our sessions by attentive PT and PTA students who posed insightful questions. (And...based upon the loud applause from the adjacent meeting room...the presentations on Acute Care were also very well received.) At the Section booth, Stella and I talked with hundreds of students and fellow exhibitors about the Section on Geriatrics and its many member benefits. It was great to see outgoing Student Assembly Treasurer, Ben Braxley, PT, DPT, our Section's liaison, who stopped by the booth to update us on his work at Wesley Woods Geriatric Hospital, in Atlanta.

Most importantly, toward the end of the Conclave I attended a meeting of PT/PTA faculty and program directors who were concerned about facilitating

their students' participation in Conclave. I found it interesting that most of these folks already had significant numbers of students in attendance. On the other hand, no students from my program were participating this year... Various strategies for freeing up students from demanding curriculums for a couple developmental days and innovative funding schemes were openly shared. This proved to be the final evidence that my perspective on the National Student Conclave was in need of drastic revision!

In summary, I've come to believe that as we work to excite PT and PTA students about careers focused on working with aging and older individuals, we need to appreciate the role that the National Student Conclave can play as a venue for sharing our message about the Section on Geriatrics. Section members who are PT or PTA program faculty members should strive to make Conclave accessible as an important developmental experience for their students (along with state component meetings, CSM, and Annual Conference). Faculty and program alumni should work with their students to raise and mobilize financial resources so that Conclave attendance is affordable. Given my revised perspective, I plan to work with my own faculty colleagues at St. Ambrose University to achieve greater student involvement at the national level of our profession.



John Barr and Stella Bakarich, staffing booth, promote Section continuing education courses to a PT student at the National Student Conclave; photo courtesy of Norma H. Gonzales, PTA

Dr. Barr is a Professor in the Physical Therapy Department at St. Ambrose University, Davenport, Iowa. A previous member of the Section's Board of Directors, he serves on the editorial board of the Journal of Geriatric Physical Therapy.

***Education is the movement
from darkness to light.***

— Bloom

EDITOR'S NOTE

Find a Mentor, Be A Mentor

Carol Schunk, PT, PsyD



Residency is a topic that I try to include in *GeriNotes*. The Section has been a leader in development of residencies, one of the progressive directions of our profession. In this issue, the Meet the Leaders column features Greg Hartley who is on the Section Board of Directors and serves as the Section's Residency Chair. We are very fortunate to have a person like

Greg who is knowledgeable and passionate about residency and developed one of the first residencies in Geriatrics. Greg, like many of our leaders, had people who were mentors who encouraged him to go above and beyond.

Combined Sections Meeting is happening in Boston in February. The Section has a tremendous program for those of you who plan on attending. The entire program is in the back of this issue. Besides numerous educational sessions, there are many Section activities that are social. This is a tremendous opportunity to Meet the Leaders, one of which may turn out to be a mentor for you. Sometimes the term mentor is a bit daunting. One might think you have to be a star to be a mentor, but all you have to do is be friendly to someone. You might have some experience working with a specific group of patients or developing a program that would be new information for someone. Your interaction will be positive for both of you. There are many Section members who are in a position to mentor someone. There are many opportunities at Section activities to meet that person who is a first time attendee at CSM.

As I have mentioned in previous Editor's Notes, I always enjoy publishing articles from students or therapists in graduate school. There is so much work involved in writing a paper and the result is often a potential article that has great content for *GeriNotes*. I depend on professors to identify the student material that is appropriate for *GeriNotes*. Several months ago, Dr. Carole Lewis sent me 4 papers from a class she taught on patient advocacy. Two papers were too locally oriented to be of general interest but the other two will be great contributions. One is included in this issue, a very complete review of Advocacy Agencies for adults. I encourage all Section members who are educators or those who have gone back to school to always keep *GeriNotes* in mind for sharing student papers.

Recognition is the best motivator.
—Eakedale

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EFFECTS OF STRONG FOR LIFE EXERCISE PROGRAM ON FUNCTIONAL PERFORMANCE OF OLDER ADULTS

Analisa Kolb, SPT; Christine Valentine, SPT;

Shannon Williams, PT, MEd, FAAOMPT; Oren Renick, JD, MPH, FACHE

INTRODUCTION

In 1996, the Surgeon General's Report on Physical Activity and Health established the importance of a physically active lifestyle in the prevention of chronic disease and the promotion of health and well being.¹ Despite documentation of the physical and psychological benefits derived from regular activity, many adults do not engage in physical activity on a regular basis. Trends show that activity levels progressively decrease with age.¹

Adults aged 65 and older will soon be the fastest growing segment of the American population.² The growth can be attributed to the aging baby boomers and longer life expectancy. A baby boomer is someone born in a period of increased birth rates, such as those during the economic prosperity following World War II. In the United States, demographers have put the generation's birth years at 1946 to 1964.³

Older adults who are not active tend to suffer more from depression and declining health. Low levels of physical activity and lower extremity weakness have been identified as risk factors for functional status decline and falls.⁴ Few contraindications to exercise exist and almost all older persons can benefit from additional physical activity.⁵

Often, a motivating factor to begin an exercise program is a physician's or other health care provider's advice.^{5,6} For many older adults, starting an exercise program is a big change. The behavior change must be worth the investment of participating.⁶ Many view exercise as a recreational pursuit instead of necessary medical therapy.¹ Two of the more important factors involved in the adherence to an exercise program are the maintenance of health and social cohesiveness (exercise with others for similar reasons).⁷

Muscle strength is considered to be the most physiologically limiting factor of the older adult and a determinant

of their functional status.⁷ Research on strength training has consistently shown that older adults are capable of marked improvements. Strength gains may lead to improvements in functional capability, which is vital to the maintenance of community independence⁸ and quality of life.

Effective exercise intervention strategies are needed that can be widely disseminated to the older population in need of increased activity.⁵ An evidence-based older adult exercise program that improves function, is versatile, and inexpensive would have widespread beneficial implications for the growing population of older adults and the burdened health care system.

Given the growing proportion of older adults, the suboptimal levels of physical activity in the United States represents an increasing public-health problem.¹ Although exercise programs geared toward this population exist, their feasibility and compliance are questionable. The Strong for Life (SFL) senior exercise program was designed for use in an unsupervised home setting. Strong for Life is a video exercise program designed for older adults that consists of a 5-minute warm-up, 11 exercises consisting of sitting and standing using a TheraBand® for resistance, and a 5-minute cool down. The exercise video was created by Physical Therapists at Texas State University through a grant from Robert Wood Johnson Foundation in 2002. It is now a self sustaining program as part of the Service Learning programs. Two previous SFL studies by Jette et al^{9,10} acknowledged modest gains in strength and function due to the low level of supervision and lack of social contact. The potential for performance error and decreased adherence is a problem with an unsupervised home based exercise program.^{9,10}

The purpose of our study was to determine the effects of the SFL exercise program on the functional performance

of older adults, when performed in a group setting and supervised by trained volunteers, as measured by the Timed Up and Go test (TUG). This test is a measurement of functional mobility. Positive effects will provide evidence from which to base promotion of the SFL program to benefit community dwelling older adults.

METHODS

Design

This project was implemented using a quantitative research method with a quasi-experimental design. There was no control group or randomization of groups; Campbell and Stanley¹¹ refer to this as a pre-experimental design.

Subjects

The sample was one of convenience, consisting of male and female community dwelling older adults who regularly attended the San Marcos Senior Citizen's Center in San Marcos, Texas.

Procedures for Data Collection

Subjects were asked to participate on a voluntary basis. Informed consent was obtained by participants reading and signing the form, or having the form read to the participants in Spanish and a written copy was provided for them to sign. Information regarding subject profiles was gathered for descriptive data analysis. IRB approval was obtained through Texas State University. The SFL video was previewed and yellow Thera-Band® was measured for each subject in the first session. Measurement protocol specifies the band length to reach from the subject's nose to one extended arm length while facing forward. Then the band was tied onto Thera-Band® handles. The TUG was administered to participants in the second session. One student researcher timed all TUG tests while the other student researcher monitored participants and documented times. Additional participants

were timed in the third session by the other student researcher. After TUG measurements, participants practiced the SFL exercises with the assistance of the student researchers. The SFL program includes a warm-up, 11 strengthening exercises using Thera-Band®, and a cool down.

All exercise sessions were conducted in a group setting at the San Marcos Senior Citizen Center. Exercises were demonstrated and supervised by trained student researchers at every session. Student researchers provided verbal and tactile correction to subjects in order to perform proper exercise techniques. Students learned basic Spanish phrases that assisted with exercise instructions. The program began on the fourth session and continued 3 times per week (Monday, Wednesday, and Friday) for 9 weeks during the time period of 12:30 p.m. to 1:00 p.m. Data collection occurred between February 6 and April 17, 2006.

As mentioned, 2 previous SFL studies by Jette et al^{9,10} administered the program in a home setting. These studies acknowledged modest gains in strength and function due to the low level of supervision and lack of social contact. Our study was conducted in a supervised group setting due to the potential for performance error and decreased adherence. These discrepancies have been found to be a problem with unsupervised home based exercise programs.¹²

Instrumentation

The Timed Up and Go test is an objective tool to assess functional mobility and was developed by Diane Podsiadlo. The patient's physical mobility was tested by asking them to rise from a chair, walk forward 10 feet (3 meters) to a line on the floor, turn around, return to starting spot, and sit again.¹³

The research on this instrument has shown that it has high intra-rater (ICC 0.99) and inter-rater (ICC 0.99) reliability.¹³ The study conducted by Nilsagård¹⁴ confirmed the high reliability and validity of the TUG test for older people.

Equipment consisted of the SFL exercise video, VCR, TV, subject profile form, subject informed consent, subject roster, pens, stop watch, tape, tape measure, scissors, Thera-Band®, Thera-Band® handles, chairs, computer, SPSS statisti-

cal software, and student researchers/instructors.

Data Analysis

Results of the study were analyzed and recorded on the SPSS program. Frequency measure descriptive statistics were used to compile information gathered from the subject profile and the pre- and post-TUG measures. Paired t-test inferential statistics were used for the group of subjects having 2 different TUG measures, before and after the SFL exercise program. Comparison was made with the single-group test-retest design to determine if there was any difference in the time taken to perform the test.

RESULTS

A convenient sample of 12 older adults attending the San Marcos Senior Citizen's Center participated in the SFL study. The sample consisted of 2 males and 10 females. The mean age was 81.3 years and ranged from 66 to 92 years (Table 1).

Paired t-test inferential statistics were used for the group of subjects to determine the difference between TUG data gathered before and after the 9-week intervention. The significance level to support the directional hypothesis was set at an alpha level of .025.

The TUG pretest time for the 12 subjects ranged from 9.2 to 17.3 seconds, with a mean time of 11.7 seconds. The TUG posttest time ranged from 7.4 to 11.6 seconds with a mean time of 9.1 (Table 2). The decrease in TUG time ranged from 1.7 to 5.7 seconds.

The mean time for the posttest was less than that of the pretest with a resulting probability of .0015 (Figure 1).

DISCUSSION

Our results demonstrated that when SFL is performed in a supervised group setting TUG times decrease, indicating improvement in functional performance. The outcomes of our study are clinically significant and applicable to a broader population of older adults.

Our study contributes to a larger body of work regarding the benefits of physical activity in older adults. SFL challenges the trend of age related decline in physical activity and its associated adverse side effects. Cable et al¹⁵

found that age related changes can be reversed by increasing levels of physical activity. Continued exercise will result in healthier lifestyles and reduced need for medical care.¹⁶

Motivation and adherence are barriers to exercise with older adults. Barriers may be overcome and fitness achieved, by older adults increasing their confidence.¹⁵ Also, compliance can improve when a program meets the criteria of affordability, access, and convenience. Our study showed that SFL, in a supervised group setting, can be implemented at a low cost using existing services and facilities in the community where it can be transferred to other settings.

Schutzer and Graves¹ found a significant relationship between social support and exercise adherence. A sense of belonging to something special may also motivate older adults to maintain their participation in an exercise program. One of the advantages of a group exercise program is that it provides a recreational activity as well as therapeutic benefits.^{9,10} Another advantage is group cohesiveness. In an investigation involving 2 separate studies focused on group cohesion, perceptions of similarity, and closeness within the group predicted both short- and long-term adherence.^{1,7} We believe that these factors contributed toward a decreased TUG time for each individual in our study.

Some individuals are capable of setting goals and achieving them. Others learn by observing the actions of others and imitating that behavior. Strong for Life in a group setting provides the opportunity for older adults to improve their performance by observing the other participants.

Miller and Iris¹⁷ determined that socialization and social support are fundamental to participation in programs, as well as interpersonal engagement. They found flexibility in structure contribute to older adults' sense of control over their health; such as allowing for modifications to exercise routines.¹⁷ These modifications become increasingly important as older adults become frail. Rubenstein et al¹⁸ concluded that older adults with chronic impairments and risk factors for falls can safely participate in structured group exercise. Improvements in endurance, strength, gait, and function can also be accomplished.¹⁸

Table 1. Age and Gender Distribution

Age	Years	Gender	Percent
Mean	81.3	Female	83.3%
SD	7.5	Male	16.7%
Range	26		
Minimum	66		
Maximum	92		

Table 2. Pretest and Posttest Times

TUG Times	Pretest (Seconds)	Posttest (Seconds)
Mean	11.7	9.1
SD	2.5	1.2
Range	8.1	4.2
Minimum	9.2	7.4
Maximum	17.3	11.7

Since SFL is a program designed by physical therapists for older adults and is scalable in difficulty allowing modifications for different strength and functional levels, it facilitates older adults' sense of control. However, being a home-based program by design takes away the socialization and increases risk through lack of supervision. Within our study, supervision in the group setting assured that exercises were performed correctly. As discovered by Page,¹⁹ positioning during exercise is essential for appropriate muscle activation. Our SFL instructors advised participants on proper progression of sets, repetitions, and resistance. We found that supervision provided by the instructors during exercises was especially important for safety precautions.

The tool used to assess functional mobility in the older adults was the

Timed Up and Go test due to its high reliability and validity, and ease of administration. Podsiadlo¹³ found that the TUG has both inter-rater (ICC 0.99) and intra-rater (ICC 0.99) reliability and validity. Nilsagård¹⁴ confirmed the high reliability and validity of the Timed Up and Go test for older people. Siggeirs-dóttir¹⁵ also found inter-rater reliability of the time-scoring of the TUG test. The TUG test required minimal training to administer, was easy to score, was quick to perform, and required only a standard chair and watch with a second hand.

Older adults who are able to complete the test in less than 20 seconds have been shown to be independent in transfer tasks involved in activities of daily living (as tested by the Barthel Index of ADL), have high scores on the Berg Balance Scale, and walk at gait speeds (as tested by the Gait Speed Test) that should be

sufficient for community mobility (0.5 m/s).¹³ As a descriptive tool, the TUG test provides information about the patient's level of functional capacity.¹³ Schumway-Cook¹⁶ found this test to be a sensitive and specific predictor for falls occurring in community-dwelling older adults with no known neurological diseases.

In 1996 and 1998 SFL studies by Jette et al^{9,10} were conducted to determine the effectiveness of the in-home exercise program. The first study acknowledged less than expected strength gains and variability in adherence due to the low level of supervision, which only consisted of periodic follow-up phone calls by a physical therapist.⁹ The second study used a motivational videotape to encourage participation by providing a perception of social contact in addition to the periodic phone calls by the monitoring therapist.¹⁷ This study also showed modest gains in strength and function. Our study showed significant improvement in TUG times after 9 weeks of SFL in a supervised group setting, indicating increased functional mobility. These results suggest that SFL may be more effective at improving functional performance of older adults when performed in a supervised group setting versus a home setting.

Currently, there are no other SFL studies performed in a supervised group setting for comparison of our results.

There were several limitations of our study. First, there was no control group which prevented a true experimental

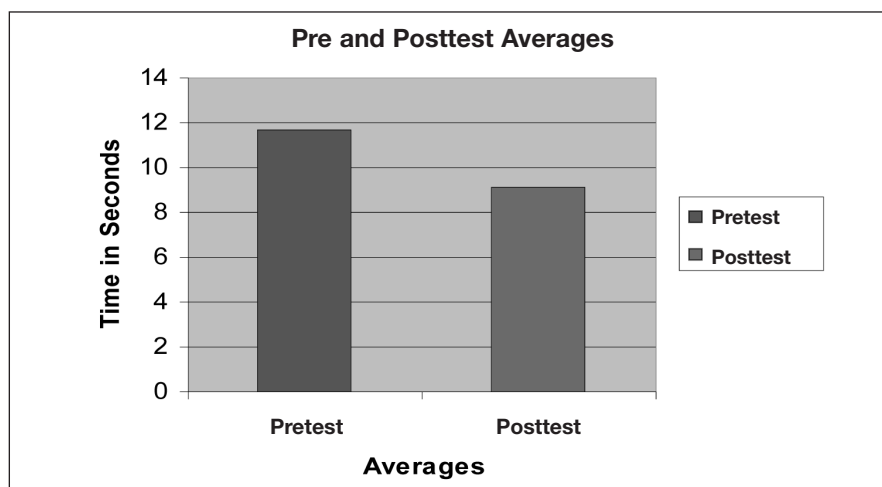


Figure 1. Pretest and posttest averages.

study from being performed. Second, there was a small sample size with no randomization, limiting our ability to generalize to the larger population. A potential third limitation of our study was the limited communication between the student researchers and primarily Spanish speaking participants. This prevented detailed instruction, resulting in reliance on tactile cues for appropriate exercise technique; regardless, all participants showed improvement in their TUG times.

Suggestions for further study include having more subjects, a bilingual instructor, a control group, and randomization of groups. Additional testing, such as the Tinetti Assessment Tool for gait and balance, ROM and MMT for movement and strength, and SF-36 for overall well-being, all of which could help provide more comprehensive results.

CONCLUSION

Our results suggest that the SFL program, in a supervised community based group setting, increases the functional mobility of older adults as evidenced by decreased TUG times of all participants. These findings are in contrast to previous SFL studies which showed modest gains in strength and function. Our study indicates a more effective exercise program for older adults, contrary to SFL being performed in a home setting where there is potential for performance error and decreased adherence. Further research is needed to substantiate our favorable results.

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Shannon Williams graduated from Physical Therapy School in 1992 from Texas State University, received her Masters in Education in 1998 from Texas State University, and is currently Program Director for Strong for Life, as well as an Orthopaedic specialist in the field of Physical Therapy and a Fellow of the American Academy of Manual Physical Therapists (FAAOMPT).



Oren Renick, JD, MPH, ThM, FACHE, Professor and Chair, Department of Health Administration, Texas State University has served as Chair and Vice Chair of the Faculty Senate and as Vice Chair of the Interfaith Caregivers Alliance. Oren has been selected to present the annual Presidential Seminar, chosen Faculty of the Year and Teacher of the Year in the College of Health Professions. A frequent contributor to professional journals and presenter at professional conferences, his major scholarly interests are civil rights, civic engagement, continuous quality improvement, managed care, health care law and ethics, and baseball and American culture.

RHEUMATOID ARTHRITIS: SYSTEM INVOLVEMENT AND EFFECTS OF HIGH INTENSITY EXERCISE

Kimberly A. Steinbarger, PT, MHS

Rheumatoid arthritis (RA) is a systemic, chronic, autoimmune disease, the effects of which vary widely across the population. The most commonly listed symptoms of this disease include pain, stiffness, joint swelling, fatigue, weakness, low grade fever, and anorexia.¹ Just as the symptoms and severity of the disease vary, so do the treatments. Medications, such as nonsteroidal anti-inflammatory drugs (NSAIDs), disease modifying anti rheumatic drugs (DMARDs), and corticosteroids are used in an attempt to control the rampant inflammation, decrease the patients' symptoms, and improve or maintain the patients' functional mobility. As a treatment, exercise, especially high intensity exercise, was historically discouraged, as it was thought to increase the destruction of joints already weakened by this disease. However, in light of the increasing evidence of the enormous benefits of exercise in the general population of all age groups, many studies have examined the effects of exercise on patients with rheumatoid arthritis. The purpose of this review is to discuss the articular and extra-articular changes caused by rheumatoid arthritis on the body, and the effects of several types of exercise on those changes.

ARTICULAR EFFECTS

The effects of RA on the body are divided into 2 categories, articular and extraarticular. The initial and more common changes are the articular effects. Even though the precipitating factor of RA is not known, the first symptoms are inflammation of the synovium, most often symmetrical, of one or more joints. The small joints of the hands and feet, wrists, and ankles are most commonly affected. As the synovial inflammation continues, the synovial tissue becomes hypertrophic, taking up more space in the joint, causing swelling and a decrease of the arrival and distribution of nutrients to the joint. After this stage, granulation tissue, called a

pannus, forms within the joint, which encourages erosion of the periarticular cartilage and bone cartilage. During this active phase of the disease, autoantibodies concentrate in the joint, causing further destruction by degrading collagen.² The result is a painful, swollen, 'hot' joint. These changes often lead to decreased range of motion in the affected joint, articular deformity, and decreased functional mobility of the limb overall.³

Other than gentle range of motion activities, exercise has been historically discouraged for joints affected by RA. However, recent studies indicate that more vigorous exercise can be beneficial in the treatment of individuals with this disorder. For example, as the hand is one of the most common areas affected by RA, several studies have investigated the effects of various types of exercise in this area. Buljina et al⁴ studied the effects of physical therapy (modalities and exercise) on the rheumatoid hand. The experimental group of 50 subjects received physical therapy treatment that included modalities plus 20 to 30 minutes of range of motion (ROM) activities and resisted putty exercises. This group demonstrated significant improvement in pain, joint tenderness, activities of daily living (ADL) scores, and joint ROM. The study authors credited the exercises as the main factor in the improvement.

Aerobic Exercise

Other studies have focused on the effects of aerobic exercise on RA symptoms. Harkcom et al⁵ found decreased joint pain, decreased joint counts, and increased ability to complete ADL in 20 subjects who participated in low intensity aerobic exercise. For this study, low intensity aerobic exercise was defined as 15 to 35 minutes at 70% of the subject's maximum heart rate on the lower extremity ergometer 3 times per week for 12 weeks. A study by Semble et al⁶ recommended aerobic exercise for patients

with RA and osteoarthritis (OA) at 50% to 70% of the maximum heart rate.

Radiologic Changes

While the previous studies demonstrated functional joint improvements with the use of exercise, they did not address the concern that the exercise could be damaging to the joint surfaces. However, a study of 281 subjects by De Jong et al⁷ found that long-term, high intensity exercise did not increase large joint damage in patients with RA, as demonstrated by pre- and postexercise bone mineral density scans of the hips and spine. The only possible exception was in subjects with severe baseline damage. High intensity exercise did not mean high impact, but whole body exercise performed to the point of tiredness, as opposed to conventional range of motion exercises performed joint by joint. The subjects participated in the "RA patients in training" (RAPIT) program twice a week for 75 minutes each session. The RAPIT program consisted of bicycle training, an exercise circuit, and participation in a sport or game (badminton, volleyball, basketball, etc.) for 20 minutes each, accompanied by the appropriate warm up and cool down activities. Another study by Stenstrom⁸ also found no relationship between radiologic progression of joint destruction and exercise frequency in patients with RA. This research supported the conclusion that exercise, both high intensity and joint specific, benefited the articular effects of RA without increasing joint destruction.

EXTRA-ARTICULAR EFFECTS

The second category of RA effects includes the extra-articular changes. These effects alter many body systems in several ways, but the one commonality is the presence of mononuclear cell infiltrate with fibrinoid necrosis and nodule formation.² Several secondary effects, while they are not altered by exercise, may necessitate modifications to

exercise programs to decrease the risk of injury. Examples of these effects include changes in the skin, eyes, gastrointestinal, renal, skeletal, muscular, cardiac, and respiratory systems.¹

In the skin, rheumatoid nodules can form in the subcutaneous tissue. These nodules are associated with advanced disease, and generally form over areas of pressure. Common sites of formation include the extensor surface of the forearm and the achilles tendon. These nodules can be painful; therefore, care should be taken to avoid pressure over these areas during therapy or exercise.¹

Ocular effects include the development of Sjogren's syndrome, which causes dry eyes and mouth. If untreated, this can lead to mouth sores and visual complications. Another less common ocular effect is scleritis, which can also be a danger to vision, as the inflammation can rupture the sclera, permanently damaging the eye. In patients with visual deficits, written exercise programs should be in large print with enlarged and clear illustrations. Visual deficits can also make it difficult to participate in a group aerobic exercise program if it is offered in a crowded or cluttered room. To decrease the risk of falls, the exercises should be completed in a wide open space with adequate lighting.⁹

There are few documented gastrointestinal, renal, or nervous system complications related to RA; however, these systems are often affected adversely by the medications taken to control or suppress the disease, or by secondary effects resulting from other disease damage. For example, gastritis and peptic ulcer formation are associated with NSAID use. Neurological deficits are secondary to other disease consequences. Cervical spine instability and peripheral nerve entrapment can cause neurological symptoms. Vasculitis in the small arteries can result in mononeuritis multiplex, which gives rise to peripheral neuropathy.² Therefore, patients with RA should be questioned about any major medication or disease side-effects prior to beginning an exercise program to determine if any modifications need to be made.

SKELETAL SYSTEM

Patients with RA are especially vulnerable to osteoporosis due to the use of steroids, joint damage from the disease, and a decrease in physical activ-

ity. In the past, many patients were instructed by their health care providers to rest affected joints, which exacerbated the skeletal complications of the disease. However, some research has demonstrated the beneficial effects of specific types of exercise on bone health. De Jong et al¹⁰ investigated the effects of high intensity, weight-bearing exercise on bone loss in patients with RA. Subjects in the exercise group participated in a group exercise program that consisted of bicycle training, circuit training, and a sport or game, for a total of 1 hour 15 minutes twice weekly for 2 years. The subjects who participated in the exercises demonstrated slower rates of bone loss in the hip than the control group. While many studies agree that high intensity exercise, as long as it is not high impact, does not increase the progression of bone destruction, several studies, such as Hansen et al,¹¹ found no difference in bone loss between exercise and control groups. More research needs to be completed in this area in order to arrive at a supported conclusion.

MUSCULAR SYSTEM

The muscular system is another area that is adversely affected by RA. Joint pain and fatigue inhibit physical activity, causing an overall decrease in muscle strength and function in patients with RA. The long term effects include both muscle wasting and a decrease in ADL ability. However, research has demonstrated that physical activity can prevent some of these sequelae. Stenstrom et al¹² instructed 11 females with RA in a daily 30-minute exercise program. This program included 15 minutes of strengthening, stretching, or extremity mobility and 15 minutes of low impact aerobic activity, such as biking or walking. The subjects were tracked for 4 weeks. Results indicated that subjects demonstrated an increase in muscle function as measured by the Index of Muscle Function, grip strength, and upper extremity lifting activities.

A review by Kettunen and Kujala¹³ on the effects of exercise therapy on aerobic capacity, muscle strength, and function of individuals with RA and OA concluded that, "Exercise therapy would appear to be effective at increasing aerobic capacity and muscle strength in patients with RA, and no detrimental effects on disease activity or pain com-

pared with controls has been observed." This research supported the use of high intensity exercise for the purpose of improving muscular strength and function in patients with RA. It was also stressed that this patient population is to avoid any exercise that involves high impact, high load activities, or a rapid progression of difficulty, both of which increase the risk of injury.^{5,7,10,13}

CARDIORESPIRATORY SYSTEM

On autopsy, the majority of patients with RA show alterations in the respiratory system, such as interstitial lung disease, with the presence of pulmonary fibrosis and nodule formation. Episodic pleurisy, another consequence of RA, will also affect a patient's respiratory function.³ Mortality from pulmonary disease in this group is twice that of the general population.² In addition, some patients have their mobility so impaired by the joint changes that the respiratory problems are never detected given that the system is never taxed to the point of causing clinical symptoms.

Cardiovascular consequences of RA include pericardial effusion, found in 50% of patients with RA. The effusion is often asymptomatic unless it progresses to chronic constrictive pericarditis, which is rare. Rheumatoid nodules can also form in the myocardium and valve leaflets. The small vessels of the vascular system can become inflamed, but the more serious complication is in a form of aortitis, which can lead to aortic insufficiency or aneurysmal rupture.²

Because the cardiac and respiratory complications of RA can be severe, and are within the top 5 causes of death in this population,² several studies have examined the effect of high intensity exercise on aerobic capacity. The majority of the literature reviewed was in agreement that aerobic exercise programs can produce an increase in aerobic functioning in patients with RA, without detrimental effects on their disease activity, pain, or bone health. For example, Harkom et al⁵ instructed 20 women with RA in 1 of 3 low-impact aerobic exercise programs using a bicycle ergometer. The subjects participated in the program for 12 weeks, 3 times a week. The programs varied in length, each being 15, 25, or 35 minutes long. The authors found that all of the subjects showed improved aerobic capacity and exercise time after

12 weeks. They concluded that up to 35 minutes of aerobic exercise appeared most effective, but that more severely limited patients could benefit from as little as 15 minutes of exercise 3 times a week. Another study by Noreau et al¹⁴ used a 12 week, 2 times a week, dance-based aerobic exercise program, along with patient education, to demonstrate a 13% increase in aerobic power (Vo2 max) in individuals with RA who were in the exercise group.

SUMMARY AND RECOMMENDATIONS

In summary, research literature demonstrates that articular and extra-articular consequences of RA most affected by exercise include the joints, skeletal system, muscular system, respiratory system, and cardiac system. Current research supports the use of a high intensity exercise program that is a combination of strength training and some form of low impact aerobic activity, such as biking, walking, swimming, sports, or dance. Exercise duration and intensity recommendations ranged from 15 minutes to 75 minutes at 50% to 70% of the maximum heart rate, and frequency ranged from 2 times a week to daily. In general, the shorter durations were paired with higher frequencies, resulting in totals of 105 to 150 minutes of exercise per week.

Other recommendations included precautions to be followed before, during, and after exercise with this population. A complete assessment of strength, flexibility, and cardiac function should be completed in order to evaluate the patients' abilities, goals, and risk factors.¹ Patients need to be trained to recognize the symptoms of an acute joint flare, so that the exercise to that area can be decreased to gentle ROM activities until the flare subsides. Acute joint pain, vague pain lasting more than 2 hours post exercise, undue fatigue, increased weakness, increased swelling, and decreased ROM all require exercise modification to decrease the risk of injury.¹⁵

While more research was needed in some areas, such as specifics regarding exercise duration and frequency and the relationship of exercise to bone density and disease activity, several trends were apparent. Range of motion exercise was linked to improvements in joint func-

tion and movement in the rheumatoid hand. Patients with RA who participated in high intensity, low impact exercise programs demonstrated increased range of motion, decreased pain, increased muscle strength and function, and increased aerobic capacity. Several studies also reported enhancements in subjects' ADL function, mood, and life satisfaction.^{5,6,10,12} Others recommended supervised or group exercise, both for the social benefits as well as the improved compliance to the prescribed program.^{1,16,17} In conclusion, current research supports the use and benefit of high intensity exercise in the treatment of patients with RA without the danger of causing increased joint damage or pain.

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LIST OF ADVOCACY AGENCIES FOR OLDER ADULTS WITH NEUROLOGICAL DEFICITS

ShaLynn Smith, MS, MPT, GTC

INTRODUCTION

The following article is a final student project from a University of Maryland DSci program on-line course taught by Past Section on Geriatric President, Dr. Carole Lewis. The course was a follow up to her Clinical Geriatric Neurology Course. In designing this course, Carole worked with Dr. Fran Huber and together they decided to identify skills that a master clinician and advance degree therapist should have in the realm of clinical geriatric neurology. One skill identified was expert witnessing and advocacy. Students were asked to identify advocacy agencies for patients with neurological deficits and to develop a consumer piece based on the information they gathered. We appreciate Dr. Lewis and her students' willingness to share their work with readers who may be interested in our professional role as advocates for seniors.

AGING

- **The American Geriatrics Society (AGS)** is the premier professional organization of health care providers dedicated to improving the health and well-being of all older adults. With an active membership of over 6,000 health care professionals, the AGS has a long history of effecting change in the provision of health care for older adults. Anyone with an interest in geriatric health care is welcome to join the American Geriatrics Society. Current membership is comprised primarily of geriatrics health care professionals, including physicians, nurses, researchers, medical educators, pharmacists, physician assistants, social workers, physical therapists, health care administrators, and others. As the primary organization representing geriatric health care today, the Society provides leadership for health care professionals, policymakers, and the public. To ensure the provision of quality health care to older persons, the AGS develops, implements, and supports programs in patient

care, research, professional education, public policy, and public education.

- **American Association of Retired Persons (AARP)** is the nation's leading organization for people age 50 and older. It serves their needs and interests through information and education, advocacy, and community services provided by a network of local chapters and experienced volunteers throughout the country. The organization also offers members a wide range of special benefits and services, including Modern Maturity magazine and the monthly bulletin.

- **The National Institute on Aging (NIA)** was established in 1974 to conduct and support biomedical, social, and behavioral research and training relating to the aging process, and the diseases and other special problems and needs of the aged. The Institute provides for the study of biomedical, psychological, social, educational, and economic aspects of aging through in-house research conducted at its Gerontology Research Center in Baltimore, Maryland, and through grant support of extramural and collaborative research programs at universities, hospitals, medical centers, and nonprofit institutions throughout the country. NIA also provides support to institutions training scientists for research careers in aging.

- The independent, not-for-profit **Alliance for Aging Research** was founded in 1986 to promote medical research into human aging. Since then, the Alliance has grown to become the nation's leading citizen advocacy organization for improving the health and independence of older Americans through public and private research. The Washington D.C.-based Alliance is also recognized for promoting healthy aging among Americans of all ages.

- **The National Association of Area Agencies on Aging (N4A)** is a private, nonprofit organization that represents the interests of approximately 665 Area Agencies on Aging and more than 2330 title VI Native American aging programs across the nation in dealing with the Congress, the Administration, and other national organizations. It provides leadership to the member Area Agencies by providing technical assistance, materials, information, and training. It encourages cooperation between the public and private sectors in serving the elderly. It serves as a clearinghouse for the exchange of information on programs, legislation, and resources in the private sector.

- Founded in 1950, **The National Council on the Aging (NCA)** is the nation's first charitable organization to serve as a national voice and powerful advocate on behalf of older Americans. NCOA is an innovator, developing programs such as BenefitsCheckUp, Foster Grandparents, and Family Friends. NCOA is an activator, working with thousands of its community organization members nationwide to provide needed services to older people. NCOA is a private, nonprofit association of some 3,500 member organizations and individuals that include senior centers, area agencies on aging, employment services, congregate meal sites, faith congregation's health centers, and senior housing. NCOA also includes a network of more than 17,000 organizations and individuals including its members, professionals and volunteers, service providers, consumer groups, businesses, government agencies, religious groups, and voluntary organizations.

MENTAL HEALTH/HOSPICE

- **The American Association for Geriatric Psychiatry (AAGP)** is a national, nonprofit organization dedicated to

promoting the mental health and well-being of older people and improving the care of those with late-life mental disorders. AAGP's mission is to enhance the knowledge base and standard of practice in geriatric psychiatry through education and research and to advocate for meeting the mental health needs of older Americans.

- Created in 2005 by the unification of **Compassion In Dying and End-of-Life Choices**, Compassion & Choices supports, educates and advocates for choice and care at the end of life. As the oldest and largest choice-in-dying organization in the country, Compassion & Choices has more than 25 years of experience in advocacy and service. Their Client Support Program serves individuals, families and others who may be facing the end of life or planning ahead. These services include: support and counsel; local referrals to pain specialists, hospice programs, social service agencies, disease-specific support groups and others; assistance in completing living will/advance directive and in talking to families, friends, and health care providers about health care wishes; and advocacy for people in nursing homes or who are receiving inadequate care.

- **Caring Connections**, a program of the **National Hospice and Palliative Care Organization (NHPCO)**, is a national consumer engagement initiative to improve care at the end of life, supported by a grant from The Robert Wood Johnson Foundation. Caring Connections provides free resources, information, and motivation for actively learning about end-of-life resources; promotes awareness of and engagement in efforts to increase access to quality end-of-life care; helps people connect with the resources they need, when they need them; and brings together community, state and national partners working to improve end-of-life care.

ALZHEIMER'S DISEASE AND DEMENTIA

- The **Alzheimer's Disease Education and Referral (ADEAR) Center** is a service of the federal government's National Institute on Aging (NIA), one of

the National Institutes of Health. The Center provides accurate, up-to-date information about Alzheimer's disease (AD) and related disorders to patients and their families, caregivers, health care providers, and the public. The center operates a toll-free information and referral line, 1-800-438-4380, 8:30 a.m. to 5:00 p.m. Eastern Time, Monday through Friday. Callers can get answers to basic questions about AD, care giving, research findings, and treatment studies; free publications; and referrals to other organizations for additional information and services. Information seekers can also visit the ADEAR Web site at www.alzheimers.org, or e-mail the center at adear@alzheimers.org.

- The **Alzheimer's Disease Research Center (ADRC)** is a program of research at the Johns Hopkins University School of Medicine. Supported by a major grant from the National Institute on Aging, the ADRC seeks to discover the causes of Alzheimer's disease (AD), effective treatments, and ways to help those afflicted with the disease and their families.

- The **Alzheimer's Association** is a nonprofit organization founded in 1980 to heighten public awareness of this degenerative brain disorder, provide support for patients and their families, aid research efforts, and advocate for legislation that responds to the needs of patients and family members of Alzheimer's Disease. The network includes more than 100 chapters and 1,800 support groups across the country. The Alzheimer's Association also maintains a toll-free 24-hour information and referral telephone number which provides information packets and referral to the nearest Association chapter. The Green-Field Library provides standard library services.

PARKINSON'S DISEASE, TREMORS AND OTHER MOVEMENT DISORDERS

- The **Dystonia Medical Research Foundation (DMRF)** is a tax exempt organization, incorporated in 1976, created to increase awareness and understanding of Dystonia among doctors

and researchers and to spark innovative exploratory research projects directed at finding the causes of Dystonia and related disorders. These disorders are characterized by loss of voluntary control over body posture and movement. To date, the DMRF has supported over 400 Dystonia specific research grants, totaling over \$20 million. The DMRF supports workshops, doctor-patient education, and research grants. The Foundation has over 60 chapters and support groups located throughout the United States and Canada and can supply referrals for local treatment. The DMRF is supported by donations from individuals, corporations, and foundations. The Foundation deals with all forms of dystonia.

- The **Bachmann-Strauss Dystonia and Parkinson Foundation (BSDPF)** is a nonprofit organization established to find better treatments and cures for the movement disorders Dystonia and Parkinson's disease. The goals of BSDPF are to (1) raise funds to support advanced medical research of Dystonia and Parkinson's disease, (2) educate patients and the medical community about the most recent advances in treatment and research, and (3) increase awareness of Dystonia and Parkinson's disease among the general public and the medical community. BSDPF supports research and provides treatment. BSDPF also promotes patient and medical education by providing annual patient symposia focus on Dystonia and Parkinson's diseases.

- The **Huntington's Disease Society of America (HDSA)** is an organization of over 30 chapters and affiliates nationwide. The Society provides written and audiovisual materials pertaining to all aspects of Huntington's disease; information and referral to local support groups, chapter social workers, physicians, nursing homes, and a variety of other resources via local representatives; support for research into the causes, treatment and cure of Huntington's disease.

- The **International Essential Tremor Foundation (IETF)** is an international

nonprofit organization; its priorities are patient services and education, public awareness of tremor disorders, and support of research in tremor disorders. IETF has begun a program of educational symposia for patients and families. These take the format of experts addressing lay audiences in the field of tremor research and clinical care. Funds raised over operating costs are used to support neurologic research.

- The **Parkinson's Disease Foundation (PDF)**, founded in 1957, is a leading national presence in Parkinson's disease research, patient education and public advocacy. PDF is working for the nearly one million people in the US living with Parkinson's by funding promising scientific research and supporting people with Parkinson's, their families, and caregivers through educational programs and support services.

- The **National Parkinson Foundation (NPF)**, founded in 1957, provides answers to patients and their families on problems relating to Parkinson's disease and maintains the Bob Hope National Parkinson Research and Rehabilitation Institute, devoted to the diagnosis, treatment, and rehabilitation of Parkinsonism. Physical, speech, and occupational therapies are available at the Institute on an outpatient basis. NPF also conducts research in the cause and possible cure of the disease. NPF sponsors a variety of educational programs, including a national awareness program designed to explain the workings of the Institute and to help the public understand the nature of Parkinson's disease. Its toll-free number is for information on the disease, publications, and physician referrals.

SENSORY DISORDERS

- The **American Tinnitus Association (ATA)** is committed to a cure. ATA provides funding for tinnitus research. In addition, the ATA provides information about tinnitus and maintains listings of hearing healthcare professionals. ATA self-help groups serve most major U.S. population areas. The Association also sponsors workshops for hearing professionals. Public education includes information about prevention and treatments for tinnitus.

- The **Center for the Partially Sighted (CPS)** offers rehabilitative services to the partially sighted, of all ages, including the legally blind. Services include low vision evaluations, prescription of visual aids and training in their use, orientation and mobility training to improve daily functioning, community referrals, psychological counseling, peer counseling, follow-up visits, support groups, outreach programs, presentations to community groups, referrals to low vision specialists nationwide, independent living skills-group and private, diabetes education support group, HIV and vision loss education support group, and boundary-limited transportation program.

- The **Vestibular Disorders Association (VEDA)**, formerly the Dizziness and Balance Disorders Association of America, was founded in 1983 as a nonprofit, membership organization that provides a support network for people coping with dizziness and balance disorders. VEDA acts as a resource for information and services on balance disorders, specifically vestibular disorders, and seeks to educate the public and health professionals. VEDA also supports activities that improve the quality of life for people affected by dizziness and balance disorders. Fees are charged for some publications.

- The **American Health Assistance Foundation (AHAF)** is a non-profit charitable organization dedicated to funding scientific research on age-related and degenerative diseases, educating the public about these diseases, and providing emergency financial assistance to Alzheimer's disease patients and their caregivers. AHAF's current programs are Alzheimer's disease Research; National Glaucoma Research; National Heart Foundation, Macular Degeneration Research and Alzheimer's Family Relief Program. Since its inception in 1973, AHAF has provided more than \$47 million in research funds for age-related and degenerative disease research, and \$1.5 million to help cover emergency expenses related to patient's care and treatment. Currently AHAF supports a total of 54 research efforts at several universities, hospital and medical centers across the country.

The organization responds to inquiries by mail, telephone, and electronic mail.

- The **Glaucoma Research Foundation (GRF)** is a national, nonprofit organization dedicated to protecting the sight of people who have glaucoma through research and education. GRF was established in 1978 to support medical research into the causes and treatments of glaucoma. The organization also coordinates the Glaucoma Support Network, a national, telephone-based (1-800-826-6693) peer support network for glaucoma patients and their families (8:30 am - 5:00 pm, PST, Monday-Friday). GRF welcomes inquiries and encourages public and professional education.

- **Macular Degeneration Foundation Inc.** was established as a tax exempt not for-profit organization. Macular Degeneration patients can call toll-free 888-MDF-EYES (Voice-Toll-free, (633-3937) for phone support and counseling. Information packets are sent, free of charge by request. Their web page provides detailed and specific information at a glance. Contributions designated for research are used 100% to fund research grants to restore vision.

- The **National Association for Visually Handicapped (NAVH)** was founded in 1954 to provide services for the partially seeing. NAVH has supplied services to all 50 states and 98 foreign countries, including a FREE by-mail large print loan library available throughout the United States; counseling and referral to "Hard of Seeing" adults, children, and their families; self-help discussion groups for visually impaired adults and seniors; distribution of a wide array of visual aids worldwide; public and professional educational programs to help enlighten all to the needs of the low vision person; and, emotional support services to supply low vision individuals an opportunity to retain independence, hope, and dignity. NAVH also conducts testing of optical aids and lighting available from commercial sources, and serves as consultant to commercial publishers seeking the NAVH Seal of Approval for NAVH large-print standards.

INCONTINENCE

- **National Association for Conti-**

nence is the world's largest and most prolific consumer advocacy organization dedicated to helping people who struggle with incontinence and related voiding dysfunction. Its mission is focused on public education and awareness, collaboration to disseminate information, and advocacy on behalf of the estimated 25 millions adult Americans who suffer with incontinence. As a 501(c)3 corporation, the not-for-profit is broadly funded through consumer and professional memberships, individuals contribution and grants from industries and private foundations.

STROKE

- The **National Institute of Neurological Disorders and Stroke (NINDS)**, conducts and supports research and research training on the causes, prevention, diagnosis, and treatment of neurological disorders and stroke. The Institute awards grants for research projects, program projects, and center grants; provides training support to institutions and fellowships to individuals in the fields of neurological disorders and stroke; conducts intramural and collaborative research; and collects and disseminates research information. Requests for information should be directed to the Office of Communications and Public Liaison.

- The **American Stroke Association** is committed to reducing disability and death from stroke through research, education, fund raising, and advocacy. A Division of American Heart Association, the agency offers a wide array of programs, products, and services, from patient education materials to current scientific statements and reports for healthcare professionals. Life after stroke, resources and access to support groups throughout the nation for survivors, caregivers, and healthcare professionals are available through the American Stroke Association's Stroke Family Support Network. You can access this information by calling 1-888-4-STROKE and ask for the Stroke Family Support Network.

- The **National Stroke Association (NSA)**, founded in 1984, is a nonprofit organization dedicated to educating stroke survivors, families, health care

professionals, and the general public about stroke. It seeks to reduce the incidence and impact of stroke through activities related to prevention, medical care, research, rehabilitation, and re-socialization. NSA develops and distributes educational materials and a new full color magazine "Stroke Smart"; publishes a stroke journal; operates a national clearinghouse for information and referral; promotes research and disseminates research findings; advocates; develops workshops; provides guidance in developing stroke clubs and stroke support groups; operates a Stroke Center Network program to help professionals provide the best services to stroke patients; and offers a Clinical Trials Acceleration Program.

CAREGIVER

- **Children of Aging Parents Society (CAPS)**, was founded in 1977 to assist caregivers of the elderly. It was incorporated as a non-profit, charitable organization in 1980 and today has a national mission to provide the 22.4 million family caregivers with reliable information and referrals, a network of support groups, and publications and programs that promote public awareness of the value and the needs of caregivers. CAPS provides phone numbers and names of nursing homes, retirement communities, elder law attorneys, day care centers, medical in-home services, respite care, assisted living centers, state and county agencies and more. CAPS writes, collects, and disseminates fact sheets on various topics. To continue its work CAPS welcomes memberships, memorial donations, bequests, grants and deferred gifts.

- The **Eldercare Locator** connects older Americans and their caregivers with sources of information on senior services. The service links those who need assistance with state and local area agencies on aging and community-based organizations that serve older adults and their caregivers.

- **National Alliance for Caregiving (NAC)** is a non-profit joint venture dedicated to providing support to family caregivers and the professionals who help them. The NAC founding partners include the American Society on Aging,

the Department of Veterans Affairs, and the National Association of Area Agencies on Aging. The Alliance was created to conduct research, develop national projects, and increase public awareness of the issues of family caregiving.

GENERAL NEUROLOGY

- The **American Academy of Neurology (AAN)** is a professional society composed of neurologists and professionals in related fields who share a common goal of continued growth and development of the neurological sciences.

OTHER

- The **Central Nervous System Vasculitis Foundation, Inc.** provides information and support to patients, families, and the medical community and the general public about the rarity of CNSV; its devastating impact on lives; diagnosis, and treatment in order to improve overall quality of life, affect more positive patient outcomes, to develop effective medical treatments, and to assist in discovering a cure through scientific research.

- The **Les Turner Amyotrophic Lateral Sclerosis (ALS) Foundation** is a non-profit organization that offers support to patients and families living with the day-to-day difficulties associated with ALS--also known as Lou Gehrig's disease. Services available include the Lois Insolia ALS Center, an out-patient clinic with a multi-disciplinary team, at Northwestern Memorial Hospital, Chicago, Il, a Home Liaison visiting nurse program; equipment and communication system banks; educational materials and programs; and support groups. The Foundation also supports scientific research on ALS; currently this research is being conducted at the Les Turner ALS Research Laboratory at Northwestern University Medical School, where scientists are working to discover the cause of the disease and ultimately a cure. These experts in the field of ALS help both professionals and patients keep current with ALS research and patient care.

- The **Restless Legs Foundation**, is dedicated to improving the lives of the men, women, and children who live with this often devastating disease. The

(Text continued on page 18.)

QUICK WEB REFERENCE GUIDE TO NEURO ADVOCACY AGENCIES FOR OLDER ADULTS

How to use this guide: This guide was designed to help physical therapists and other healthcare professionals find valuable web resources for providing care and services to the neurologically impaired older adult and their caregivers. Each of the advocacy agencies listed in this guide have direct links to their website for easy reference. The grid can be utilized to help you locate the type of resource or information you need quickly.

	Patient/ Caregiver Education Resources	Patient/ Caregiver Support Services	Healthcare Professional Resources	Journal/ Magazine/ Publication/ Newsletter	Local Agencies	Referral Resources	Medicare Resources	Scientific/ Clinical Research Resources
AGING								
American Geriatric Society www.americangeriatrics.org	X		X	X		X	X	X
Amer. Assoc. of Retired Persons www.aarp.org	X	X		X			X	
National Institute on Aging www.nia.nih.gov	X		X	X				X
Alliance for Aging Research www.agingresearch.org	X		X	X				X
Natl. Assoc. of Area Agencies on Aging www.n4A.org	X	X		X	X		X	
National Council on Aging www.ncoa.org	X	X	X	X			X	X
MENTAL HEALTH /HOSPICE								
Amer. Assoc. for Geriatric Psychiatry www.aagponline.org	X		X	X		X	X	X
Compassion & Choices www.compassionandchoices.org	X	X	X	X		X		
Caring Connections www.caringinfo.org	X	X	X			X		
ALZHEIMER S DISEASE / DEMENTIA								
Alzheimer s Disease Education & Referral Center www.nia.nih.gov	X		X	X				X
Alzheimer s Disease Research Center www.alzresearch.org	X	X	X	X				X
Alzheimers Association www.alz.org	X	X	X	X	X		X	X
PARKINSON S DISEASE/TREMORS/ MVMT DISORDERS								
Dystonia Medical Research Foundation www.dystonia-foundation.org	X	X	X	X	X	X		X
Bachmann-Strauss Dystonia & Parkinson Foundation www.dystonia-parkinsons.org	X		X	X				X
Huntington s Disease Society of America www.hdsa.org	X	X		X	X	X		X
International Essential Tremor Foundation www.essentialtremor.org	X	X	X	X		X		X
Parkinsons Disease Foundation www.pdf.org	X	X		X				X
National Parkinson Foundation www.parkinson.org	X	X	X	X	X	X		X

	Patient/ Caregiver Education Resources	Patient/ Caregiver Support Services	Healthcare Professional Resources	Journal/ Magazine/ Publication/ Newsletter	Local Agencies	Referral Resources	Medicare Resources	Scientific/ Clinical Research Resources
SENSORY DISORDERS								
American Tinnitus Association www.ata.org	X	X	X	X				X
Center for the Partially Sighted www.low-vision.org	X	X	X	X				
Vestibular Disorders Assoc. www.vestibular.org	X	X	X	X		X		
American Health Alliance Foundation www.ahaf.org	X	X		X				X
Glaucoma Research Foundation www.glaucoma.org	X	X		X				X
Macular Degeneration Found. Inc. www.eyesight.org	X	X		X				X
Natl. Assoc. for Visually Handicapped www.navh.org	X	X		X				
INCONTINECE								
Natl. Assoc. for Continence www.nafc.org	X	X	X	X		X		X
STROKE								
Natl. Inst. Of Neurological Disorders and Stroke www.ninds.nih.gov			X	X				X
American Stroke Assoc. www.strokeassociation.org	X	X	X					X
Natl. Stroke Assoc www.stroke.org	X	X	X	X				
CAREGIVER								
Children of Aging Parents Society CAPS4caregivers.org	X	X		X	X	X		
Eldercare Locator www.eldercare.gov		X	X		X	X		
Natl. Alliance for Caregiving www.caregiving.org	X	X		X			X	
OTHER								
American Academy of Neurology www.aan.com	X		X	X				X
Les Turner ALS Foundation www.lesturnerals.org	X	X						X
Restless Leg Foundation http://www.rls.org	X	X	X	X		X		X
Trigeminal Neuralgia Foundation www.tna-support.org	X	X		X		X		X
REHABILITATION								
American Physical Therapy Association www.apta.org	X		X	X		X	X	X
American Occupational Therapy Association www.aota.org	X		X	X		X	X	X
American Speech Language & Hearing Assoc www.asha.org	X			X		X		X
NEUROPATHY								
Neuropathy Association www.neuropathy.org	X	X		X	X	X	X	X

Organization's goals are to increase awareness of Restless Legs Syndrome (RLS), to improve treatment, and, through research, to find a cure.

- The **Trigeminal Neuralgia Association** was established in 1990 to provide a support network for individuals suffering from trigeminal neuralgia. Trigeminal neuralgia, or tic douloureux, is a neurological disorder characterized by sudden, recurring attacks of acute pain in the areas of the face where the trigeminal nerve is distributed - lips, cheeks, jaw, forehead, nose, and eyes. The goals of the association are to provide mutual aid, support and encouragement to individuals and families affected by the disorder; act as a resource for information on trigeminal neuralgia; and increase public and professional awareness of the disorder.

REHABILITATION

- The **American Physical Therapy Association (APTA)** is a national professional organization representing more than 75,000 physical therapists, physical therapist assistants, and students throughout the United States. The Association's efforts are directed toward serving its members and the public by increasing the understanding of the physical therapist's role in the nation's health care system and by fostering improvements in physical therapy education, practice and research. Headquartered in Alexandria, Virginia, APTA works to fulfill its objectives in the areas of accreditation, clinical research, continuing education, legislative representation, minority and international issues, practice issues, publications, and more. Some of the activities that foster APTA's goals include: Accreditation--APTA is recognized as the sole accrediting agency for entry-level physical therapist and physical therapist assistant programs in the U.S.; Information Dissemination--To increase understanding of the physical therapist's role in the nation's health care system, many APTA resources are devoted to providing accurate information to the general public, members of the media, federal, state, and local governments, other health care professionals, and APTA members; Professional Development--Conferences, seminars, workshops, and other

professional development activities are regularly sponsored by APTA and its components; Research--APTA promotes research through graduate education programs, presentation and publication of research reports, and research awards, among others.

- The **American Occupational Therapy Association (AOTA)** is a national professional society established in 1917 to represent the interests and concerns of occupational therapy practitioners, and to improve the quality of occupational therapy services. Occupational therapy is a vital health care service whose practitioners help to restore and sustain the highest quality of productive life to persons recovering from illnesses or injuries, or coping with developmental disabilities or changes resulting from the aging process. Current AOTA membership numbers approximately 40,000, including occupational therapists, occupational therapy assistants, and occupational therapy students. Members reside in all 50 states, the District of Columbia, Puerto Rico, and 65 foreign countries. AOTA's major programs and activities are directed toward assuring the quality of occupational services; improving consumer access to healthcare services, and promoting the professional development of members.

- Founded in 1925 as the American Speech and Hearing Association, the **American Speech-Language-Hearing Association (ASHA)** is a nonprofit organization established to maintain professional standards, encourage development of comprehensive clinical service programs, promote research with regard to human communication and communication disorders, and assist information exchange. The Association accredits institutions offering masters and degrees in speech-language pathology and audiology programs offering clinical services in these areas to the public. With its 50 State affiliates ASHA maintains a national career information program, a governmental affairs program, a public information program, and an information and referral service for consumers.

NEUROPATHY

- **Neuropathy Association.** The mission of this nonprofit organization is to: support research into the causes and

treatment of peripheral neuropathies; provide support through education and sharing information and experiences related to peripheral neuropathy; increase public awareness of the nature and extent of peripheral neuropathy and the need for early intervention and research; encourage pharmaceutical and biotechnology companies to develop new therapies and devices for treatment of neuropathy; encourage government support for research into the causes and treatments of neuropathy, and the need for special accommodations and facilities for people with neuropathy; encourage medical providers, including hospitals, HMOs and insurance companies, to provide coverage, proper care and treatment; and participate in national and international awareness, research and information exchange.

ShaLynn Smith resides in Kerrville, TX where she shares her time between being a mother of two girls ages 5 and 7, pursuing a Doctorate of Science degree in Physical Therapy from the University of Maryland, and managing her own business as a wellness and prevention consultant for older adults.

GERICOMICS

by Jennifer M. Buchwald
& Jennifer M. Bottomley



MEET THE LEADERS: GREG HARTLEY

When, how, and why did physical therapy appear on your radar screen as a career choice?

While on summer break from college, I helped care for my grandmother, who had been in an automobile accident some time earlier. It was during this summer that I had my initial exposure to physical therapy. Accompanying her to her physical therapy appointments, I saw the impact of the care she received. While my grandmother never fully regained complete independence, I could clearly see the value of PT in enhancing her quality of life. The relationship she had with her therapists was something I found profoundly meaningful. Throughout the summer, I tried to learn as much as I could about this profession, and in doing so, I discovered how much physical therapists actually know, and what impact they have on their patients. This early exposure to strong clinicians and dedicated professionals has shaped my practice throughout my career, and guided me in the direction of both geriatrics and clinical education.

What was your most fun times/memory of PT school?

Those days bring back many pleasant memories, and it's hard to highlight just one or two. I had just moved from a small town in Alabama to Miami to go to school. I was in for some major culture shock! Unlike many people who

visit the area for the first time, I reveled in the diversity, culture, and 'big city' that Miami was (and is). This became a real personal growth period for me, as I left behind many stereotypes and really soaked-up the funky culture that is South Florida. I developed many friendships in PT school as my class was on its way to become the 'infamous class of '90' at UM (I won't go into that). I continue to stay in touch with many former classmates, who have remained life-long friends.

Who do you consider to be a professional mentor?

First to come to mind is David Morris, PT, PhD. Dave was one of my clinical instructors when I was a student. He taught me true professionalism and became a role model for me as I began to instruct students in the clinic later on. Throughout the years, I have watched Dave transition from clinician to ACCE to academician and clinical researcher. He has also served as both a Chapter (AL) and Section (Aquatics) President in the APTA. He has been a mentor for me throughout my entire career, since I was a student, and continuing today. Carol Davis, PT, EdD, MS, FAPTA has also been a mentor for me. She was a professor during my entry-level education, and has also been an active member of the SoG since I have known her. She helped form my clinical communication style, and has continued to inspire and encourage me throughout my career. Dr. Davis and I frequently work and/or teach together, and I will always learn from her.

What course has your professional life taken in your career?

I started as we all do, as a staff therapist. I worked in acute care and outpatient for a few years at VA Medical Centers in Miami and in Birmingham, AL. Eventually, I was promoted to Chief Physical Therapist at the Birmingham VAMC. I wanted to become a specialist in geriatric PT, and knew that I needed experience in other settings (like SNF, home health, in-patient rehab, or



With former Section President, Jennifer Bottomley

LTC). I took a job as PT manager in a home health contract company in Birmingham, and as the company grew, I found myself leading the organization as Director of Clinical Services (PT, OT, and ST). It was during this time that I became a GCS (fellow Board member Ellen Strunk and I would study together for the exam...we were both in B'ham at the time). After some time in that position, I realized that I was not done with my education yet. I returned to Miami with the intent of pursuing a PhD at the University of Miami (where I had completed my entry-level education). I accepted a job as Sr. PT and CCCE in a facility that concentrated on geriatrics across the entire continuum of care. I've been there for 6 years, and am presently the Director of Rehabilitation and Program Director of the Geriatric Residency. A career highlight happened in 2005 when I was the recipient of the Signe Brunnström Award for Excellence in Clinical Teaching. Currently, I am also teaching in the entry-level program at the University of Miami (geriatrics and clinical decision making courses) as I continue to pursue a PhD there.



Enjoying APTA Foundation Dinner with GeriNotes Editor, Carol Schunk and Section President, John Barr

You have been a leader in the area of residency within the Section, how did that happen?

As Director of Clinical Services in a Home Health organization, I saw the need for geriatric specialists, having just become a GCS myself. The word about residency education was just getting out and the credentialing process was fairly new territory (especially for specialties other than orthopaedics). I began exploring the idea of residency education as a way for PTs to become a board certified specialist. When I became Sr. PT and CCCE at a new employer, I was encouraged to pursue the goal of developing a new residency program in geriatrics. Within 2 years, we had the only APTA credentialed geriatric program in the US. As the Director of the only credentialed geriatric residency training program for PTs in the US, I was asked to Chair the SoG Task Force on Residency Education. The rest evolved from there.

If you look out 10 years how do you see the residency program influencing our profession?

I would like to see residency education become the normative model of postgraduate specialty training. There would always be a way for people to become specialized by themselves, but residency education would be the norm. This would require a tremendous number of residency education programs around the country. Given the numbers of program required, 10 years might be a few years short, but still, it is my mission. This type of model could help us to verify our Board certification process even more. APTA credentialed programs undergo a tremendous amount of scrutiny to become credentialed. In doing so, they prove that they are offering a quality program that meets expected criteria for board certification. The residency programs therefore become the clinical training grounds for specialists. Currently, the only way of proving clinical expertise is by examination. Residency programs offer an advantage in that they substantiate the clinical skills of the candidate. This is similar to the medical model, and I think, only adds to the value of the specialization process and credential.



The Hartley Family

What are the benefits for an employer to develop a residency program?

In short: professional development of clinical staff, contributions to the profession's growth and autonomy, marketing opportunities, *recruitment and retention benefits*, and increased career and job engagement from employees. I have recently written an article on this topic, and would refer readers who are interested to The Section on Health Policy and Administration's Newsletter, *HPA Resource*, Vol. 6, No. 2, Aug 2006.

If you were a therapist trying to decide if a residency was a good choice for you, what would be the 3 questions to ask yourself?

1. Do I need broad-based education on a specialty area (geriatrics) that is organized and designed to cover the spectrum of specialty practice?
2. Can I devote up to a year to learn it?
3. Am I willing to make sacrifices during that time to be better prepared to become a specialist?

What are some of your favorite experiences as a leader in the Section?

Being able to interact personally with 'movers and shakers' has been inspiring. And the networking opportunities are bountiful. Being involved with the growth and development of the SIGs has been rewarding, as has the development of many new consumer and member educational materials now available on the website (<http://www.geriaticsppt>).

org/). I hope the membership will take advantage of these new resources. Many people have devoted countless hours of time in the development of these projects.

How did you become more than a member in the Section?

As Chair of the Section's Task Force for Residency Education, I was asked if I'd consider running for the Board of Directors. I agreed. The experience has moved me forward on a personal and professional level. It is so important to understand the value volunteering to serve the Section can have. It can lead to things one never expected...in a very positive way.

What do you see as the most pressing issue for physical therapy as a profession?

Right now, the most pressing issue is being able to define ourselves as a doc-



St. Croix, US Virgin Islands 2006



Costa Rica 2006

toring profession, including establishing a greater sense of autonomy in all settings. Sometimes, (and I think this is especially true for those in acute care, SNF, and LTC settings), seeing ourselves as autonomous (yet collaborative) is a difficult thing. We must understand that our professional preparation allows us to function as decision-makers. Too many times, we do not take leadership roles, nor do we assert our knowledge in the role of a consultant. We must begin to see ourselves in this light, and function as the experts we are during team meetings, utilization reviews, setting RUGs levels, and in care planning. Particularly when we work in hospitals, sub-acute, SNF, home health, or LTC settings.

What is Greg like on the weekends or off hours?

When I am not studying (which is not often enough, I'm sorry to say), I love to travel. The more exotic, the better. Although I must admit, I haven't been to that many exotic places. I can still dream. I enjoy nature, hiking, and anything on or near the water. I'm working (ever so slowly) on my PhD in PT at the University of Miami. Right now, that is occupying most of my 'down time.' I also enjoy gardening, my pets, and hanging out with friends and family.

THE SECTION ON GERIATRICS WEB SITE IS THE PLACE TO BE ...

DID YOU KNOW . . . IF YOU GO TO THE WEB SITE . . . YOU CAN:

- Find the latest information on the CSM schedules.
- Get resources for you and your patient for various conditions and diagnoses.
- See the Geriatric Link of the Month and archives of past links.
- Find information about the 14 Section awards presented at CSM.
- Print 14 different patient education handout brochures.
- Access *GeriNotes* and the *Journal of Geriatric Physical Therapy* archives for article retrieval.
- Locate any GCS or Section on Geriatrics member email on the Geriatricspt.org web page.
- Advertise potential employment opportunities from your organization.

The web site is exciting, a great member benefit!!! You too can be part of the WebTeam to enrich and enhance the web experience with updates and new ideas. If interested contact Jessica Sabo, SOG Executive Director, at jessicasabo@apta.org

Lucy Jones PT, GCS, MHA
WebCommittee Chairperson

St. Catherine's Rehabilitation Hospital and Villa Maria Nursing Center Residency in Geriatric Physical Therapy

- Do you want to specialize in geriatrics but don't know how to start?
- Are you considering postgraduate education?

Our residency in geriatric physical therapy is a unique opportunity for you to begin both. The program is the first (and only) fully credentialed geriatric residency in PT in the United States. The year-long program offers therapists the ability to gain structured experiences in a variety of settings. Residents are mentored by expert faculty, including board certified geriatric specialists. Additionally, residents will take applicable courses at the University of Miami or Sacred Heart University. Tuition is paid by St. Catherine's/Villa Maria. Residency graduates will be prepared to sit for the GCS exam, and may elect to continue work towards their MS in Geriatric Rehab and Wellness or a Certificate in Gerontology. For an application or further information, please visit our website at www.catholichealthservices.org, send an email to TGravano@aol.com. *Applications are accepted year round.*



American Physical Therapy Association
Credentialed Postprofessional Clinical Residency Program

RAGE AGAINST AGE

Upcoming CSM presentation from the Health Promotion & Wellness Special Interest Group of the Geriatric Section of the APTA

Love clam chowder, the smell of the ocean, and meeting old friends?

Need another reason to visit Boston in February 2007?

*Please come and join us for what promises to be an excellent, clinically relevant
seminar presented by the HPW Sig on Saturday morning; entitled*

RAGE AGAINST AGE.

This 2 ½ hour seminar will be presented by a panel of knowledgeable clinicians from various geographic locations, practice settings, and educational backgrounds. The overall educational objective for this presentation is to prepare physical therapy clinicians from all over the country to take the lead in our health care delivery system in supporting America's population to age successfully.

WHAT DOES IT MEAN TO AGE SUCCESSFULLY? HOW CAN PTS PROVIDE THE NEEDED CATALYST TO ACHIEVE SUCCESSFUL AGING?

There is no consensual definition of 'successful aging.' Our aim is to review the literature regarding definitions of successful aging, predictors and objective measures, research, and various clinical criteria of successful aging. Before attending our seminar, you might stop and think of 3 elders whom you admire. What is it about them that could be quantified to define successful aging? What do you hope to achieve in your later life? How could that be objectively measured? What could you do now to achieve those goals later?

IS AMERICA AGING?

Our population is facing a major shift in demographics that will impact our health care delivery system. Come and learn what the American population will look like and how to prepare yourself and your clinic to address those changing needs. What are Baby Boomers doing now? What legislative changes are needed?

CAN WE OBJECTIVELY QUANTIFY AGING IN A CLINICALLY RELEVANT WAY?

As clinicians, we are inundated with objective measures that hope to quantify our patients' abilities and our clinical effectiveness. Which measures are applicable to which populations of elders? Are these results valid, reliable and reproducible? Which measures are simple, safe, and cost effective?

HOW DO WE REACH THE WELL-ELDER POPULATION TO OFFER TRUE HEALTH PROMOTION RATHER THAN BE RESTRICTED TO THE CARE OF ILLNESS AND/OR INJURY?

Offering health fairs can be intimidating, but certainly does not need to be. Perhaps after hearing our presentation you won't shy away from volunteering to offer a fantastic health promotion fair in your community! We can answer the who, why, where, when, and how questions for you!

Are you aware of all of the 'ready-made' health promotion kits available to you? For little or no cost you can get your health fair all prepared for you! Do you access the free government publications and services available to your elders? Come and increase your health promotion tool belt!

CAN WE HELP OUR WELL-ELDERS TO DOCUMENT THEIR SUCCESS AND PRESENT THESE RESULTS TO THEIR HEALTH CARE PROVIDERS?

A few simple tools will be presented for you to take home and use. You will be able to simply and effectively teach your patients and well-elders how to keep a diary or log of their wellness program to present to their primary care providers. This type of documentation is key to self-advocacy in our health care system.

IN SHORT, YOU DON'T WANT TO MISS THIS PRESENTATION! SEE YOU THERE!

GERIATRICS EXPERT NAMED DISTINGUISHED ALUMNA

Jennifer M. Bottomley, PhD, MS, PT '86, a physical therapist and an internationally recognized consultant in geriatrics, was presented with the second annual Distinguished Alumni Award from MGH Institute of Health Professions, at the twenty-sixth annual commencement ceremonies in May.

Over the years Dr. Bottomley has served with distinction on a variety of federal panels and task forces for the US Department of Health and Human Services, the Office of the Surgeon General, and the White House Conference on Aging during the Clinton Administration.

Within the physical therapy profession, she has worked on the National Blueprint Initiative, a broad-based effort to increase physical activity among people 50 and older. Dr. Bottomley recently completed her second term as president of the American Physical Therapy Association's Section on Geriatrics.

Dr. Bottomley has long advocated on behalf of elder homeless and has been active with the Boston Committee to End Elder Homeless (now called, Hearth-Home for Good), for over a decade. She also spearheaded various programs with AARP and the Gray Panthers.

In accepting her award Bottomley told the audience, "Although listening to, being concerned with, and respond-

ing to the needs of others are evidence of our highest human motivations, volunteering is not simply something we do for others. It brings significant benefits to individuals and communities and helps to nurture and sustain a richer social texture and a stronger sense of mutual trust and cohesion."

Bottomley pointed out that her "inspiration to give back to society comes from life-long role models and mentors," including her parents, grandmother, and life partner, also named Jennifer, "who not only supports my

efforts but volunteers as well, working side-by-side towards improving the lives of elders who don't have a roof over their heads or shoes on their feet."

Dr. Bottomley has lectured and published extensively--more than 75 articles to date--on a wide variety of research interests that include nutrition and exercise, foot care in the elderly, wound care, diabetes and peripheral vascular disease, balance and falls in the Alzheimer's population, Tai Chi as an alternative form of exercise to prevent falls, as well as social policy development for the elderly.



SECTION MEMBER APPOINTED TO NATIONAL COMMITTEE

Section on Geriatric Bylaws Committee Chair, Pam Duffy was recently appointed to the APTA Committee on Oral History. This 'virtual' committee works closely with APTA staff to ensure that the voices of past leaders and members are preserved and included in the association archives. Duffy said, "I have a keen interest in both the life stories of these influential APTA leaders as well as their assessments and memories of the context of the times in which they set the course for our profession." The APTA Committee on Oral History seeks input from members on their work. Please contact Pam (duffypam@aol.com) or Gini Blodgett at APTA with your suggestions on members with whom the committee should interview during the ensuing years.

APTA CELEBRATION OF DIVERSITY ATTENDED BY SECTION MEMBERS

Members of the Section on Geriatrics attended the Celebration of Diversity: Commitment for the 21st Century fundraiser on October 7, 2006, at the Women in Military Service for America Memorial in Arlington, Virginia. This 14th annual fundraiser for the American Physical Therapy Association Minority Scholarship Fund provides financial assistance and monetary awards to physical therapy students and faculty.

Welcoming remarks were delivered by R. Scott Ward, current APTA President. The program included dinner, followed by presentation of awards and a silent auction. Celebrated was a record attendance to this event of over 300 people from the physical therapy community. The dinner and presentation took place in the main rotunda amid the pictorial display of our recent fallen heroes of the Iraq war. The contributions of our military women were well represented by the displays from the traditional medical professionals and non-traditional roles in defense of national and international concerns. Displayed among the items of the silent auction was one of the first uniform garments worn by the physical therapist, the cape. The grey cape with the red emblems on the collar conjured thoughts of the early beginnings of the profession and sparked humorous discussion about experiences around standards of dress that have emerged over the years.

Appreciated during the evening were the conversations and presenter recognition regarding the many individual and



Eva Phelps, Assistant to the Director for the Department of Minority/International Affairs, next to a handmade lap quilt which was a raffle item for the silent auction.

section contributions to the promotion of diversity within the profession. The Section on Geriatrics has played an active and generous role in the Minority Scholarship Fund. This year's recipient of the Scholarship Award, Rolando T. Lazaro, PT, DPT, GCS, professor at Samuel Merritt College, was recognized and honored for his work, dedication to diversity, and is a Section member. Additionally Salome Brooks, PT, MBA, MS, from Sacred Heart University, the 2005 award recipient was recognized by the gathering and is also a Section member. The Section on Geriatrics should be pleased with the quality of work that is being fostered by its membership and positive outcomes generated by its members in various areas, all in support of the profession as a whole.



Enjoying the evening were Rodney A. Miyasaki, 2006 Diversity 2000 award recipient, his wife, Nicole Taniguchi, Geriatric Section member and other guests.



The pictures in the background represent soldiers who have lost their lives during the Iraq War.



APTA President R. Scott Ward; Johnette Meadows, Director, Department of Minority/International Affairs; and other faculty.

SECTION ON GERIATRICS

CSM 2007

Preconference course, Tuesday February 13, 2006

Focus Geriatrics 1: Aging Issues and Common Diagnoses Across Practice Patterns

8:00 am - 4:30 pm

Speakers: Jill Heitzman, PT, DPT, GCS, FCCWS, Mary Greeley Rehab and Wellness, Ames, IA; Deb A Kegelmeyer, PT, DPT, MS, GCS, Columbus, OH; Ann Myer, PT, DPT, GCS, FCCWS; William Staples, PT, DPT, GCS, University of Indianapolis, Indianapolis, IN

This is an evidence based pre-conference course covering aging issues as related to each of the four preferred practice patterns (Musculoskeletal, Cardiovascular/pulmonary, Integumentary, and Neuromuscular). Common diagnoses, pharmacological interventions and implications for physical therapy will be addressed. This is a great course for PT's planning to sit for the Geriatric Board Certification; PTA's pursuing Advanced Clinical Proficiency or any practitioner looking to improve their clinical skills with the older adult.

Upon completion of this course, you will be able to:

- 1) Recognize biological and pathological changes associated with aging.
- 2) Integrate examination and intervention strategies for the geriatric client utilizing the Guide to Physical Therapy Practice as a resource.

(Multiple Level) 7.5 CEU

Preconference course, Wednesday February 14, 2006

Focus Geriatrics 2: Exercise Prescription, Functional Outcomes Testing, and Fall/Balance Issues Related to the Older Adult

8:00 am - 4:30 pm

Speakers: Dale Avers, PT, DPT, PhD, Syracuse, NY; Deb A Kegelmeyer, PT, DPT, MS, GCS, Columbus, OH; Patrick J. Van Beveren, PT, DPT, MA, OCS, CSCS, Syracuse, NY

This evidence based, hands on session will focus on skills needed for prescribing exercises for the older adult across various spectrums of care. Functional assessment for mobility and balance will be presented using a variety of standardized instruments relevant to the geriatric clinical management. Through case study presentation the participants will develop their clinical reasoning skills to successfully prescribe appropriate exercises for the older adult. Participants will be given the opportunity to practice and analyze tools that measure function. This course is ideal for those wanting to improve their outcomes with the older adult as well as those Physical therapists planning to pursue board certification in geriatrics and PTA's pursuing Advanced Clinical Proficiency.

Upon completion of this course, you will be able to:

- 1) Choose, implement and analyze results of functional assessment tools appropriate for geriatric clients.
- 2) Prescribe the appropriate exercise program for the older adult based on their functional goals.

(Intermediate) 7.5 CEU

Preconference course, Wednesday February 14, 2006

Clinical Residency/Fellowship 101: Getting Started and Doing it Well

8:00 am - 4:30 pm

(Joint Program; Women's Health)

Speakers: Carol Davis, PT, EdD, MS, FAPTA; Greg Hartley, PT, MSPT, GCS, St Catherine's Rehabilitation Hospital & Villa Maria Nursing Center, N Miami, FL; Patricia A. McCord, PT, FAAOMPT, Evergreen, CO; Teresa L. Schuemann, PT, SCS, ATC, CSCS, White Salmon, WA

This workshop will provide the tools needed for potential sites to develop and implement a successful postprofessional clinical residency or fellowship program that meets the criteria for APTA credentialing. Learn about the process from individuals who have guided their clinical residency through a successful credentialing process and from representatives of APTA's Committee on Residency Credentialing. Innovative ways to address the credentialing criteria will be explored to make a clinical residency fit your unique situation. **This course is not applicable for Physical Therapist Assistants.

Upon completion of this course, you will be able to:

- 1) Justify the rationale for a clinical residency/fellowship that includes a discussion of the benefits and challenges.
- 2) Assemble the necessary resources for the development of a clinical residency including the development of unique partnerships.

- 3) Market a clinical residency to administration and to potential residents.
 - 4) Formulate a budget and establish cost effectiveness of a clinical residency.
 - 5) Prepare an application for the credentialing process.
 - 6) Develop mentors for teaching in a residency program.
- (Multiple Level) 7.5 CEU

Thursday, February 15

The Globalization of Physical Therapy During War: Spectrum of Care Across Different Levels of Medical Care, Settings, Ages, Cultures, and Disciplines

8:00 am - 11:00 am

(Joint Program; All Sections) **Moderator:** MAJ Peter Glover, PT, Newark, DE

Speakers: Jill Black Lattanzi, PT, EdD, Lewes, DE; Heather Lynn Malecki, PT, Lorton, VA; LTC Josef H Moore, PT, PhD, SCS, ECS, OCS, ATC, United States Military Academy, Keller Army Community Hospital, San Antonio, TX; LTC Barbara A Springer, PT, PhD, OCS, SCS, US Army Walter Reed Army Medical Center, Washington, DC; Hugh Watts, MD, University of Southern California, Los Angeles, CA

Physical Therapists are in an environment where they are responsible for making functional diagnostic decisions that will determine if an individual is able to stay on the job / on the battlefield or sent to a different or higher level of care. In many cases, physical therapists are the primary entry of care for injury or dysfunction, working directly with other medical specialties to determine appropriate surgical, medical, and rehabilitation interventions. The physical therapist may also be the primary consultant to a supervisor, or in the military setting, the commander on physical strength, endurance, core stability, and agility. Internationally during war, physical therapists are working with patients with poly-trauma injuries that may include: traumatic brain injuries, limb amputations, cardio-vascular compromise, etc. These diagnoses may result in life-long conditions that will be treated by physical therapists at different intervals of life.

Upon completion of this course, you will be able to:

- 1) Attendees will be able to demonstrate the diagnostic decisions to evaluate if an injured person is able to return to activities of work and daily living.
- 2) Attendees will have an overview understanding of rehabilitation from point of injury on the battlefield back to full recovery and return to the battlefield and the long term rehabilitation needs after poly-trauma injury.
- 3) Attendees will develop a global understanding of the needs of rehabilitation in countries that do not have formal rehabilitation and have suffered from the effects of war.
- 4) Attendees will be able to demonstrate understanding of the clinical skills needed to provide physical therapy care as the primary entry point after injury or dysfunction.
- 5) Attendees will have a further understanding of the knowledge required as the primary consultant for the physical strength, endurance, core stability, and agility for a group of people that perform physical skills as part of their work and recreation.
- 6) Attendees will understand the changes in a large medical system to promote physical therapy as a preferred provider for nonsurgical interventions for musculoskeletal injuries and impairment.

(Multiple Level) 3 CEU

Geriatric Certified Specialists/Newcomers Celebration Breakfast

6:30 am - 8:00 am

Moderator: Anne Meyer, PT, GCS, CWS, Kalamazoo, MI

Speakers: Alice Bell, PT, GCS, Genesis Rehabilitation Services, Agawam, MA; Reenie Euhardy, PT; Jill Heitzman, PT, DPT, GCS, FCCWS, Mary Greeley Rehab and Wellness, Ames, IA; Sue Schuerman, PT, PhD, GCS, Las Vegas, NV; Carol Schunk PT, PsyD

If you are a newly certified Geriatric Specialist or a newcomer to CSM, come celebrate with members of the Section on Geriatrics. This is a great way to start your day and learn more about the section and how to make the most of your specialty.

Section on Geriatrics Advocates to the States Meeting

11:30 am - 12:30 pm

Moderator: Jill Heitzman, PT, DPT, GCS, FCCWS, Mary Greeley Rehab and Wellness, Ames, IA

All Section on Geriatrics State Liaisons are invited to this meeting as we move to being Section on Geriatrics Advocates to the states.

PTA Programming: The Music of Our Lives: Using Music to Motivate Movement

12:30 pm - 2:00 pm

Speaker: Rebecca S Crocker, PT, DPT, Ozarks Technical Community College, Springfield, MO

This course is designed to increase the awareness of and cultural sensitivity of PT and PTAs in regards to the influences of music across the lifespan. There will be interactive sessions for valuing and incorporating music into the rehabilitation process across the lifespan. Evidence will be presented for utilizing music in rehab and also how to utilize today's technology to bring music into the patient care setting.

Upon completion of this course, you will be able to:

- 1) Describe various eras and influences of music from 1990 to 2007.
- 2) Discuss the connection between music and movement.
- 3) Select music that is age and rehab appropriate.
- 4) Describe ways to incorporate music within the PT Plan of Care.

(Basic) 1.5 CEU

Clinical Decision Making Across Cultures: Practical Strategies for Exploring and Integrating Health Beliefs With Patient Care

2:00 pm - 4:00 pm

Speakers: Stella Bakarich, PT, MS, Las Vegas, NM; Teresa M Cochran, PT, DPT, MA, GCS, Creighton University, Omaha, NE; Beverly D Fein, PT, EdD, Sacred Heart University, Fairfield, CT; Caroline Goulet, PT, DPT, Creighton University, Omaha, NE; Eunice Y Shen, PT, DPT, PCS, California Children's Services, El Monte, CA; Nicole Terumi Taniguchi, PT, Anchorage, AK; Maria Vasquez Morgan, PT, PhD, Shreveport, LA

This session will provide strategies for healthcare professionals to identify and integrate essential elements of a patient's background with the physical therapy goals and interventions to optimize patient-centered care. Practical models related to accessing patient health beliefs and behaviors will guide decision making and allow the clinician to differentiate between interpersonal skills which cross cultural boundaries and strategies needed to explore essential culture-specific information.

Upon completion of this course, you will be able to:

- 1) Apply elements of existing health models and practical tools for gathering information during a therapeutic interview.
- 2) Recognize challenges to patient interaction across cultures.
- 3) Generate strategies to optimize patient-centered care utilizing culture-specific information revealed in the therapeutic interview.

(Intermediate) 2 CEUs

Section on Geriatrics Balance & Falls SIG Meeting and Programming: Dizziness in the Older Adult

6:30 pm - 8:30 pm

Moderator: Ann S Williams, PT, University of Montana, Mc Allister, MT

Speakers: Gregory Marchetti, PT, PhD, Duquesne University, Pittsburgh, PA; Patrick Sparto, PT, PhD, University of Pittsburgh, Pittsburgh, PA; Susan L Whitney, PT, PhD, NCS, ATC, University of Pittsburgh, Pittsburgh, PA

Benign Paroxysmal Positional Vertigo (BPPV) is often unrecognized in older persons. Dizziness is the most common complaint of older persons over the age of 75. An evidence-based analysis of the differential diagnosis of BPPV, the interventions for BPPV, and review of literature on the success and indications for why and who develops BPPV will be presented. Demonstration of techniques and videos will reinforce learning.

Upon completion of this course, you will be able to:

- 1) Determine when and how to perform the different techniques used to differentially diagnose and intervene with the dizzy older adult.
- 2) Discuss the anatomy and physiology as related to BPPV.
- 3) Utilize evidence based practice with regard to interventions and post-treatment instructions for the older adult with BPPV.
- 4) Access web sources on BPPV in order to educate their patients.

(Intermediate) 2 CEU

Friday, February 16

Section on Geriatrics Osteoporosis SIG Meeting

7:00 am - 8:15 am

Moderator: Nancey A Bookstein, PT, PhD, Denver, CO

This Special Interest Group educates and promotes safe interventions for the population with or at risk of developing osteoporosis.

Section on Geriatrics Platform Presentations-Session II

8:15 am - 11:00 am

To Bend or Not to Bend While Testing Individuals with Osteopenia or Osteoporosis

8:15 am - 9:45 am

Speakers: Dale Avers, PT, DPT, PhD, Syracuse, NY; Karen L. Kemmis, PT, Syracuse, NY; Marilyn Moffat, PT, DPT, PhD, FAPTA, CSCS, New York University, New York, NY

The purpose of this presentation will be to analyze the most frequently used reliable and valid tests and measures (eg, balance, strength, aerobic capacity) and the modifications that may or may not have to be made for individuals with osteopenia and osteoporosis.

Upon completion of this course, you will be able to:

- 1) Demonstrate knowledge of the most frequently utilized reliable and valid tests and measures for individuals with osteopenia or osteoporosis.
 - 2) Discuss the myths related to tests and measures for individuals with osteopenia or osteoporosis.
 - 3) Determine when modifications of these tests and measures should be made.
 - 4) Demonstrate knowledge of the modifications that may be made in these tests and measures.
- (Intermediate) 1.5 CEU

Yoga Techniques for Skeletal Health

9:45 am - 10:30 am

Speaker: Sara M Meeks, PT, GCS, Sara Meeks Physical Therapy, Gainesville, FL

This interactive session will review Yoga techniques that are safe to use with patients with or at risk for osteoporosis. Be ready to get out of your seats and try them. A short discussion of osteoporosis and the research behind Yoga will also be presented.

Upon completion of this course, you will be able to:

- 1) Discuss Yoga techniques in relation to treating patients with osteoporosis.
 - 2) Safely teach simple Yoga techniques to your patients Yoga Techniques for patients with osteoporosis.
 - 3) Discuss the risks behind specific Yoga techniques in relation to patients with osteoporosis.
- (Intermediate) 2.5 CEU

Panel Discussion on Osteoporosis/Osteopenia

10:30 am - 11:00 am

Moderator: Nancey A Bookstein, PT, PhD, Denver, CO

Speakers: Dale Avers, PT, DPT, PhD, Syracuse, NY; Karen L. Kemmis, PT, Syracuse, NY; Sara M Meeks, PT, GCS, Sara Meeks Physical Therapy, Gainesville, FL; Marilyn Moffat, PT, DPT, PhD, FAPTA, CSCS, New York University, New York, NY

This session will give participants a chance to ask questions related to physical therapy interventions with osteoporosis.

Upon completion of this course, you will be able to:

- 1) Develop safe interventions with patients with osteoporosis/osteopenia.
 - 2) Discuss rationale of modifications of interventions with patients with osteoporosis/osteopenia.
- (Intermediate) .5 CEU

The Importance of Vital Signs with Physical Therapy Intervention

1:00 pm - 2:30 pm

Speakers: Cathy H Ciolek, PT, GCS, University of Delaware, Newark, DE; Anne Mejia Downs, PT, MPH, CCS, University of Indianapolis, Indianapolis, IN; William Staples, PT, DPT, GCS, University of Indianapolis, Indianapolis, IN

Recent evidence demonstrates a lack of vital sign monitoring in physical therapy clinical practice. This has clinical as well as legal implications for the physical therapy profession. By presenting case studies, the clinical significance of monitoring vital signs with a variety of populations, settings and activities will be demonstrated. Ways to incorporate and interpret vital sign measurement into practice which will also include a review of available equipment, will support the practitioner to include this vital aspect of health care in their daily clinical practice.

Upon completion of this course, you will be able to:

- 1) Identify normal ranges and age related changes for each vital sign at rest.
 - 2) Distinguish between normal and abnormal vital sign response to activity.
- (Multiple Level) 1.5 CEU

Clinical Residency and Fellowship Programs: Credentialing Forum

1:00 pm - 3:00 pm

(Joint Program; Geriatrics; see Women's Health for more details)

(Advanced) 2 CEU

Polypharmacy and Functional Adverse Effects in the Geriatric Population

2:30 pm - 4:30 am

Speakers: Peter C Panus, PT, PhD, East Tennessee State University, Johnson City, TN; Suzanne L Tinsley, PT, PhD, Louisiana State University, Benton, LA

The geriatric population is prescribed a greater number of drugs compared with other sectors of the population. This may be due to the larger number of coexisting pathophysiologies in this population but as such drug-associated adverse events range from 5-35% in the older adult. As the physical therapy profession progresses toward independent practice, the therapist must increase their understanding of how pharmacotherapeutics impact function. By having a comprehensive understanding of adverse drug effects, the therapist will be able to make changes in the rehabilitation program and recognize the need for referrals. Utilizing case studies and reviewing the ICF disablement model, this presentation will address changes that will present in the geriatric population as a result of adverse drug reactions.

Upon completion of this course, you will be able to:

- 1) Describe the major drug classes prescribed to geriatric populations.
- 2) Summarize the major adverse effects associated with each of these drug classes.
- 3) Generalize which major drug classes have the same adverse effects that augment each other.
- 4) Review the current ICF model of disability.
- 5) Describe how these adverse drug effects present as functional deficits in the geriatric patient using the ICF model of disability as a framework.

(Intermediate) 2 CEU

Student Forum: Working With the Older Adult Can Be Fun: A Look at Various Settings for Geriatric Physical Therapy

3:00 pm - 4:30 pm

Moderator: John O Barr, PT, PhD, St. Ambrose University, Davenport, IA

Speakers: Alice Bell, PT, GCS, Genesis Rehabilitation Services, Agawam, MA; Kathryn K Brewer, PT, MEd, GCS, Phoenix, AZ; Jill Heitzman, PT, DPT, GCS, FCCWS, Mary Greeley Rehab and Wellness, Ames, IA; Jane K Okubo, PT, Carmichael, CA; William Staples, PT, DPT, GCS, University of Indianapolis, Indianapolis, IN; Ellen Strunk, PT, MS, GCS, Restore therapy, Birmingham, AL

This interactive, dynamic session is open to students and anyone else interested in learning about the various clinical settings for geriatric physical therapy. Our energetic panelists, from the Section on Geriatrics Board of Directors, will discuss their clinical settings and why they are excited to be part of the health care community working with the ever-increasing aging population. Students attending this session will also find out how they can win textbooks on aging and other prizes. If you have ever considered working with the older population or wondered why physical therapists choose this field, this session is for you. At the conclusion of the presentation, you will be able to interact with the panelists and ask your own questions.

Upon completion of this course, you'll be able to:

- 1) Describe the various settings that serve the older population.
- 2) Demonstrate understanding of the ever-changing, dynamic field of geriatric physical therapy.
- 3) Discuss the role of the physical therapist in working with the older population.

(Basic) 1.5 CEU

Section on Geriatrics Membership Meeting and Dinner

4:30 pm - 7:00 pm

All Section members are invited to the members meeting to take part in the decision making process and help direct the future of the Section.

Section on Geriatrics Awards Ceremony and Celebration

7:00 pm - 8:30 pm

Come celebrate and honor members of the Section as they receive awards for outstanding contributions to the Section and the older adult.

Saturday, February 17

Section on Geriatrics Health Promotion and Wellness SIG

7:00 am - 8:15 am

This Special Interest Group promotes health and wellness amongst the older adult. Come be part of this special group.

Health and Wellness SIG Meeting**7:00 am - 8:15 am****Geriatrics Platform Session #2****8:15 am - 11:00 am****Section on Geriatrics Health Promotion and Wellness SIG Programming: The Rage Against Age****8:30 am - 11:00 am****Moderator:** Priscilla Raasch-Mason, PT, MS2, WakeMed Zebulon, Raleigh, NC**Speakers:** Patrice Antony, PT, GCS, Elder Advocates, Orlando, FL; Jennifer Marie Fabre, PT, CSCS, PhD fellow, Louisiana State University/Therapeutic By Design Fitness and Wellness, Baton Rouge, LA; Jill Heitzman, PT, DPT, GCS, FCCWS, Mary Greeley Rehab and Wellness, Ames, IA; Mindy Oxman, PT, MS, GCS, Elder Care Associates of Billings, Billings, MT; Phillip Page, PT, MS, ATC, CSCS, Louisiana State University/Thera-Band Academy, Baton Rouge, LA

This panel presentation will present major issues related to aging successfully. Tools to help young elders establish their own “Wellness Record, tools to offer fun and stimulating community outreach education and health promotion fairs, and skills to help the therapists market the health fairs will all be presented. The panelists will discuss how these tools and skills can be used with simple assessment tools to allow collaborative longitudinal studies for future use. Come be ready to go back to your practice setting and continue the fight against Age.

Upon completion of this course, you will be able to:

- 1) Discuss assessment tools that can be easily used at a community health fair and/or education session.
 - 2) Establish fun and educational programs and health fairs to promote successful aging.
 - 3) Utilize skills presented to organize and market a wellness program.
 - 4) Describe the need for tracking the data for longitudinal studies regarding successful aging.
- (Intermediate) 2.5 CEU

Hip School**1:00 pm - 2:30 pm****Speakers:** Phillip Page, PT, MS, ATC, CSCS, Louisiana State University/Thera-Band Academy, Baton Rouge, LA; Michael Rogers, PhD, FACSM, CSCS, Wichita State University, Wichita, KS

“Hip School” is a new group exercise program from Germany. It was developed by an orthopedic surgeon and physical therapist to provide specific exercises for patients with hip osteoarthritis. This group-based program emphasizes education, submaximal eccentric training strengthening, and progressive balance training. The goal of the program is to prevent or delay hip replacement surgery, and to speed the recovery after surgery. Hip School can be implemented as a pre/post-rehabilitation program. Research has shown improvements in strength and endurance for up to two years.

Upon completion of this course, you will be able to:

- 1) Describe the research supporting Hip School.
 - 2) Demonstrate exercises specific to hip osteoarthritis.
- (Basic) 1.5 CEU

Dementia: Considerations for Physical Therapy Interventions**2:30 pm - 4:30 pm****Speaker:** Kerri Bednarcik, PT, Yardley, PA

This session will provide a brief overview of dementia and a framework for understanding dementia via the use of the Global Deterioration Scale. Key points will be highlighted for planning treatment interventions based on the stage of dementia. Videos will be used to illustrate behavioral/functional performance at several stages.

Upon completion of this course, you will be able to:

- 1) Discuss the dementia disease process through the use of the Global Deterioration Scale (GDS).
 - 2) Identify behavioral and functional performance changes throughout the dementia disease process that correlate to the GDS Stages of Dementia.
- (Intermediate) 2 CEU

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Strangers

are friends

that you have yet to meet.

- Lieberman

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