

GERINOTES

SECTION ON GERIATRICS, AMERICAN PHYSICAL THERAPY ASSOCIATION

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Topics in Geriatrics

Volume 4



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Course Description

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- Reimbursement Issues in Health Care: Understanding the Medicare and Medicaid System—*Bob Thomas, PT, MS*
- Breast Cancer: The Role of the Physical Therapist—*Nicole L. Stout Gerlich, MPT, CLT-LANA*
- Issues in the Veterans Health Care System: A Focus on the Veterans Health Administration for the Physical Therapist—*Alice Dorworth Holder, PT, MHS*
- An Interdisciplinary Approach to End-of-Life Issues—*Nancy R. Kirsch, PT, DPT, PhD*
- Pharmacokinetics, Pharmacodynamics, and Disease Management: Implications for Physical Therapists—*Orly Vardeny, PharmD, and Bryan Heiderscheit, PT, PhD*

Editor

Sue Wenker, PT, MS, GCS

Additional Questions

Phone toll free 877/766-3452 • Fax 608/788-3965

Section on Geriatrics, APTA, 2920 East Avenue South, Suite 200,
La Crosse, WI 54601

Current Courses Available

- Topics in Geriatrics: Volume 3—30 contact hours (topics include the older driver, bariatric geriatrics, fall prevention, public health, exercise prescription, and successful aging)
- FOCUS: Geriatric Physical Therapy—30 contact hours

- Topics in Geriatrics, Volume 2—30 contact hours (topics include: therapeutic exercise, chronic obstructive pulmonary disease, post-polio syndrome, aquatic exercise, physical and chemical restraints, ethics) (Formerly named Topics in Geriatrics 2005)
- Topics in Geriatrics, Volume 1—20 contact hours (topics include: issues in home care, Alzheimer disease, diabetes) (Formerly named Topics in Geriatrics 2004)
- Focus on Physical Therapist Assistants in Geriatrics—10 contact hours
- Cultural Diversity of Older Americans—30 contact hours

Fees for Current Home Study Courses

	Section on Geriatrics Member	APTA Member	Non-APTA Member
Topics in Geriatrics: Volume 4 (available thru Dec 2013)	\$200	\$300	\$400
Topics in Geriatrics: Volume 3 (available thru Dec 2012)	\$200	\$300	\$400
FOCUS: Geriatric Physical Therapy (available thru Dec 2011)	\$200	\$300	\$400
Topics in Geriatrics: Volume 2 (available thru Dec 2010)	\$200	\$300	\$400
Topics in Geriatrics: Volume 1 (available thru Dec 2009)	\$135	\$200	\$270
Focus on PTAs (available thru Dec 2009)	\$50	\$75	\$100
Cultural Diversity of Older Americans (available thru Dec 2008)	\$150 \$75 while supplies last	\$225 \$175 while supplies last	\$300 \$250 while supplies last

WI residents add applicable state sales tax.

If notification of cancellation is received in writing prior to the course, the registration fee will be refunded, less a 20% administrative fee. Absolutely no refunds will be given after the start of the course.

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Name _____ Credentials (circle one) PT, PTA, other _____

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I wish to join the Section on Geriatrics and take advantage of the membership rate.

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The Section on Geriatrics' website offers members and others easily accessible information about the Section, upcoming events and conferences, continuing education, specialist certification, and research as well as information for clients and their families.

www.geriatricspt.org

EDITOR'S MESSAGE

OUR RESPONSIBILITY BEYOND DISCHARGE

Carol Schunk, PT, PsyD



I was able to attend the APTA annual conference in San Antonio to participate in the Section Board Meeting. The Section was in good form having presented a motion to

the house that passed unanimously. The focus of the bill is to recognize the role of physical therapists and physical therapist assistants as promoters and advocates for physical activity and exercise. We are in such a primary position to influence the continued health and wellness of older adults. The Section on Geriatrics is being increasingly proactive with the concept of promoting our expertise and continued education of exercise and continued wellness in older adults. Just prior to traveling to Texas, I traveled with a friend from Phoenix to Telluride, Colorado for the Telluride Jazz Festival. A wonderful 3 days of music and dancing surrounded by incredible scenery. I digress, but while in Telluride I read an article in one of the local magazines on "The Demise of the American Medical Industry." The premise of the author who is a physician was formulated around a cute story that long ago, a community of people lived high on a cliff and occasionally someone would fall off the cliff. As opposed to teaching people to not fall off the cliff (think balance), the community built a medical facility at the bottom of the cliff to treat the people who fell off. The author then expanded this premise into the woes of today's health care system which only deals with consequences, not prevention. I was struck with the content as it was indeed a case for what the Section on Geriatrics is attempting to do, being proactive with a focus on prevention and wellness. The Section is not waiting until someone is no longer able to function but to intervene and keep older adults active and fit.

The article in this issue of *GeriNotes* by Barnes, Colson, and Current is a perfect example of clinicians recognizing that our obligation continues after the patient is discharged. Their project of a wellness

booklet was in response to the concern that all the attention and progress made during rehab is lost after a person is discharged and on their own. With a fitness focus, they looked beyond discharge with material and education. When I teach home health courses, I also try to instill among home health therapists that their responsibilities go beyond discharge. While not appropriate for all patients, some have the capacity to return to being active adults in the community. This should be part of the plan of care, even though reimbursement is sometimes difficult. The role of being an advocate for continued fitness is one that can not be ignored.

Sandra Levi's article in this issue includes research on the lack of continued use of assistive devices after discharge. She emphasizes ways that therapists can influence postdischarge compliance which includes the need for therapists to include patient's perceptions as part of their assessments and work to assure that the progress and function gained continues past discharge. John Cheeks wrote an outstanding article on Pay for Performance in the May issue. He is back with new information in an article on the models of long-term care which fit right in with the concept of the active healthy older person.

On a personal note, my father recently had home health therapy. As in Helen Cornely's article in the May issue when she described being on the other side of the fence with her husband's cancer treatment, this was an interesting place to be. There is much insight to be gained when a family member receives therapy. To start off, my father was very upset that the therapists talked too loud "Why do they have to yell, do they think all old people are deaf?" Then came the issue compliance with the home exercise program or should I say the noncompliance. Again as Sandi describes, there has to be an assessment of the patient's health beliefs and the incorporation of principles of changing health behavior to increase compliance with a home exercise program. Making the exercise functional for my Dad, such as playing piano, was definitely the most successful.

As you may notice, this issue again has fewer pages than previous issues. As a fall out of the current economic times, our advertising has dropped significantly. While there are a comparable number of articles, with minimal advertising, the pages are fewer. The Section is working on the advertising side of publishing. This issue includes several very fun interviews. Something we have not included for a while. You have the opportunity to "Meet a Leader" in the personality of SOG Board member, Alice Bell. As our new Section Executive, we also invite you to meet Andrea Saevoon. Tim Kauffman, in recognition of the Sections 30 year anniversary, interviewed some of our leaders. For those of us who have been Section members for many, many years it is amazing our progress in being recognized in the Association as a progressive, active group. As I mentioned in the beginning of this message, our Section leadership promoting the role of therapists for our expertise and skill in the area of exercise, wellness, and fitness for the older adult is impressive. The evidence is there through our House motion, continuing education, and the Exercise Task Force. We are definitely a model for the saying from years ago... "You have come a long way baby."

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ARTICLES FOR GERINOTES

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OR AN IDEA

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CONTACT CAROL SCHUNK, GERINOTES
EDITOR

carolschunk@earthlink.net

PRESIDENT'S PERSPECTIVE: WE NEED TO BE ACTIVE IN RETOOLING FOR AN AGING AMERICA

John O. Barr, PT, PhD



On April 14, 2008, the Institute of Medicine's Committee on the Future Health Care Workforce for Older Americans released its 312 page report *Retooling for an Aging America: Building the Health Care Workforce*.¹ Two days later during Senate testimony, committee chairman John Rowe, MD, stated, "I am here today to call your attention to a looming crisis that is quickly approaching: the considerable shortfall in the quality and organization of the health care workforce to care for tomorrow's older Americans."² This report is a call for fundamental reform in the way that the workforce is both trained and used in the care of older adults.

Unfortunately this report focuses almost exclusively on other health care workers such as nurses, physicians, physician assistants, pharmacists, dentists, and social workers. Since there is scant mention of physical therapists and physical therapist assistants in this report, findings and recommendations summarized below must be extrapolated to our profession. The report adopts a 3-pronged approach:

1. Enhancing geriatric competence of the entire workforce. The health care workforce overall was found to receive very little geriatric training, and was thus deemed as unprepared to deliver the best possible care to older patients. Among the evidence cited was a 1995 HRSA report on the status of geriatric education that revealed less than 20% of PT programs had at least 75% of their students complete a geriatric internship. Also, less than 1% of nurses and pharmacists are certified in geriatrics. It was determined that geriatric competence could be improved via significant enhancements in curricula and training. Finally, it was recommended that competence in the care of older adults be a criterion for licensure and certification.

2. Increasing recruitment and retention of geriatric specialists and caregivers. It was determined that geriatric specialists are needed in all professions, not only for their expertise, but also because they will be responsible for training the workforce and other caregivers in geriatric principles. It was recommended that financial incentives (eg, improved payment for clinical services, awards to increase numbers of faculty, loan forgiveness, scholarships & direct financial incentives to become geriatric specialists) be provided to increase the number of geriatric specialists in all health professions.

"I am here today to call your attention to a looming crisis that is quickly approaching: the considerable shortfall in the quality and organization of the health care workforce to care for tomorrow's older Americans."

- Dr. John Rowe

3. Improving the way care is delivered. Needed are models of care which address elder health care needs, while encouraging older persons to be active partners in their own care. Among the examples of models described to have supportive findings, and which included specific mention of physical therapists (or "rehabilitation therapists"), were: proactive rehabilitation, as a supplement to primary care; caregiver education and support; and interdisciplinary

team care. Unfortunately, the sharing of models has been very limited, often due to financing systems that don't provide payment for patient education, coordination of care, and interdisciplinary care. The activities of professional groups were seen to reflect a growing awareness of the importance of health promotion and disease prevention for older patients. Remarkably, our Health Promotion & Wellness Special Interest Group was cited for its aims to improve the education, clinical practice, and research of physical therapists in health and wellness among older adults. Committee recommendations included: improved dissemination of effective and efficient models; increased federal and private foundation support for programs that develop new models of care (eg, in the areas of preventive and palliative care). The committee suggested an expansion of the roles for members of the workforce (largely at technical and informal levels) and recommended that federal agencies support development of technological advancements to enhance individuals' capacity to provide care for older persons.

Given the very limited inclusion of material specific to the physical therapy profession, it is important to examine our own sources of information. Relative to geriatric competence, the evaluative criteria for entry-level professional physical therapist education programs, issued by Commission on Accreditation in Physical Therapy Education, offer only limited direction in specifying that:

(CC-4) The physical therapist professional curriculum includes clinical education experiences for each student that encompasses:

- a) management of patients/clients representative of those commonly

seen in practice across the lifespan and the continuum of care;

- b) practice in settings representative of those in which physical therapy is commonly practiced.

Graduates will be able to:

(CC-5.18) Identify, respect, and act with consideration for patients'/clients' differences, values, preferences, and expressed needs in all professional activities.

(CC-5.30) Examine patients/clients by selecting and administering culturally appropriate and age-related tests and measures.

In 2001, Wong and colleagues reported on their survey of physical therapist education programs in the U.S.³ While findings suggested a substantial increase in geriatric content compared to studies conducted 10 to 20 years earlier, fewer than 75% of respondents agreed that topics well or optimally covered were: clinical sciences of pharmacology, physical management of well-elderly, and interpretation of special tests; behavioral sciences of psychology of aging, research design and methodology (related to the older adult), consultation, policy issues and economics, program development, and epidemiology of chronic diseases; examination skills related to pain, reflex integrity, prosthetic requirements, environmental/home/work, and community and work reintegration; and intervention skills related to physical agents and mechanical modalities, prescription/application/ and fabrication of devices/equipment, manual therapy techniques, functional training in community and work reintegration, and airway clearance techniques. Using their survey instrument as a template,

it would be interesting to assess the geriatric content of contemporary PT education programs. Five years of service learning experiences in geriatric physical therapist education have been described by Village and Village.⁴

APTA data reveals that 1.8% of active members are Geriatric Clinical Specialists; but this percentage drops to less than 1% when all PTs in the U.S. are considered. Earlier this spring, we submitted a proposal to the APTA for Recognition of Advanced Proficiency in geriatrics for the PTA. While commendable, we have at this time only two credentialed geriatric clinical residency programs. Relative to increased recruitment and retention, a number of Section initiatives regularly appear in this publication (eg, continuing education and professional development opportunities; a range of aging/geriatrics-related awards; funding for postprofessional doctoral study and initiation of residency programs). In March, Senators Boxer and Collins presented their bill (S 2708), the Caring for an Aging America Act, which promoted a geriatric and gerontology loan repayment program, however, without inclusion of physical therapists. Relative to improving the way that health care is delivered, states and associates recently described their program for reaching ethnically diverse elders via community health education.⁵ Workshops based on interdisciplinary collaboration among 7 health care professions are presented at the website www.GERIE.org, which provides access to instructional and resource materials. This program is intended to address the health education needs of a growing population of older adults from diverse ethnic, cultural, and language minorities.

Like many other health care professions in the U.S., we clearly have made

some, but not yet enough, progress in building the health care workforce to care for tomorrow's older Americans. I encourage you to scrutinize this report and related documents for yourself. Then, join me in taking both intra- and interprofessional actions to assure our productive contribution to this "retooling" process by the target completion date of 2030.

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Dr. Barr is a Professor in the Physical Therapy Department at St. Ambrose University, Davenport, IA. He also serves on the Editorial Board for the Journal of Geriatric Physical Therapy.

Annual Fundraiser for APTA's Minority Scholarship Fund

The 16th Annual Fundraiser for APTA's Minority Scholarship Fund Celebration of Diversity is scheduled for Saturday, October 4, 2008 at the Heard Museum of Native Cultures and Art in Phoenix, AZ. The fundraiser is being co-hosted by the Academic Administrators and Clinical Education Special Interest Groups of the Section for Education. Single ticket prices for the dinner/dance are \$100. Contributions of any amount are welcome. You can also participate by donating items for the Silent Auction. Ad space in the souvenir book may be purchased at \$500 for a full page, \$250 for a ½ page, and \$100 for a business card. For further information, please contact APTA's Department of Minority/International Affairs at 800/999-2782 ext 8554.

FALL PREVENTION: ARE ASSISTIVE DEVICES AND PREVENTION PROGRAMS APPROPRIATE?

Meri Goehring, PT, PhD, GCS

Anyone working in the geriatric field knows that falls among older people create a major public health problem. Falls in the elderly can cause death, disability, dysfunction, depression, anxiety, fear, and reduced quality of life.¹ About one-third of elderly living in the community fall each year. This rate is about 3 times higher among institutionalized elderly. Falls are the leading cause of accidental death and the seventh leading cause of death in persons more than 65 years of age.²

Factors responsible for falls are often classified as intrinsic or extrinsic. Intrinsic factors include physical and mental changes that may cause a person to fall, such as musculoskeletal weakness or cognitive problems. Vestibular disorders, proprioceptive system changes, nocturia, metabolic, and cardiovascular problems as well as problems associated with medications are usually considered intrinsic factors. Extrinsic factors include things such as environmental hazards. Household clutter, inadequate lighting, uneven or slick surfaces are examples. Extrinsic factors can also include assistive devices such as walkers or canes which are often considered devices that can prevent falls.

However, assistive devices designed, in part, to prevent falls, may not necessarily be the best way to ensure falls will not occur. There is some indication that assistive devices may prevent our natural balance reactions. Further, there is some evidence that there may be barriers to the use of assistive devices that should be considered prior to advising use of such a device.

A review article written by Hamid Bateni and Brian Maki in the 2005 *Archives of Physical Medicine and Rehabilitation* offers interesting insight to the use of assistive devices.³ This article reviews the biomechanical principles and related literature regarding the advantages and possible disadvantages associated with single tip canes and pickup walkers. They conclude that the clinical and biomechanical evaluations of canes and

walkers indicate that these devices can improve balance and mobility. However, they also found that straight canes and standard, pick-up walkers can interfere with the ability to maintain balance in certain situations. Further, they found that the strength and metabolic demands while using these devices can be excessive.³

Additionally, in another study by Hamid Bateni et al, it was found that the use of a standard, pick-up walker or straight cane interfered with compensatory stepping reactions when normal subjects underwent large lateral perturbations.⁴ The author clearly indicates that the results should not be generalized to older adults, however, the normal stepping reactions that occur with a fall appear to be difficult with a walker or cane when large and unpredictable balance disturbances occur. Certainly, more research is needed in this area and development of safer assistive devices should be investigated.

When considering barriers to the use of assistive devices, social stigmas that may be attached to aging, disability, and device use can be a powerful influence on an older adult's decision to accept or reject such a device.⁵ Canes and walkers may be considered by some to be a symbol of frailty and loss of function. The social stigma that any individual may associate with an assistive device may be very strong in some cultures.

Therefore, use of an assistive device in fall prevention should be considered carefully. Certainly, there are many appropriate uses for assistive devices. It is important, however, to keep in mind that the socioeconomic and cultural values that an individual may have can also contribute to the successful and appropriate use of an assistive device. Whenever possible, a comprehensive balance and fall prevention program should be incorporated with use of an assistive device.

When designing or recommending a fall prevention program, certain aspects of such a program should be consid-

ered. In a review article by McInnes and Askie,⁶ important insights into fall prevention programs are provided. The key implications of their evidence based review of older people's views and experiences of falls prevention strategies suggests certain key concepts that may be useful.

1. Practitioners who are involved in developing falls prevention programs should ensure that such programs: (1) are flexible enough to accommodate participant's different needs and interests and (2) promote the social value of such programs.
2. Prior to recommending a falls prevention program for an individual, practitioners should consult with people about the changes that are realistic for the individual to make.
3. Assistance or referral to the appropriate service should be provided to address modifiable individual factors that may be barriers to participation, such as fear of falling, denial of risk of falling, and lack of motivation to participate in a program with a physical activity element.
4. To engender and maintain interest in falls prevention programs, potential participants should be given written and verbal information on:
 - the preventable nature of some falls,
 - how to stay motivated, and
 - the physical and psychological benefits of physical activity and of modifying falls risk.

Whether or not to advise an individual to use an assistive device to prevent falls can be a difficult decision for the clinician and client. It is hoped that the information herein will help clinicians working with the geriatric population to help their clients in appropriate and successful fall prevention strategies with or without use of an assistive device.

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Meri Goehring, PT, PhD, GCS, is an Assistant Professor in the Physical Therapy Program at Northern Illinois University and an active clinician at Kishwaukee Community Hospital in DeKalb, Illinois. She is the District Chair for the Illinois Physical Therapy Association's North Central District and is co-chair of the Federation of State Boards of Physical Therapy Examination Development Committee.

FUTURE APTA NATIONAL MEETINGS

National Student Conclave 2008
October 17-19, 2008
San Jose, CA

CSM 2009
February 9-12, 2009

Annual Conference: PT 2009
June 10-13, 2009

National Student Conclave 2009
October 29-31, 2009
Miami, FL

DREAMCATCHERS 2: REVITALIZING ETHICS IN REHABILITATION

Section on Geriatrics Supports Interdisciplinary Ethics Workshop

Mary Ann Wharton, PT, MS

An interdisciplinary group of occupational and physical therapist leaders in ethics education met at the Ithaca College – Rochester Center in Rochester, New York from April 24 – 27, 2008 for a working conference entitled "Dreamcatchers 2: Revitalizing Ethics in Rehabilitation." This was the second meeting of this ethics consortium. The first meeting, held in September 2003, culminated in the award winning textbook entitled, *Educating for Moral Action: A Sourcebook in Health and Rehabilitation Ethics* (Philadelphia, FA Davis) and provided a framework for continued dialogue among participants about essential ethics education for practice and policy initiatives.

Geriatric Section members, Carol Davis and Mary Ann Wharton served on the planning committee for the Dreamcatchers 2 conference. Laurie Kontney was one of the newly invited participants. This conference focused on issues and challenges specific to rehabilitation ethics. The purpose was to foster the scholar-educator in rehabilitation ethics. Specific objectives were to recommend effective curricular

approaches to ethics and professionalism in the classroom and clinical settings, establish a vision and strategic agenda for the development of scholarship in ethics and professionalism in physical and occupational therapy, and promote scholarship in ethics and professionalism in physical and occupational therapy. Conference participants worked with several outstanding ethics consultants, each of whom presented a focused talk that challenged conference participants to reflect on issues specific to rehabilitation ethics. Dr. Robert Nash and Ms. DeMethra LaSha Bradley introduced the concept of 3 moral languages. Dr. Joseph Allegretti presented a provocative lecture that addressed career as calling, contract, or covenant. Dr. Madeline Schmitt focused her remarks on interprofessional education and collaborative practice. Dr. Ruth Purtilo built on the theme of her Mary McMillan lecture and challenged the group to look to a new season in ethics education that prepares students to be virile, cultivate moral virtue, and examine the potential for expanding moral imagination.

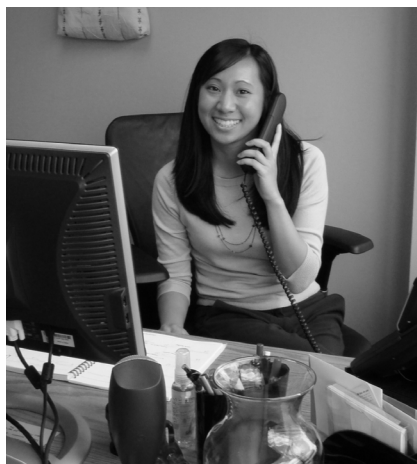
At the conclusion of the conference,

workgroups comprised of conference participants were formed to foster ongoing dissemination of scholarly reflection in ethics through publications, papers, and presentations. The goal of the group is to continue their efforts in rehabilitation ethics through additional working conferences and collaborative scholarly products.

The planners of Dreamcatchers 2 would like to thank the Section on Geriatrics for their generosity in assisting with funding for this conference.

Mary Ann Wharton is an Associate Professor and Curriculum Coordinator at St. Francis University, Loretto, PA. Chair of the PA Chapter Ethics Committee for the past 14 years, she was an invited educator for the first Dreamcatchers Conference and a member of the planning committee for Dreamcatchers II. She has been a chapter author addressing ethical issues in the Geriatric Rehabilitation Manual and in Educating for Moral Action: A Sourcebook for Rehabilitation Professionals. Mary Ann was Program Chair for the Section on Geriatrics from 1983 to 1997.

SECTION ON GERIATRICS GETS NEW EXECUTIVE DIRECTOR



Working in the office.

Andrea Saevoon was recently named the Section Executive of the Section on Geriatrics. She replaces Jennifer Sabo who resigned in anticipation of her new baby. Below is a brief interview with Andrea to introduce her to our members.

TELL US A BIT ABOUT YOUR SELF:

I grew up in Falls Church, Virginia and graduated from James Madison University, Magna Cum Laude. At James Madison University, I majored

in Health Service Administration and minored in Business. Traveling is my passion, some of the best places I have visited include Russia, Croatia, Austria, Italy, Thailand and China!

WHAT WERE YOU DOING PRIOR TO JOINING THE APTA:

Immediately prior to joining the American Physical Therapy Association, I worked as a business analyst for BearingPoint, a management consulting firm in located in McLean, Virginia. There I worked with the Department of Health and Human Services Office of the Secretary and the Administration for Children and Families.

WHAT HAS BEEN YOUR EXPOSURE TO PHYSICAL THERAPY:

As a volunteer at Hess Orthopedics and Generations Crossing's Adult Day Care center I have seen the tremendous value of physical therapists and their work with aging adults.

WHAT APPEALED TO YOU ABOUT THIS POSITION:

I love to organize, plan, and interacting with members to help physical therapist deliver the best health care



With Jennifer Sims, senior administrative assistant, for the Section on Geriatrics.

to their patients. I also look forward to working with a dedicated group of volunteers who are passionate about health care and people!

TELL US A BIT ABOUT YOUR NONWORKING LIFE:

During my nonworking life, I enjoy volunteering with middle school youth group and Sunday school at my church. I also enjoy baking, reading, and art. I also love outdoor markets and the beach!

ANNUAL CONFERENCE 2008



Section Board Meeting.



Geriatric Section Table for the Foundation dinner--Carol Schunk, Jill Heitzman, Section President John Barr, Cathy Ciolek, Joe Lucca

DEVELOPMENT OF A WELLNESS EDUCATION BOOKLET

Lisa J. Barnes, PT, DPT; Sherry L. Colson, PT; David A. Current, SPT

INTRODUCTION

Health care professionals at rehabilitation facilities provide the care and educational programs that patients need in order to transition back into the home environment. Often, as the patients begin to make progress in the rehabilitation process, they express that they are functioning better than they did prior to admission. In an effort to expand upon this improved level of function and facilitate a long-term improvement in the quality of life for patients, the concept of a wellness tool was created. The project of developing a wellness education booklet to be used in a short-term geriatric rehabilitation facility was undertaken as a clinical site project for a physical therapy student in preparation for graduation. The clinic had identified a need, and the student was able to help incorporate the needs of the clinic into the educational requirements of the physical therapy program to address real-life clinical issues. This patient-centered program was developed for use within a company of short-term rehabilitation facilities that serves the people of Mississippi. It was a great example of a symbiotic relationship between the student and the clinical site. The student was afforded the opportunity to investigate all needs of the patients within this specific type of facility for a better educational experience, and was able to “give back” to the facility and the future clients who will reap the benefits of his work.

TRADITIONAL HOME EXERCISE PROGRAM

The education and care provided during a traditional inpatient stay includes many health care professionals readily available to provide assistance and support with daily activities and therapy programs. The patients are served within the clinical environment and are provided repeated verbal reminders and encouragement to meet the stated goals of the program. When the patients are discharged from the facility, they are traditionally given home instructions which are specific to the individual disciplines in which they have taken part. For example, the physical therapy discharge instructions

might include a home exercise program that describes lower extremity exercises, a walking program, and safety information.

THE PROBLEM

As patients are discharged into the home environment, the support from caregivers and health care professionals in the facility is no longer available. Individuals find themselves back into their everyday lives with new and different things to think about. This may lead to a decreased level of motivation to continue with the activities they learned while in the facility. They may also have difficulty re-entering into social gatherings due to transportation issues, architectural barriers, or a sense they have been excluded during their absence. The development of a wellness education booklet was undertaken as a way to expand the educational process and improve continued motivation to strive for a healthier lifestyle following discharge. Therapists had a desire for a new tool to use as a guide during the rehabilitation process. This tool would ensure that the patients have ample opportunity to listen, practice the new skills, and review the information in order to confidently take more responsibility for individual choices and behaviors.¹ By taking responsibility for his or her own lifestyle choices and health status, patients would be more highly motivated to continue activities and decisions that they learned while participating in the rehabilitation process.

THE NEW PROGRAM

The new wellness education booklet is a spiral notebook that is used during the rehabilitation process to facilitate education, daily reminders, and encouragement to help the patients to stay on track for the return to a healthy lifestyle and an improved quality of life. The booklet is a written guide for a comprehensive and systematic educational program that is to be used during the rehabilitation stay as well as after discharge. The goal of this tool is to focus the patient's attention on wellness as the rehabilitation team facilitates the educational process and models appropriate choices.¹ The aspect

of this booklet that makes it different from many traditional home exercise programs is the comprehensive focus on health and wellness. Instead of patients being given a list of exercises and instruction related only to the physical activities recommended by the therapists, this booklet provides a more holistic approach for healthy lifestyle choices. In addition to specific exercises, the booklet contains information on living in a manner that promotes health and wellness, fitness, fall prevention, and nutrition. It also includes educational references for use by the patients and families. As the patients are discharged into the community, they are encouraged to actually take part in social activities within the community as they did prior to the illness or injury that facilitated their time spent in rehabilitation. The desire is for patients to leave the facility with the attitude that they are healthy, and that they know how to proceed with their lives in a manner that helps them to stay healthy in the future.

CONTENTS OF THE BOOKLET

Patient and family educational material is compiled into one tool that serves as a catalyst for an increased personal effort to live a healthier and more active lifestyle. The booklet is designed to assist in the development of a comprehensive set of skills and attitudes that are developed throughout the rehabilitation process. It is used during the patients' clinical sessions to promote a deeper level of understanding. Designed to be more than a traditional home program, the intent is to go beyond educating the patients on the “how,” and to facilitate learning as to the “why” involved in daily activities and lifestyle choices. As patients reflect upon the various consequences of their decisions, a new perspective on the meaning of wellness and quality of life could be realized.

What is Wellness?

The booklet includes a specific definition of wellness which is described by the National Wellness Institute as “a conscious, self-directed and evolving process of achieving full potential.”² It also presents general guidelines for well-

ness as they relate to topics such as diet, fall prevention, fitness, personalized home exercise programs, and resources available for further information. Several specific topics included in the booklet illustrate the types of information included in this client reference guide (see Table 1).

Eating healthy

In the section related to nutrition, patients are oriented to the general guidelines for healthy eating in conjunction with specific recommendations from their physician. The American Dietetic Association reports that the comprehensive pattern of eating and making food choices that include an assortment of foods in correct portion sizes are key to a healthy diet.³ The team of health care professionals within the facility work together to provide information and examples that demonstrate the type of food choices that are deemed appropriate for the individual patients in a multidisciplinary effort to help the patients learn the components of a healthy eating program. The staff educates the patients and attempts to ensure understanding of the information provided within the wellness booklet for use after discharge.

Fall Prevention

The booklet also includes a section related to fall prevention. As rehabilitation professionals, physical therapists involved in the care of the elderly are keenly aware of the risk for falls and the sometimes-devastating consequences that follow. Falls in the elderly population have been shown to be the main cause of accidental deaths in those who are greater than 65 years of age.⁴ Unfortunately, many patients do not internalize the risks and subsequent disruption in their lives until a fall actually occurs. Risk factors for falls in the elderly include things such as deficits in strength and flexibility, cognitive changes, gait disturbances, and the use of multiple medications.⁵ Rehabilitation specialists routinely identify risk factors specific to their individual patients as they are related to the potential for falls.

Although the health care professional may fully understand the risks that the patients face, the challenge of achieving complete comprehension from the patients' standpoint continues to exist. In order to facilitate behavioral changes that may lead to a decrease in the risk of falls, patient education that includes

critical reflection is facilitated through the use of the wellness booklet. There are many fall prevention tools available to the rehabilitation professional for assistance in the education of patients. This booklet provides adjunct information to facilitate understanding of why falls occur, prevention techniques, and understanding of the possible consequences.

Fitness

General information about fitness throughout the aging process is incorporated into the booklet in addition to an individualized home exercise program for each patient. Understanding of the normal changes that occur with aging may help the patient to have a clearer understanding of the types of activities in which they can safely and enjoyably participate while improving his or her overall fitness level. One-on-one investigation into lifestyle choices, leisure activities, hobbies, etc., can assist the rehabilitation professionals in developing realistic fitness related activities for each client. Attention should be paid to individual likes and dislikes in order to avoid putting valuable time and effort into a program that will not be followed once the patient returns home. By involving the patient in the planning process and incorporating fitness activities into the rehabilitation setting, the patients can return home with confidence that the activities can be performed safely. They will develop an understanding of the specific benefits of a fitness program both physically and emotionally.

Home exercises

In addition to fitness related activities, there is a section that is similar to a more traditional home exercise program. This section contains 12 printed exercises that the staff chose as the ones used most often in home programs. These are personalized by the staff for each patient. There is also an area for the addition of other specific exercises to meet individual needs.

Things to Remember

As a follow-up to the section containing the individualized home exercises there are specific "do's" and "don'ts" related to exercise. For example, do not "ignore new pains or symptoms while exercising," and do "contact your doctor" if this does occur.

SUMMARY

This article described a booklet that

Table 1. Contents of Wellness Education Booklet

WELLNESS EDUCATION BOOKLET

- What is wellness?
 - Explanation of wellness
- Eating Healthy
 - Benefits of a healthy diet
 - Food pyramid recommendations
- Fall Prevention
 - Facts about falls and complications
 - Understanding risk factors for falls
 - Ways to reduce the risk of falls
- Fitness
 - Information on changes in the aging body
 - Guidelines for choosing enjoyable fitness activities
- Home Exercises
 - Pictures and explanations of twelve basic exercises are included that can be personalized
 - Space for additional exercises as appropriate
- Things to Remember
 - "Do's and Don'ts" for healthy exercise
- Educational Resources
 - Websites recommended for additional information on topics included in the booklet
 - Phone numbers for additional information from local agencies

was developed to assist patients in transitioning from the rehabilitation setting to the home. The booklet is a compilation of educational materials and instructions to assist patients in continuing to use the information on wellness and healthy lifestyle choices outside of the rehabilitation setting. Its concept derived from a genuine concern by the physical therapists within a small rehabilitation facility that the patients served by the facility receive the highest quality of care. There was a desire to help these patients return to the home and community settings with improved knowledge and motivation in their quest for a healthy and active life. Physical therapists have a responsibility to work with individual patients as educators and as guides for healthy lifestyle choices that will facilitate active participation within the home and community.⁶ This booklet offers educational material, guidance, instructions about risks and prevention, and other types of educational resources that can be used by the patients and their families. Through the integration of this tool into discharge planning and daily therapy activities within the rehabilitation facility, a deeper level of understanding and motivation can be developed within the

individual patients that may result in positive lifestyle choices that lead to increased levels of health and wellness.

1.

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Lisa J. Barnes has practiced physical therapy in the clinical setting as a clinical practitioner, manager, and educator since she graduated from the University of Mississippi Medical Center in 1984. She received the Doctor of Physical Therapy Degree in 2005, and is currently working toward her PhD in adult education at the University of Southern Mississippi. Presently, she is an assistant professor of physical therapy at the University of Mississippi Medical Center, where she teaches and serves as a coordinator of clinical education. She also serves as the Chair of the Ethics Committee for the Mississippi Physical Therapy Association.

Sherry L. Colson has practiced physical therapy since receiving her B.S. degree in 1981 from the University of Mississippi Medical Center. She has served the clients of Lakeland Nursing and Rehabilitation for the past 12 years. Currently she is working toward a transition Doctor of Physical Therapy degree from the University of Mississippi Medical Center in Jackson, Mississippi.

David A. Current is a student in the physical therapy program at the University of Mississippi Medical Center School of Health Related Professions. He is scheduled to graduate on May 23, 2008 with a Doctor of Physical Therapy.

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ENSURING PATIENTS USE PRESCRIBED MOBILITY DEVICES

By Sandra J. Levi, PT, PhD



Many older adults receive adaptive equipment for mobility during rehabilitation. Research suggests that much of this equipment is not used after discharge. Physical therapists can increase the likelihood that patients will regularly use prescribed assistive devices by including strategies to change health behavior in patient management.

Older adults use a lot of adaptive equipment. Nearly one fourth of community-dwelling older adults in the United States use adaptive equipment. Among the 17 million persons in the United States who used assistive devices in 1994, 7.4 million used devices for mobility impairments. Mobility device users included 575,000 persons with crutches, 4.7 million with canes, 1.8 million with walkers, 677,000 with medical shoes, 1.5 million with wheelchairs, and 140,000 with scooters.

Many older adults who receive adaptive equipment do not use the assistive devices prescribed by health care providers. From 18% to 47% of older adults who are given assistive devices during a hospital stay seldom or never use those devices during the first post-hospital month.²⁻⁴ Usage rates in Canada and the United Kingdom seem to be similar.⁴ In addition, nearly 50% of persons with quadriplegia do not use the upper extremity assistive devices that they used during their rehabilitation stays 12 months later.

Few demographic characteristics explain non-use of devices prescribed for older adults. Among studies that examine the differences between personal characteristics of users and nonusers, only age seems to consistently and strongly predict use. Those using devices tend to be older.^{1,6} Characteristics such as lower education and living alone may

be weakly associated with use.¹ For characteristics such as gender, research results are equivocal. Females may be more likely than males to use devices⁴ or males and females may use devices at similar rates. Lower socioeconomic status predicts use¹ or it may not predict use.⁶ Being sicker may predict use⁴ or it may not.⁶ Fallers and nonfallers may be equally likely to use devices.⁶

Many older adults receive adaptive equipment for mobility during rehabilitation. Research suggests that much of this equipment is not used after discharge.

The social circumstances of patients may help explain differences between users and nonusers of mobility devices. Many physical therapists recall a patient like Ms. B. Ms. B was 72 years old and presented to a physical therapist with weak left hip musculature, a Trendelenburg gait pattern, and a high level of pain when bearing weight on the left lower extremity. Although she had severe osteoarthritis, she did not desire hip replacement surgery. After 8 physical therapy sessions provided over 8 weeks, Ms. B. walked pain free 2,000 feet with a wheeled walker. A month following discharge from physical therapy, the physical therapist ran into Ms. B. at church. Ms. B. grimaced as she wobbled without any assistive device.

With a smile, the therapist asked Ms. B., "Where is your walker?"

Ms. B. explained, "I know I should use the walker, but..."

"At home it's easier to hold on to furniture. When away from home, I don't want people to think I am frail."

After reflecting on the amicable conversation, the physical therapist thought about what she could do to influence

Ms. B. to use the walker. Perhaps the therapist could have increased the likelihood that this patient would have sustained use of the prescribed assistive device by addressing the social meaning of the device.

For many older adults, using a mobility device constitutes a major life change. The transition from mobility without an assistive device to mobility with an assistive device is a health behavior change. Health behaviors are the actions that individuals take to maintain or promote well-being. A large body of research demonstrates that changing diet and exercise behaviors are difficult. Many people know that a good diet and regular exercise enhance health. By itself, this knowledge rarely motivates people to sustain changes in their diet and exercise habits. Similarly, the continued use of an assistive device for mobility requires much more than knowing. Knowing that an assistive device will improve safety and knowing how to use the assistive device may not be enough to influence patients to use assistive devices for a long duration.

Explicitly managing patient perceptions may increase the likelihood that older adults will use mobility devices. A body of literature demonstrates that patient self-perception strongly influences whether or not an older adult will continue to use an assistive device prescribed for chronic mobility problems.^{3,8,9} Physical therapists routinely evaluate patients' physical functioning and the procedural requirements (eg, reimbursement rules) in their decision-making regarding mobility devices for older adults.¹⁰ Many therapists also evaluate patients' perceptions of their environment, needs, roles, and values/life plans. Physical therapists usually explicitly document their prediction of the physical function outcome to be achieved with the use of a particular assistive device. Less frequently, physical therapists explicitly predict and document the self perception outcomes to

be achieved with the use a particular assistive device. Some therapists may excessively rely on physical functioning to make clinical decisions regarding the usefulness of a mobility device for a patient. By explicitly including examination, evaluation, diagnosis, and intervention related to patient perception, physical therapists could help patients sustain the use of needed mobility devices for the duration of the need.

Explicitly managing social pressure may increase the likelihood that older adults will use mobility devices. Social pressure affects the use of assistive devices.^{11,12} At least among persons with post-polio syndrome, assistive device usage may have more to do with a sense of being accepted by others than by self-acceptance.¹² Many older adults view mobility devices such as canes as symbols of aging. Older adults who feel stigmatized by aging are less likely to use a cane than older adults who do not feel stigmatized by old age.⁹ In a study of 100 patients discharged with assistive devices, those with 2 or 3 home occupational therapy visits were more likely to use equipment and be satisfied with equipment. By explicitly including the examination, evaluation, diagnosis, and intervention of a patient, physical therapists could help patients use a needed mobility device for the duration of the need.

Physical therapists can influence personal perceptions and social meaning of mobility equipment. During the examination and evaluation components of patient client management, physical therapists can identify what a device will mean to a patient's self concept and social interactions. They can develop diagnoses and prognoses related to the likelihood that a patient will sustain the use of a device. They can address the personal meanings and social consequences of using devices in intervention plans. I believe that most physical therapists consider patient's perspectives on a regular basis. In order to ensure continued use of mobility devices, I believe it is also important to explicitly develop a management plan to deal with the personal and social meanings of assistive devices.

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Sandra J. Levi an Associate Professor in the Physical Therapy Program at Midwestern University, focuses her teaching and research in the areas of professionalism and geriatrics. She currently serves on the Section's Advanced Clinical Practice Committee. She has been a co-investigator on three grants from the Health Resources and Services Administration (HRSA), an agency of the U.S. Department of Health and Human Services.

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MEET THE LEADERS OF THE SECTION:

Featuring Alice Bell, PT, GCS

The following is an interview with Alice Bell a member of the Section on Geriatric Board of Director. This is part of our ongoing in series in GeriNotes of Meet the Leaders.



From left to right—Me, my baby brother Peter and my oldest brother Jimmy at the St. Patrick's Day parade; an annual even for family and friends.

What led you down the path of Physical Therapy as a career?

From a very early age I knew I wanted to work in health care. I began researching various careers, and by seventh grade I had decided on Physical Therapy. I entered high school with only one goal in mind—to gain acceptance to a Physical Therapy program. Although there were tears and frustration at times, and moments of profound anxiety, the majority of my PT school experience was wonderful. I made great friends, had wonderful professors, and learned a great deal. My clinical experiences were all amazing. I was truly blessed with exceptional clinical instructors at Mount Auburn Hospital in Cambridge, Columbia Presbyterian Medical Center in New York, and Mercy Rehabilitation Unit in Springfield, Massachusetts. My education at Northeastern University was very strong and I am grateful for the experience.

What or who got you started on being professionally active?

My first motivation to be professionally active came during PT school. Several of my professors spoke of the importance of being an active member of the APTA. Within a year of graduation, I began to get involved at a local level by attending meetings. I went through the APTA Clinical Instructor Credentialing Program and, as soon as possible, started supervising students. I found I really enjoyed having students and mentoring new staff. When I began to work in long-term care, I really started to recognize how important my involvement in the association was. I had accepted a position in a nursing home in 1988 after having worked in acute rehab, acute care, and home care. I was excited to be entering a facility that was very progressive and recognized the critical role of rehabilitation therapy in the skilled nursing setting. At that time, I also began to realize that I needed to become more of a leader in rehabilitation and a role model and mentor for other therapists.

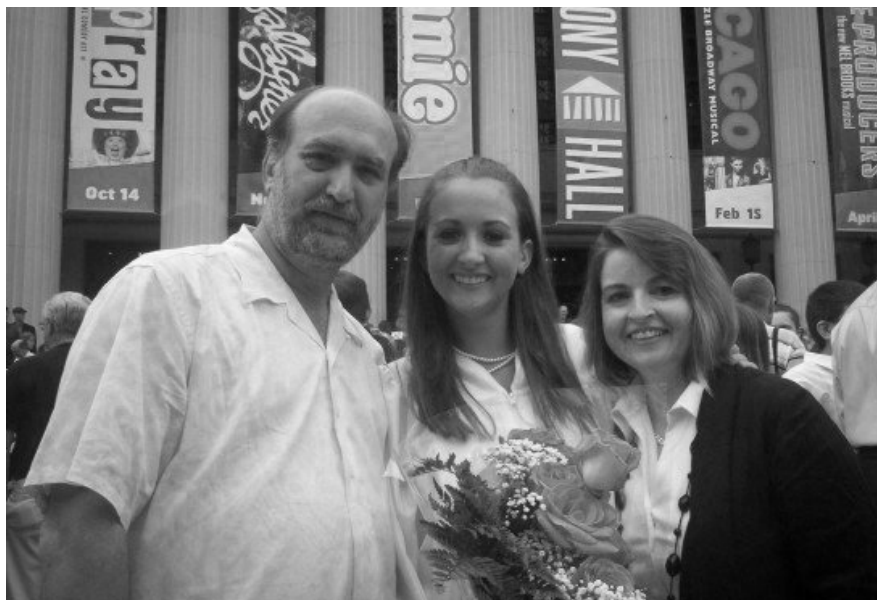
How did you first get initiated in the Section?

In 1993 I decided to pursue my

Specialty Certification in Geriatrics. I attended the Focus course at the Combined Sections Meeting in San Antonio. It was at that meeting I met Kate Kline (now Mangione). Kate was my first strong connection to the SOG, and I thank her for all she did to help me network and find my place in the Section. I am also grateful to Carole Lewis who was always so gracious and welcoming to me. Anne Meyers took me under her wing as I worked to become more involved in the Membership Committee and guided me as I became chair of that committee. Jennifer Bottomley is one of the most generous and kind individuals I have ever met. Dale Avers has had an amazing influence on me in terms of my passion and desire for continued pursuit of excellence in practice. I currently serve with an exceptional group of individuals. John Barr is an amazing President and a friend. Anne Coffman, Rubye Walker, Bill Staples, Jill Heitzman, Greg Hartley, Ellen Strunk, Kathy Brewer, Lucy Jones, Missy Criss, Tim Kaufman, Michele Lusardi, Cathy Ciolek, Marilyn Moffat, Carol Schunk, I am so proud to serve with you. I wish I could name everyone from the Section to whom I am grateful but the list would be too long. Please



My family at my brother's wedding this past April.



My husband Michael, our daughter Lauren, and me at her high school graduation.

know that I appreciate everyone I have come in contact with and am so grateful for all you have shared with me.

What is your present position in the Section and what do you like about it?

In my present position as a Director for the Section on Geriatrics, I am honored to be part of the group currently serving the Section and to share a title with past leaders in the Section. I have an opportunity to contribute to the direction of the Section, to hear and respond to member concerns, to represent members on issues facing those of us working with older adults, and to contribute to a profession that has given me so much. I have gained so much from being an active member of the Section including professional and personal growth, an opportunity to network with the "best of the best," friendships, and a feeling of satisfaction to have contributed in some small way to the profession I love so much.

What do you see as the biggest challenge to physical therapy in the next 10 years?

I think one of the biggest challenges for Physical Therapists in the next 10 years is to fully embrace our role as health care professionals and health care leaders. We need to ensure that we are providing the best care at the right time in the most effective way to all of the

patients we serve. We need to demonstrate our effectiveness in a responsible way and educate the public, the government, and the payors about our value



Dancing with my Dad.

while advocating for our patients to receive the best and most appropriate care at the right time. This should include preventative care particularly for older adults to insure that function and quality of life are optimized in all situations and under all conditions.

In what direction would you like to see the Section move?

I would like to see the Section on Geriatrics continue to promote research, education, a commitment to professionalism, and to act as a strong and ef-

fective advocate for Physical Therapists working with older adults, caregivers of older adults, and community health initiatives for older adults.

Tell us about your nonprofessional life?

I am one of six children from a wonderful, close, and supportive Irish family. My brother John passed away 10 years ago and we miss him immensely. Between the six of us, there are 13 grandchildren. I have one child, Lauren who is 18 and is getting ready to attend the Art Institute of Tampa in the Fashion Marketing and Merchandising program. She did some modeling for a little while and has a real interest in fashion. My husband Michael and I will celebrate our 25th wedding anniversary in October. He went back to school in February as a Culinary Arts student at the age of 53. After closing his sheet metal fabrication shop which he worked in since he was 17, he decided to pursue his lifelong passion. He is finally getting to do what he has always wanted to do. My daughter might tell you that my 3 favorite things to do are to work, clean, and worry about her. Really my favorite things are spending time with my family and friends, anything that involves music (dancing and singing, although I'm very bad), golf (although I'm not very good), traveling, and learning.

What advice would you give someone who would like to become more active in the Section?

For those who would like to get involved in the association or Section I would say find a mentor or two or three. Make contacts, ask questions, attend meetings, find ways to participate at a local level, and just stay involved. It took me a while to actually become a leader in the Section but it was well worth the time and effort, and I learned so much and met so many wonderful people along the way.

LONG-TERM CARE PLANNING: TWO HOUSING OPTIONS TO MEET YOUR LONG-TERM CARE NEEDS

John M Cheeks, PT, DPT, MHS, CSST



INTRODUCTION

According to the United Nations, the population of those age 60 and over will increase from 10.4% of the population in 2005 to 21.7% of the population in 2050.¹ By the year 2030, approximately 1 in 5 Americans will be 65 years of age or older; and by the year 2050, 1 in every 10 Americans will be over the age of 85.²

With the number of aging individuals increasing each year, public policy should incorporate the idea that the majority of these individuals desire to age in place. This is indicated by the fact that, according to the American Housing Survey of 2005, in 2004 only 5 ½% of elderly homeowners moved from their homes to other living arrangements.³ Policies ought to reflect that as these individuals become frail, they should still have the option to remain independent and functional. They are able to derive benefits from living in environments that allow them to remain engaged with each other as well as intergenerationally with those of different aging cohorts.

Traditionally, the term aging in place has referred to individuals growing older in their own homes with the emphasis on modification of home environments to compensate for limitations and disabilities.⁴ Some individuals are just not able to successfully age in place at home. Home and where one ages in place have been expanded in recent years to include a variety of environments, including nursing homes and other housing arrangements such as continuing care retirement communities.⁵ Aging in place can be described as the phenomenon of growing older within a specific environment,⁶ or generically as a phenomenon of long-term residency, the

result of cohort aging in the same place of residency.⁷

The United States passed legislation in 1965 as Title XVIII of the Social Security Act which created Medicare. The legislation went into effect July 1, 1966.⁸ Due to the aging of the “Baby Boomer” generation, it is estimated that by 2010, 76 million baby boomers will begin to turn 65 and become eligible for Medicare benefits.⁹ Our current worker-retiree ratio, the number of working individuals age 18 to 64 years compared to those 65 and older, will begin to change. Prior to the inception of Medicare in 1950, the worker-retiree ratio was 7.5 to 1, it decreased to 5.3 to 1 by 1980, 5 to 1 by 2000¹⁰ and is expected to be 3 to 1 by 2020, and just above 2 to 1 by 2030.¹¹

Hospital insurance is one part of the Medicare program. It helps pay for hospital, home health, skilled nursing, and hospice care for those aged 65 and older and disabled individuals who have enrolled.¹² On March 25, 2008, the Annual Report of The Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds released their 2008 annual report. The report states that the hospital insurance tax or Medicare tax collected from workers is expected to fall short of expected hospital insurance expenditures in 2008 and all future years at the current spending levels.¹² It is suggested that the deficit in revenues versus expenses would cover only 94% of Medicare’s expenses in 2004, 78% by 2019, and only 30% over the long-term.¹² Medicare was not designed, nor was it ever intended, to pay for long-term care or custodial services. The uncertain future of Medicare and its limited coverage is a problem and will be a greater problem in the future.¹³

Every older individual needs to prepare for some ‘aging shocks:’ the cost of medical care not paid for by Medicare or private insurance, the cost of gap or supplemental insurance that is designed to fill in the gaps in coverage left by what Medicare does not pay, and the uncov-

ered cost of long-term care.¹⁴ Long-term care covers a wide spectrum of services that addresses the needs of individuals who are frail or disabled and require help with the basic activities of daily living. The services vary from home care, assisted living, or nursing home care needs.¹⁴

Based on a survey completed yearly by LifeCare, Inc. for MetLife Mature Market Institute, (MetLife Mature Market Institute [MMMI], 2007) the average daily rate for a private nursing home room in 2007 was \$213 or \$77,745 annually. This reflects an increase from \$206 or \$75,190 in 2006. In 2007 the average daily rate for a semi-private nursing home room was \$189 or \$68,985 which is an increase from \$183 or \$66,795 in 2006. According to the same survey, the average monthly private pay rate for assisted living facilities was \$2,969 or \$35,616 annually. Of the 881 assisted living facilities surveyed in the MetLife study, 59% offered dementia care units with 54% of these charging an extra average of \$1,110 per month for the extra dementia related care provided (MMMI, 2007).

According to the National Association of Insurance Commissioners, the cost of nursing home care has been rising at an annual rate of 5% for the past several years.¹⁶ Almost 80% of Americans today will live past the age of 65, with the life expectancy of men extending another 15 years and women 19 years.¹³ Currently, 6.4 million individuals age 65 or older need long-term care, with one in two over the age of 85 requiring care and assistance with activities of daily living such as bathing, feeding, eating, dressing, and toileting.¹³ As the Baby Boomers age, more individuals will survive into late old age due to medical advances and increases in technology. The sheer increase in the number of older individuals in the American society, combined with the fact that they will live longer, increases the likelihood that chronic illness will develop, resulting in

a greater need for assistance with long-term care needs for the elderly.¹³ By the year 2030, the number of individuals over the age of 65 needing long-term care services will double to 12 million.¹⁷

There is widespread misconception in the United States about how long-term care is paid for. Many individuals think that their personal savings will cover any services that they may require, while others think that long-term care is an entitlement paid for by the federal government.¹³ Some feel that just by paying into social security they are covered for whatever long-term care needs they may have over their lifetime.¹³ No matter what the perception is, long-term care is expensive and continues to grow more expensive each year. Because of the uncertain future of Medicare and many states' Medicaid plans and questions about the rising cost of long-term care, individuals must come to understand that long-term care is a personal responsibility and requires planning ahead in order to be prepared to meet their long-term care needs. Public education endeavors should include information about the individual's responsibility for long-term care planning, both from a financial and housing standpoint.

There are many different housing options emerging to assist older citizens with the ability to age-in-place in communities that consider their potential future long-term care needs. Two types of senior housing communities currently available are continuing care retirement communities and "Green Houses."

CONTINUING CARE RETIREMENT COMMUNITIES

Continuing Care Retirement Communities (CCRC) are designed for the middle and upper income members of the population. Individuals who enter CCRCs are those who want to maintain an active lifestyle, have access to activities and amenities within walking distance of their residence, want to know that their health care costs are covered at a reasonable fixed fee, and have access to assistive services when needed.¹⁸

The CCRCs first began to be developed 100 years ago. They were originally faith-based organizations that provided for the long-term care needs of individuals who had no family to care for them. The senior, in exchange for the care they received, would turn over their assets to the organization. Continuing Care Retirement Communities are located throughout the United States and are growing at a rate of

15% to 20% per year.¹⁸ The facilities range in design from high-rise, mid-rise, low-rise, or garden style homes. The independent living housing can take on the form of townhomes, apartments, cottages, or single family homes. Services vary from community to community to include club houses, swimming pools, golf courses, golf cart lanes, housekeeping, maintenance services, meals, transportation, religious, recreational, cultural, and social services.

The CCRCs consist of a continuum living environment designed to meet the needs of its residents as they change over their lifetime. Living arrangements offered within a CCRC consist of 3 basic types.

Independent living units are designed for individuals to continue to live independently, functioning just as they did in their own homes, but with access to the greater services of the CCRC and with the option to transfer to assisted living or nursing home care as their circumstances dictate.

Assisted living units are designed for individuals to have help performing activities of daily living such as bathing, dressing, transferring, toileting, eating, or taking medications.

Nursing care units are designed as the final stage of care. They can serve as short-term or long-term care nursing units where one can receive rehabilitative and 24 hour a day nursing services. These units are for those who need 24-hour per day monitoring or assistance.¹⁸

The operational structure of a CCRC consists of paying a one-time fee to gain entrance to the CCRC.¹⁹ The entrance fees vary from \$38,000 to \$400,000 depending on the location of the CCRC, services offered, size of the residence, number of individuals residing in the residence, whether the living space is rented or owned, and whether the individual has a "life care contract." After the entrance fee is paid, then there is a monthly service fee that varies by individual CCRC based on the type of contract for services signed by the resident. Once in the CCRC, no matter at what level of care one entered at, they can then move from one level to the next at anytime their health requires them to need a higher level of care.

Continuing Care Retirement Communities offer many advantages to seniors. Most CCRCs offer various buy-in agreements. Life care agreements/contracts entitle the individual to remain in the CCRC and transition from one level of care to another as their health declines. Individuals should

be sure that if this is their expectation when moving into a CCRC, that they have such an agreement and not a limited service agreement or fee for service agreement. Other advantages that CCRCs have are that all levels of care one might need throughout their life-time are located within the CCRC. They are able to remain within their community and still access the long-term care services they need. Many of the communities are gated, but all have various methods of security for the protection and safety of the residents. The CCRCs are also designed with walkability in mind. This means that residents can access services without having to leave the community and that services are within walking distance. Another advantage to living within a CCRC is that yard care and home maintenance services can be included in one's service agreement. Continuing Care Retirement Communities offer peace of mind to their residents as the residents can rest assured that their long-term care needs will be met and that the cost of this care is covered by their entrance fee/monthly service fees and will be fixed within reasonable limits for the remainder of their lifetime. The structure and environmental nature of CCRCs allow its residents to continue to live as independently as possible on their own terms. They are free to continue to pursue hobbies and other interests as long as their health allows them to do so. The CCRCs also offer tax benefits. In most instances, a portion of the entrance fee in the year one enters a CCRC and a portion of their monthly service fees are allowed by the Internal Revenue Service (IRS) as a tax deduction. The rules are subject to change each year, and anyone considering buying into a CCRC should consult their tax advisor for the current years IRS rulings.¹⁸

Disadvantages to buying into a CCRC include the following: some CCRCs do not have refundable entrance fees, while some have a prorated refundable entrance fee structure, and therefore if one decides to back out after they have signed a buy in agreement, they may forfeit all or some of their entrance fees.¹⁸ A few CCRCs do not offer Life Care Contracts according to the commission on accreditation of rehabilitation facilities.¹⁹ In this advent then one does not have the option of moving through the various levels of care as their health may require. The cost of the entrance fees and the monthly services fees are the biggest disadvantages to CCRCs. These fees may prevent many middle to lower income individuals from being able to buy in.

Individuals should carefully research what types of contracts and service agreements are available at any CCRC they are considering buying into to ensure that their service needs and expectations are going to be met. They should also weigh the advantages and disadvantages and carefully consider whether a CCRC is in their financial reach and best long-term interest.

GREEN HOUSES

One solution to the current model of nursing home care in the United States is the Eden Alternative's Green House model of nursing home care.²⁰ The Green House model consists of a residential home that looks like any other home from the outside. They are designed for a maximum of 6 to 10 residents with each person having a private room and bath. There is a central living area with a hearth and dining room table just like in one's own home. The idea is to allow the residents to transfer home to the nursing home or assisted living environment.²¹ The houses are a radical departure from traditional nursing homes and assisted living facilities, altering size, design, and organization to create a warm, smart, and green environment.²² The Green House Project is a de-institutionalization nursing home effort. It is designed to restore individuals to home in the community by combining small homes with complete access to personal care and clinical resources expected in high-quality nursing homes.²²

The mission of the Eden Alternative is to improve the well-being of elders and those who care for them, transforming the communities in which they live and work. The vision of the Eden Alternative is to eliminate loneliness, helplessness, and boredom from the lives of elders.²³ The mission of the Green House initiative is to partner with organizations, advocates, and communities to lead the transformation of Institutional Long-Term Care by creating viable homes that spread the Green House vision, demonstrating more powerful, meaningful, and satisfying lives, work, and relationships.²² The vision of the Green House initiative is homes in every community where elders and others enjoy excellent quality of life and quality of care; where they, their families, and the staff engage in meaningful relationships, built on equality, empowerment, and mutual respect; where people want to live and work; and where all are protected, sustained, and nurtured without regard to their ability to pay.²²

Advantages to the Green House living ar-

rangements are numerous. One of the most important benefits of the Green House environment is that it allows residents to participate in decision making and the freedom to choose their own schedule. They are able to decide when they will eat, bath, and what they want to wear just like they would when living in their own homes.²⁴ Green House residents pay for services on either a private pay basis or by being on Medicaid. The private pay schedule is for those who do not qualify for Medicaid and is similar in cost to the national average for assisted living as discussed in the introductory section of this article. The Green Houses use a universal care worker, a specially trained CNA, called a shahbaz who runs the Green House on a daily basis. Their training is based on the 10 principals of the Eden Alternative.²⁵ These individuals provide direct care to the residents as well as oversee the daily operation of the Green House. They wash, cook, clean, and assist those residents who need it with activities of daily living such as dressing, bathing, toileting, and any other tasks needed.²⁵ The shahbaz has had positive effects on the CNAs working in these environments. They have better self-esteem, are empowered to make decisions, and take responsibility for their work environment. This has led to less turnover and higher job satisfaction.²⁰ The Green House environment has also been reported to result in high family satisfaction that their loved ones are being cared for to a higher degree than in most traditional nursing home environments.²⁶ Family involvement is encouraged by the Eden Alternative as a regular part of the resident's daily routines.²⁷ The Green Houses create warmth by innovative floor plans, décor, furnishings, and the use of a small number of caregivers.²¹ The homes are smart in that they use technology to assist in monitoring residents to allow family members and physicians to observe the care of the residents via web cams. This same technology connects some Green Houses via telecommunications and the internet to medical providers and demonstrates the good and effective use of technology.²¹ This use of technology will have even more impact as the worker-retiree ratio decreases over the next few years and it becomes harder to find enough workers to train. The Green House transforms the nursing home environment into a place where there is meaningful existence and where the 3 plagues of loneliness, helplessness, and boredom in the traditional nursing homes are eliminated.²⁷

The Green Houses are designed based on a home model. The houses do not look like traditional nursing homes on the inside or the outside. When driving down the street, they cannot be distinguished from other residential homes within the same community. They do not have nurse's stations, medication carts, or public address systems like traditional nursing homes.²⁸ (AU: this is not in the current reference list!) The Green Houses are designed to allow residents to transfer home to the nursing home environment. Rather than leaving home behind and moving into a traditional nursing home with all of its sights, sounds, noise, smell, and loss of dignity and privacy, one can feel at home in a Green House. In the Green Houses all meals are prepared fresh without industrial size food containers being used with food prepared in mass to feed numerous residents on a fixed schedule. The houses are built with a central hearth to promote warmth and a sense of home. Front doors have a door bell just like one has at their own home that guests ring to gain entrance to the Green House. Overall, Green Houses promote a sense of community and reciprocity among their residents.

Disadvantages to the Green House environment are far less than many other senior living arrangements. One of the biggest challenges is the ability to find the right number of universal care workers with the personalities to adapt to the principals of the Eden Alternative that govern the Green House.²⁴ One concern raised about the Green House's approach is the use of animals within the home and the potential for illnesses, injuries, and allergies resulting from the presence of the animals.²⁰ These issues have been addressed by good air filtration systems to remove allergens from the air, and in some cases the use of bells on animals so residents know where they are, can avoid them all together or decrease their risk of falling over them.²⁰ The employees have committees responsible for tasks to prevent the animals from becoming an increased risk to the residents. For example, they have one group who oversees immunizations as members of the animal committee and another group that carefully selects plants to minimize the risk of plant related illness.²⁰ No nursing environment is immune from illness or falls. The risk of liability is considered a part of residing in the United States and good professional conduct and communication reduce the liability risk. The Eden Alterna-

tive considers the benefits of preventing helplessness, loneliness, and boredom outweigh the risks of litigation.²⁰

It seems that currently there is great promise for the Green House option as a source of housing for older individuals who require long-term care. The Eden Alternative and the Green House Project have the potential to completely revolutionize the nursing home industry and redefine the perception of nursing homes in the minds of everyone.

CONCLUSION

No matter the outcome of individual states' Medicaid funding debates or the long-term solvency of the Medicare program, there still remains the issue of long-term care. Most Americans enter retirement with only modest savings and uncertainty about how they will afford routine living expenses and especially long-term care needs. Spending on long-term care for the elderly is projected to more than double over the next 30 years. With more individuals retiring than entering the workforce, the current worker's ability to contribute to a broader tax-financed solution to pay for long-term care needs will diminish. New options for long-term care housing are emerging and will offer solutions to meet the long-term care needs of the aging population, but long-term care is expensive and will continue to be so in the future. This underscores the importance of public education not only about the types of long-term care housing available, but the related cost and the need to begin planning early in life to be prepared to meet these needs at retirement and beyond.

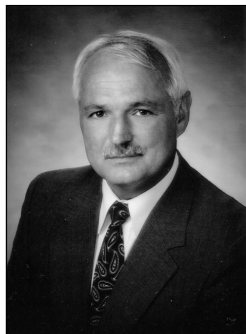
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John M. Cheeks currently works as a home health physical therapist specializing in geriatrics. He previously published an article on Pay for Performance in the May issue of GeriNotes. Currently John is a candidate for the Master's of Science in Gerontology degree at the Center for Aging and Community at the University of Indianapolis and a candidate for the Doctor of Health Science Degree through the Krannert School of Physical Therapy at The University of Indianapolis.

CONGRATULATIONS TO THE SECTION ON GERIATRICS ON 30 YEARS, 1978 TO 2008

Tim Kaufman, Section Historian



The Board of Directors of the American Physical Therapy Association approved the petition to establish the Section on Geriatrics (SOG) in

1978. The first business meeting for the SOG was held on Sunday, June 18, 1978. In order to appreciate the effort and growth of the SOG during these past three decades, Tim Kauffman spoke with several of the founding members and leaders of the SOG as well as present leaders. These are some of the answers to questions raised at Combined Sections Meeting 2008 in Nashville, Tennessee.

As a founding member of the Section on Geriatrics, did you ever think about the Section at its 30th birthday?

Carole B. Lewis: "That's such a great question, because when you're sitting there with 4 or 5 people trying to come up with something that people are telling you will never exist, the thought of the 30th birthday is the farthest thing from your mind, but to sit through that AND to see a 30th birthday on the horizon is just wonderful."

Bette Horstman: "No, I really didn't."

Clara Bright: "To be honest, no, but I am amazed at the growth of this Section in 30 years. It's just been amazing."

Neva Greenwald: "Not really at its 30th birthday."

As a founding member, why did you want to start this Section?

Bette Horstman: "I was deeply involved with long-term care and the care given to our patients was at a very low level.

I felt that therapists should be more knowledgeable in geriatrics and how to take care of the upcoming generation which I am now."

Clara Bright: "I really felt geriatrics was important. At that time, there were people in nursing homes who were in the fetal position."

Carole B. Lewis: "I practice in general medicine and there was nothing in geriatrics and I found others who felt the same way. In fact, geriatrics is a specialty which wasn't being addressed by the APTA so we pulled together, our special interest group, and eventually became the Section."

Do you have any advice for our present or future leaders?

Bette Horstman: "Yes, if I had to do it over again, I would ask the members to get deeply involved politically. We can't do it by ourselves, we have to be joined together and contact the people, the movers, and the shakers, in our own community politically."

Neva Greenwald: "Try to dream and see what might be possible and not be afraid to try to get people to do it. Keep striving towards excellence in care, excellence in scholarship. We were one of the first ones to really do posters at CSM."

Clara Bright: "I think they're doing a very great job."

Carole Lewis: "I think they need to think 5 years in the future. We have a wonderful structure here and that is there to support you (the present and future leaders). Don't be afraid to express your ideas to other people and you'd be surprised how many people might be there with similar ideas that want to do similar types of activities. With all these great ideas, it could only help to improve health care for older persons."

Fran Kern: "Actually, the past 30 years have been so awesome, so much so that it's really hard to come down to words to explain. In the future, I have high hopes simply because there is only one way and that's up. It's a great future as far as I'm concerned."

John Barr, the current President, and *Anne Coffman*, the present Vice President, of the Section on Geriatrics were also interviewed.

When and why did you join the Section on Geriatrics?

John: "I joined the Section in about 1980 because of an acquaintance of mine who talked me into joining him at a meeting. I found the Section members among the most welcoming and enthusiastic of any. Because geriatrics was an area of practice interest, it was just a natural match."

Anne Coffman joined as a student because, "...I was one of the few students in PT school who was interested in geriatrics. Pat Wilder was my chairperson and later Lynn Phillippi, who is not with us any longer but was my boss. She was a tireless advocate for geriatrics and for the Section and it was not heard of to work in her field and not join the Section and be involved."

What do you think have been some of the biggest Section on Geriatrics accomplishments in the past 30 years?

John Barr remarked, "... on strategic planning that was done a number of years ago by other leaders and really set us on firm organizational footing. We've made real progress in the quality and number of the continuing education offerings, home study and distance education, and nurturing the development of the clinical specialist. Finally, the quality of our publications, *GeriNotes* and the *Journal of Geriatric Physical*



For historical purposes, the photo was taken at CSM, Boston, 2008. The photo L to R= Clara Bright (founding member, former Section Chair), Neva Greenwald (founder member, former chair), Tim Kauffman (missed the 1st meeting but has been engaged ever since, research chair 1980-1990), Fran Kern (founding member, first newsletter editor), Bette Horstman (founding member, former chair), Evie Halas (active member since 1978) and Mary Ann Wharton (2nd program chair and her Master's Thesis was the format for our certification for specialization). Photo by Yaffa Liebermann, GCS.

Therapy which is now indexed in the National Library of Medicine database and CINAHL (Cumulative Index of Nursing and Allied Health Literature) really gets our body of knowledge out before a broader physical therapy and nonphysical therapy audience."

Anne Coffman stated, "... that establishing our research endowment fund that has really helped push the Foundation to look at geriatrics research." Ann also stated that, "...the Section started focusing on the APTA in the areas of legislation and advocacy. We pushed the APTA to think about inpatient rehab and home health issues. Medicare is more than just the orthopedic and outpatient side.

What are some of the biggest challenges?

John Barr responded that "...since the late 1990s, there was an absolute dive in membership. We have progressively been increasing our numbers. It is important for the general APTA member to appreciate the aging population is dramatically impacting our patient mix and to appreciate it's not just old people. The challenge is to get the broader physical therapy community to recognize they need to become more specialized in the care of the older individual."

Anne Coffman had similar comments in that she stated "...our primary challenge is that people don't recognize that all areas of PT practice with probably the exception of Peds involves geriatric

physical therapy. I think our challenge is getting those APTA members to recognize what the Section can do for their practice and for their clinical knowledge."

Can you envision the Section on Geriatrics in 2028, its 50th anniversary?

John Barr: "Well, certainly by 2030, 2 years after, it's already projected that 25% of the U.S. population is going to be comprised of individuals 65 and above. It will be very clear to the general membership of the APTA that they must be more knowledgeable and skilled in the area of geriatrics. So, I would expect a significant increase in our membership and the services that we provide to our members and the types of offerings.

Anne Coffman stated, "I hope by that time we'll actually have a different name. I think the Section on Geriatrics tends to be viewed as the SNF Section and rather than classify us by a setting, I would like people to recognize what we do and I think a name change will be a big part of that. I would like to see at least 7,000-10,000 members of our Section.

A number of our former leaders wanted to bring to the attention of the members that Bonnie Polvinale who is presently the Vice President for Member Relations of the APTA was very helpful in our earlier years, especially with our programming. Maryann Wharton who was the second program chair remarked

that her "...agenda was to really provide excellent programming to foster the growth of geriatric physical therapy. I always attempted to have a program that would attract a novice to the profession of geriatric physical therapy."

Concluding comments were offered by Bette Horstman who said, "I think it's a great, great Section, and I envision it to go on for another 100 years."

Carole Lewis said, concerning these interviews, "It's really a great idea. It's something that I think is nice to have on a piece of paper and I think you know where you're going because you know where you've been. Thanks for doing this. This is really special."

Timothy L. Kauffman has a Doctorate of Philosophy from LaSalle University and a Masters of Science in Physical Therapy from the Medical College of Virginia. He is the founder of Kauffman-Gamber Physical Therapy in Lancaster, PA. An adjunct professor at Columbia University, Tim also serves as a clinical professor for many Eastern physical therapy schools. Tim is co-editor of "Geriatric Rehabilitation Manual" 2nd ed.

THE EFFECT OF PRONE POSITIONING ON OXYGEN SATURATION IN ELDERLY ADULTS

Mark J. Traffes, PT, GCS; Carole B. Lewis, DPT, PT, GTC, PhD, FAPTA

We maybe dating ourselves when we ask “is it safe?” and visions of Dustin Hoffman in the movie *Marathon Man* pop up into our memories. When we teach continuing education courses, a frequently asked question is regarding placing older persons in the prone position; is safe? The answer is yes and more. In the subjects studied it was safe and did not negatively influence respiration but improved oxygen saturation.

DATA COLLECTION

To demonstrate we collected data on the first 5 patients who came into the physical therapy gym with O₂ saturation below 95. The subjects were tested for pre positioning O₂ saturation levels collected immediately after getting into the prone position, 2 minutes later, 5 minutes later and immediately after returning to the sitting position. See Table 1 for results. Additional data was collected on the next 14 patients in the clinic with normal O₂ saturation levels using the same data collection protocol. See Table 2: in subjects in the first group (Table 1) the prone position improved O₂ sat levels. Levels continue to stay in the normal range in the second group (Table 2).

DISCUSSION

This article describes a pilot descriptive study to investigate the effects of the prone position on O₂ stat. Results indicate that prone, like standing and sitting,

is safe in relation to maintaining O₂ stats for our older patients and possibly even beneficial. The works of Hayes-Bradley⁽¹⁾ Savage⁽²⁾ Pelosi⁽³⁾ and others have shown that this position can be therapeutic for various pulmonary diagnoses. The reason given in relation to improved oxygen levels in the prone position is that in this position drainage of blood is encouraged and this is the natural drainage position of the superior segments of the lower lobes of the lungs. Prone position helps to clear these airways which will allow greater ventilation and higher tidal volumes. In the supine position blood may stay in the alveoli which can be a barrier to gas exchange and drainage of this blood by the prone position may help to improve oxygenation.¹

FUNCTIONAL / EXERCISE BENEFITS

There are other benefits of putting our patients into the prone position that are well worth the effort of the therapist and the patient. In addition to the cardiopulmonary benefits it is an excellent position for stretching tight hip flexor, rectus femoris, and most tight trunk flexor muscles. Several important exercises can only be done in this position such as planks, push-ups, and certain hip stretches. Finally, many manual techniques are best done if our patients are prone.

One final point is the importance of function and how we as therapists must

stress the system of our patients to gain improvements or as Mueller states to cause hypertrophy. Mueller's excellent article on stress is a crucial reminder that if we only keep our patients at a maintenance level (even in the area of functional training) there will never be any hypertrophy.⁽⁴⁾ To help our patients gain in function we must stress the system. That has even more true for functional training. If we only work with our patients supine they will never be able to turn in bed and completely function independently yet sometimes, it is easier to just ignore that piece. We don't even measure it. But it is a necessary part of movement that becomes eliminated from non use or practice. When our patients can roll easily in bed they are more functionally independent and we know that they are able to maneuver safely as well as get up from that position whether they land there intentionally or not.

CONCLUSION

Why are therapists so hesitant to use this position? One reason is fear that it may harm our patients. We hope this pilot data as well as other references on persons with pulmonary complications will help to allay this fear. Secondly, this position takes time for our patients to get into and may initially be uncomfortable. Both of these reasons can be addressed with patience and understanding and going slowly.

So it brings us back to the first question. Is it safe? It is more than safe it is a crucial and safe part of rehabilitation of the older person.

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Table 1. Initial O₂ Sat Below 95

			O ₂ Sat in %				
Subject	Age	Diagnosis	Sitting	Prone	Prone	Prone	Sitting
			Pre	Immediately	2 min	5 min.	Immed Post
1	62	BKA	92	98	94	99	98
2	77	Bronchitis	85	90	92	92	86
3	79	Hip FX	92	98	99	98	98
4	83	Gout Exac	94	96	96	96	96
5	85	Parkinsons	90	94	93	93	94
Avg:	77.2		90.6	95.2	94.8	95.6	94.4

2002;20:1017-1028.

4. Mueller K. Tissue Adaptation to Physical Stress: A Proposed "Physical Stress Theory" to Guide Physical Therapist Practice, Education and Research; PT; 4-02.



Mr. Traffas is the Lead Physical Therapist at Vista Manor Skilled Nursing Facility in San Jose, CA. He has practiced in a variety of clinical settings from acute care to long term care to outpatient work-

ing exclusively with geriatrics patients for over 10 years. Mr. Traffas received his Geriatric Training Certification in 2001 and has been lecturing for GREAT Seminars and Books, Inc. since 2001.



Dr. Lewis is a consulting clinical specialist for Professional Sports Care and Rehab. She is President of GREAT Seminars and books and serves on the Medical Faculty at George Washington University and the University of Maryland.

Table 2. Initial O2 Saturation 95 or Above

	age	diagnosis	sitting	Prone			Sitting
Subject			Pre	Immediately	2 min.	5 min.	Immed Post
1	68	Subarachnoid Hem.	98	98	98	98	99
2	69	CVA	96	98	96	u/a	98
3		Hip Fx.	98	98	97	97	98
4		Resp. Fail.	100	100	100	100	100
5			99	99	98	98	98
6	72	Hip. Fx	98	99	98	98	98
7	72	CVA	100	97	98	97	98
8	80		99	100	100	100	99
9	80		95	94	95	97	96
10	81	MI	98	98	99	100	99
11	81	TKR	96	94	96	96	97
12	84	Asp. Pneum.	97	100	98	98	95
13	89	L-strain	98	98	98	98	98
14	91		96	96	96	95	96
15	92		97	98	98	98	98
Avg	73.8		95.9	96.75	96.95	97.26	96.95

2008 HOUSE OF DELEGATE REPORT

Cathy Ciolek, PT, DPT, GCS

The APTA House of Delegates (HOD) met in June in San Antonio, Texas. This year we were given additional information beyond the traditional reports--with town hall meetings about the Strategic Thinking and Planning Initiative and the APTA Governance review process. Additionally, we were able to hear about the new Branding Campaign--look for it in early 2009--"Move Forward".

The House took up 17 motions, passing 15, forwarding one to the APTA Board of Directors (BOD) for more information gathering on costs of monthly dues options, and not passing 1 motion. Key issues for Physical Therapists and Physical Therapists Assistants from the SOG in this HOD include:

RC 2-08 Amend: Promoting Physical Therapy (passed unanimously)--Presented by the Section on Geriatrics!

A new position on promoting physical activity/exercise amends HOD P06-03-29-28 and underlines the benefits of physical activity/exercise and the role of physical therapists (PTs) and physical

therapist assistants (PTAs) in promoting those benefits. The position calls for APTA to endorse appropriate physical activity/exercise goals and objectives put forth by government and other nationally recognized agencies; support and encourage its members to provide leadership in supporting scientific, educational, and legislative activities directed to the promotion of regular physical activity/exercise in order to enhance health and prevent disease; and encourage members to adopt healthy lifestyle choices that include meeting national guidelines for participating in physical activity/exercise.

RC 8-08 Physical Therapist of Record and "Hand-off" Communication (passed)

In an effort to reduce medical errors, improve communication and patient/client care, and accept responsibility and accountability for patient/client management, APTA encourages practices and facilities to develop and implement a process to identify the physical therapist (PT) of record and "hand off" communication

procedures. Physical Therapist of Record and "Hand Off" Communication speaks to the issue that the PT of record is the therapist who assumes primary responsibility for the management of a particular patient or client and as such is held accountable for the coordination, continuation, and progression of the plan of care for that patient or client. APTA will incorporate the concepts of PT of record and "hand off" communication into appropriate Association documents.

RC 14-08 Identification of the Role of the Physical Therapist Assistant as it Relates to Physical Therapist Practice in 2020 (passed)

This motion directs APTA to identify the anticipated role of the PTA in 2020 as it relates to PT practice and report to the 2010 House of Delegates.

If anyone has questions or would like more information about any of the motions, please send me an e-mail at Ciolek@comcast.net

GERINOTES

INSTRUCTIONS TO AUTHORS

Carol Schunk, PT, PsyD; Editor

GeriNotes is an official publication of the APTA Section on Geriatrics. *GeriNotes* is a clinical magazine which includes clinically applicable articles and Section news. It is not a refereed text but not all submissions are accepted. The publication has a distribution of over 5,000, primarily physical therapists and physical therapist assistants who work with older adults or physical therapists in academia who teach related subjects.

CONTENT

GeriNotes will consider articles addressing any clinical or nonclinical aspect of interest to physical therapist who work with older adults. Authors do not have to be Section members or physical therapists. Student papers at all levels are welcome. Submissions include but are not limited to:

Clinical Reports
Reviews of the Literature
Policy Papers
Student Papers of any Type
Case Histories
Articles Involving Interesting Issues Regarding Older Adults
Physical Therapist's Role as Advocates for the Older Adults
Community, Chapter Activity Related to Older Adults

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- contact information via e-mail
- 3-5 sentence bio
- self-photo in electronic format
- Do *not* include an abstract

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Articles are reviewed by the Editor who will be the primary contact for the author. At the Editor's discretion an article may be forwarded to member(s) of the Editorial Board for input. Minor edits will be made by the editor with communication to the author. If major re-writes are required, the author will be contacted by the editor. In some cases a member of the Editorial Board may serve as a consultant to assist with the development of an article.

FORMAT

Submissions should follow the style outlined in the *AMA Manual of Style* with the following criteria:

- Each page should be numbered
- Text should be double spaced in a 12-point font. Articles can be of any length. Authors should keep in mind that in general 4 typed pages will equal one page in printed format. Margins should be one inch on each side.
- Do *not* use tracked changes.

Headers:

Headings are encouraged as they break up the text and allow readers to follow the flow of the content. Headers should be formatted as follows:

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Tables:

Authors are also encouraged to provide tables or pull out boxes as they add to the understanding of the information provided. Charts should be labeled. If you are using data from another source, it is the author's responsibility to get permission to re-print.

Citation of reference list:

References should be numbered sequentially as they appear in the text and should correspond to the superscript number in the text. Do not repeat the same reference using a different number in the reference list. Only references cited in the paper should be listed.

Journal Articles

16. Ferguson CT, Cherniack RM. Current concepts: management of COPD. *N Engl J Med*. 1993;328:1017-1022.
17. Rueben DB, Siu AL. An objective measure of physical function of elderly outpatients (The Physical Performance Test). *J Am Geriatr Soc*. 1990;38:1105-1112.

Books

18. Steindler A. *Kinesiology of the Human Body Under Normal and Pathological Conditions*. Springfield, Ill: Charles C. Thomas; 1995:63-64.

Abbreviate United States state and territory names as specified in the *American Medical Association Manual of Style*—NOT according to the United States Postal Service abbreviations.

Editor(s) as author:

19. Scully RM, Barnes ML, eds. *Physical Therapy*. Philadelphia, Pa: JB Lippincott Co; 1989:83-98.

Reference to part of a book:

20. Goodman CC. The endocrine and metabolic systems. IN: Goodman CC, Boissonault WG, eds. *Pathology: Implications for the Physical Therapist*. Philadelphia, Pa: WB Saunders; 1997.

PUBLISHING DEADLINES

Submissions will be taken anytime,
specific deadlines for each issue are below.

DEADLINE	ISSUE
November 28	January
January 28	March
March 28	May
May 28	July
July 28	September
September 28	November



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Section on Geriatrics
1111 North Fairfax
Alexandria, VA 22314
W 800/999-2782 ext. 3238
FAX 703/706-8575
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2920 East Avenue South, Ste 200
La Crosse, WI 54601-7202
W 800/444-3982 x 202
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When they stop growing,

they become old.

- Anonymous

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