

GERI NOTES

SECTION ON GERIATRICS, AMERICAN PHYSICAL THERAPY ASSOCIATION

IN THIS ISSUE:

Editor's Message

Bonding: In a Course or on the Trail

President's Perspective

WCPT—Participating in a World Conversation about Physical Therapy

Supporting Geriatric PT Research

2007 Matching Campaign

Rehabilitation of Proximal Humeral Fractures

Seeking Home Study Course Editor

Exercise and Depression in Older Adults

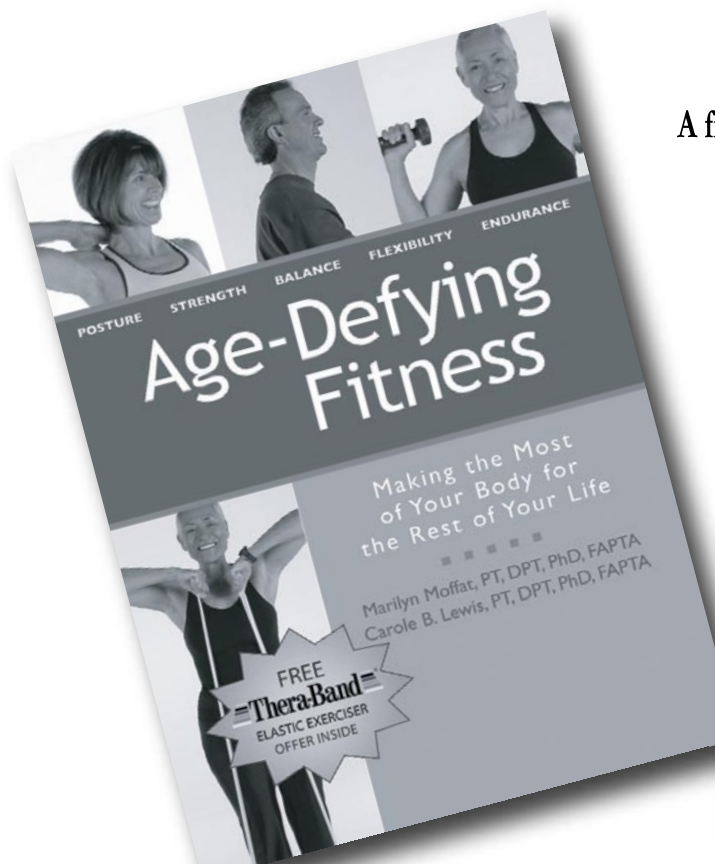
Using Clinical Scenarios to Find Evidence for Geriatric
Physical Therapy Practice

Global Perspectives in Geriatrics, Education, and Regulation
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TABLE OF CONTENTS

| | |
|---|--|
| Editor's Message Bonding: In a Course or on the Trail4 <i>Carol Schunk</i> | Using Clinical Scenarios to Find Evidence for Geriatric Physical Therapy Practice13 <i>David Scalzitti</i> |
| President's Perspective WCPT—Participating in a World Conversation about Physical Therapy5 <i>John O. Barr</i> | Global Perspectives in Geriatrics, Education, and Regulations WCPT 200716 <i>Neva F. Greenwald</i> |
| Supporting Geriatric PT Research.....6 2007 Matching Campaign | Welcome New SOG Leaders & Volunteers19 |
| Rehabilitation of Proximal Humeral Fractures7 <i>Meri Goehring</i> | Take a Tour: Your New Website Goes Live!.....20 <i>Lucy Jones</i> |
| Seeking Home Study Course Editor.....9 | SOG 2007 Election and Candidate Statements.....23 |
| Exercise and Depression in Older Adults10 <i>Kelsea Lundquist, Nora J. Francis</i> | |

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EDITOR'S MESSAGE

BONDING: IN A COURSE OR ON THE TRAIL

Carol Schunk, PT, PsyD

As I write this message I am in the Salt Lake City Airport on my way back to Oregon from Corpus Christi, Texas. Over the weekend I taught a weekend course on Home Health Rehabilitation. The weekend was fun, the reviews were good, and once again I am amazed by the natural bonding atmosphere that occurs whenever a group of physical therapists, physical therapist assistants, or occupational therapists gather for any occasion. Some of the participants in the course were acquainted previously but most were strangers, bound only by a common body of knowledge and respect and concern for their patients. Some people may be attending strictly because they need continuing education credits but most are very willing participants. They are willing to give up a weekend because they want to be a better clinician. I am not sure this occurs in all professions. Listening to friends in other professions, they go to courses only to meet a licensing requirement and return home complaining about the waste of time. They never talk about the joy and stimulation of getting together with others in their line of work. In a 20-hour course it is necessary for the sanity of those attending, to provide variety in the format therefore there were numerous small groups break out sessions. This included practice of functional assessments, developing an exercise program, solving case histories in relation to autonomous practice, or critiquing one another's documentation. From a speakers point of view the assignment becomes secondary to the excitement and active discussions that occur in the small groups. Therapists learning and being challenged by other therapists can only result in a positive outcome for all. This exchange of ideas is not limited to the teaching hours but continues on the breaks. As I walk the room, I hear snatches of conversations as therapists compare practice situations and clinical issues in an ongoing exchange of ideas.

Physical therapy bonding can occur in unlikely places. A friend of mine has an annual hike on Iron Mountain in the Oregon Cascade Mountains when the wildflowers are at a peak, which happens to coincide with her birthday. She gathers a group of friends at the trailhead for coffee and muffins and a round of Happy Birthday, and then we all venture forth on the 8-mile hike. With 20 plus hikers and 5 dogs you can not stay together, so after a mile or so the group starts to split into those who like to hike and look at wildflowers as a secondary activity and those look at wildflowers first and hike as needed. By virtue of hiking speed, I ended up with my dog and 4 new friends. After another mile, I discovered one of the men in my group was a physical therapist. His wife immediately anticipated what was to happen and banished the two of us to the front of the group knowing we were going to "talk shop." This was a good move on her part because with relish we started to discuss our relative careers and the prominent issues of the profession as interpreted by our different clinical backgrounds. It was very enjoyable as there was not any sense of tarnishing the great outdoors with work issues as we both liked physical therapy as much as we liked being on the trail. I feel every fortunate to belong to a profession where this exchange of ideas and bonding is a natural and frequent occurrence.

In this September issue there is an excellent article by Sandy Levi, a very active member of the *GeriNotes* Editorial Board, on humeral fractures as a result of falls. Nora Francis is promoting her student's work in the article on depression and exercise in the elderly. The article is yet another example of our prominent role as THE experts in exercise. David Scalzitti, who is on APTA staff, continues with our mission to promote evidence-based practice with an excellent tutorial on using the ATPA site. I regret not attending the recent

World Confederation of Physical Therapists Convention in Vancouver, British Columbia as I can feel the excitement of the event as detailed in John Barr's Presidential Perspective. Once again the bonding/networking issue is prominent. Neva Greenwald, as IPTOP Representative, provides additional details on what looked to be a great event. Section members were well represented at the meeting with member, Nancy Prickett receiving a national award and Marilyn Moffat being elected as the new WCPT President. Congratulations to Nancy and Marilyn and to the Section on Geriatrics for sharing our leaders with the world.

PRESIDENT'S PERSPECTIVE: WCPT – Participating in a World Conversation about Physical Therapy

John O. Barr, PT, PhD

Having attended 2 previous World Confederation for Physical Therapy Congresses (Montreal, 1974; Washington, DC, 1995), this 15th international meeting, held June 2-6 in Vancouver, Canada, was the first one that I really *participated* in, thanks to mentoring by Section colleagues, Neva Greenwald and Tim Kauffman. Registrants from WCPT's 92 international member organizations clearly had one common objective...enthusiastic participation in nonstop conversation about all facets of the physical therapy profession. I've never sincerely exchanged more business cards per unit time or met more folks interested in meaningful networking than I did at this event. This was not a glad-handing function. Section members are encouraged to visit the WCPT website (www.wcpt.org/congress) where abstracts of presentations and audio recordings are available, and web-based discussion forums encourage ongoing conversations.

One of congress's highlights for me was attending the business meeting of the International Association of Physical Therapists Working with Older People (IPTOP), a formal WCPT subgroup. (See Neva Greenwald's report about the WCPT, on page 16, in this issue of *GeriNotes*.) The level of international interest in providing quality physical therapy services to older individuals was truly impressive. At this meeting I had the opportunity to promote the Section using our new brochure, "Resources for International Physical Therapists and Physical Therapist Assistants" which outlines our mission, vision, and values; describes our publications and continuing education programming; lists presentations for sale and free patient education brochures; and encourages networking opportunities via our list-serv. I also distributed many samples of

our Home Study Courses, which were very well received.

Having had the privilege to nominate Section member, Nancy Prickett, PT, MPT, MA, NCS, GCS it was thrilling to be present at the formal Gala Dinner as she received a WCPT *International Service to the Profession* award. During her more than 30-year career, Nancy has been a leader in clinical practice both in the U.S. and India, and within physical therapy organizations globally...all with an emphasis on working with older people. A member of the initial group to sit for the Geriatric Specialist Examination in 1992, she served first on the Geriatric Council and was Chairman of the American Board of Physical Therapy Specialties. Nancy expanded her organizational activities as a leader of the Cross Cultural International Special Interest Group of the Section on Health

Policy and Administration, and was a dedicated member of the Steering Committee responsible for creating IPTOP. As IPTOP Treasurer, she insured the fiscal integrity of the fledgling organization and obtained the monetary management assistance of the Section. Nancy was recognized for her continuous and exceptional service, and for her many contributions as a clinician, educator, and a professional role model that benefited the profession globally. Among the 6 other service award recipients were Robin McKenzie and Brian Mulligan.

As might be anticipated, many formal 'organizational' meetings transpired. I participated in the inaugural meeting of the International Society of Physiotherapy Journal Editors on behalf of the *Journal of Geriatric Physical Therapy*. An amazing 45 journals related to physical therapy were represented! A con-



Section President, John Barr; award recipient, Nancy Prickett; and outgoing WCPT President, Sandra Mercer Moore at the Gala Dinner.

stitution was adopted, and plans for approval of bylaws and election of officers were set in motion. After attending the Focused Symposium, "Moving Electrophysical Agents Forward in an Evidence-based Practice Environment," I participated in a follow-up meeting where it was proposed that an electrophysical agents subgroup, the International Society for Electrophysical Agents (ISAP), be formed to promote clinical practice, education, and research in this area commonly used with older patients.

Conversations about the ISAP continue on the WCPT website.

My capstone congress experience was seeing our revered colleague and SOG member, Marilyn Moffat, PT, PhD, DPT, FAPTA installed as the 12th President of the WCPT. Only two other APTA members (Mildred Elson, 1st President, 1953-56; Eugene Michels, 6th President, 1974-82) have served in this capacity. Although Marilyn will undoubtedly maintain a broad organizational perspective that is sensitive to the various constituen-

cies that comprise the WCPT, I feel very confident that her conversations in the world of physical therapy will continue to advocate for aging issues and the older individuals we serve.

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

APTA Foundation GERIATRIC FUND Supporting Geriatric PT Research 2007 MATCHING CAMPAIGN

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www.apta.org/foundation**

REHABILITATION OF PROXIMAL HUMERAL FRACTURES

Meri Goehring, PT, PhD, GCS

With the increasing number of older adults in the population, osteoporosis and fall related injuries are on the rise. When an older adult with osteoporosis sustains a fall, it is common that fractures occur. Proximal humeral fractures are the third most frequent fracture in elderly patients after hip fracture and Colles' fracture.^{1,2} Approximately 70% of individuals who sustain a proximal humeral fracture are 60 years of age or older, and 75% are women.^{1,3,4}

INCIDENCE OF FRACTURES

Most proximal humeral fractures occurring in older adults can be attributed to falls.⁴ There are a number of risk factors that also increase the likelihood and severity of these fractures. These include a recent decline in health status, insulin-dependent diabetes mellitus, infrequent walking, muscular weakness, and balance problems. Other risk factors include low femoral neck bone mineral density, height and/or weight loss, previous falls, and maternal history of hip fractures.⁵

Literature on fall mechanics indicates that proximal humeral fractures occur easier in individuals who walk slowly, fall sideways or obliquely forward, and are not able to slow down or break the fall with an outstretched arm. The fall usually occurs directly on the shoulder and can occur with minimal trauma.^{6,7}

The incidence of proximal humeral fractures may be rapidly increasing. A recent study performed in Finland indicates that the current number of fractures in the older population will triple over the next 3 decades.⁵ Although this study cannot be generalized to other populations, it is likely that this trend may be similar in the United States. Therefore, this review of rehabilitation techniques may help the physical therapy clinician to promote proper treatment.

ANATOMY REVIEW

A brief review of anatomy of the shoulder reveals that the humerus is the

largest bone in the upper extremity. The proximal humerus articulates with the glenoid of the scapula to form the glenohumeral joint. The muscles and tendons of the rotator cuff, the acromion, and ligamentous attachments such as those between the coracoid process of

the scapula and the acromion, serve to both stabilize the glenohumeral articulation and provide for a wide range of motion of the shoulder joint. The proximal humerus is divided into 4 sections: the anatomical neck, the surgical neck, the greater tuberosity, and the lesser tuberosity,

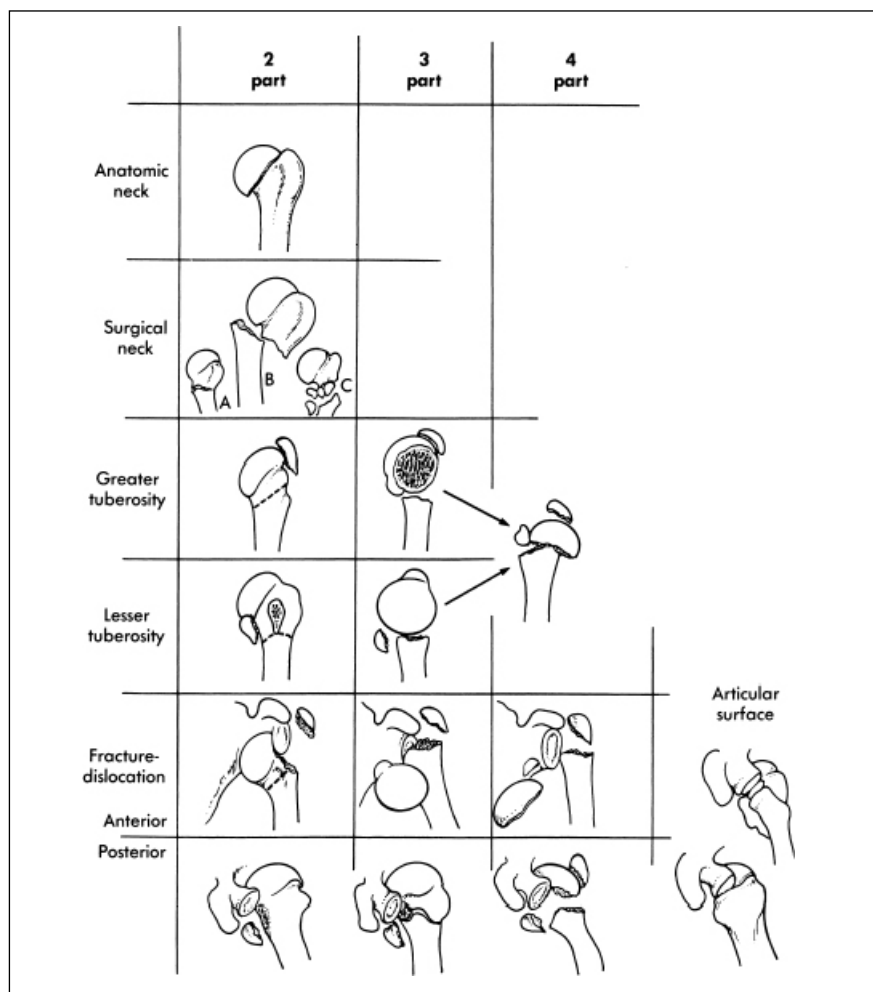


Figure. Neer's terminology of four-segment classification of displaced fractures and fracture-dislocations relates pattern of displacement (two-part, three-part, or four-part) and key segment displaced. In each two-part pattern, segment named is one displaced. Two-part surgical neck fractures are impacted, A; unimpacted, B; and comminuted, C. All three-part patterns have displacement of shaft segment, and displaced tuberosity identifies type of three-part fracture. In four-part pattern, all segments are displaced. Fracture-dislocations are identified by anterior or posterior position of articular segment. Large articular surface defects require separate recognition. (Redrawn from Neer CS II: *J Bone Joint Surg* 52A:1077, 1970.) Reprinted with permission by Canale: *Campbell's Operative Orthopaedics*, 10th ed. Mosby, Inc. 2003.

ity. The anatomical neck consists of the widened articular surface of the humeral head. The surgical neck is located at the constriction distal to the humeral head and tuberosities. The surgical neck is the site of articular capsular attachment and also for various penetrating arteries that provide some of the vascular supply to the humeral head. The greater and lesser tuberosities are the sites of attachment of the tendons of the rotator cuff muscles. The greater tuberosity is located lateral to the humeral head and on the superior aspect of the humerus. It provides the attachment for 3 of the rotator cuff muscles: supraspinatus, infraspinatus, and teres minor. The lesser tuberosity of the humerus is located on the anterior surface of the humerus and provides the attachment for the subscapularis muscle.

The humeral shaft supplies the attachment for a number of powerful muscles. The pectoralis major muscle inserts on the proximal shaft while the deltoid muscle attaches to the midshaft. The biceps/brachialis and triceps muscle groups attach further distally. The tendon of the long head of the biceps brachialis muscle passes between the lesser and greater tuberosities as it courses in a shallow groove on the anterior surface of the humerus. The long head tendon attaches to the scapula on the superior portion of the glenoid where its fibers merge with those of the fibrocartilaginous superior glenoid labrum.

Proximal humeral fractures vary in their severity. While most nondisplaced proximal humeral fractures respond to conservative treatment, displaced fractures or fractures associated with dislocations may require surgical intervention. A classification system for displaced proximal humeral fractures was established in 1970 by Neer.⁸ This system is commonly used by many health professionals when referring to proximal humeral fractures. The figure on page 7 provides more detail of this type of classification.

REHABILITATION

Rehabilitation of fractures of the proximal humerus is intended to restore normal shoulder function. Although surgery is often suggested for more complex fractures, one study indicates there may be little difference in outcomes between patients who had surgery or those

Table. Rehabilitation Program for Proximal Humerus Fractures

Early Rehabilitation (injury to 2 weeks)

- Educate the patient regarding the benefits of early movement.
- Prevent inappropriate shoulder movement patterns.
- Passive accessory movements to the shoulder, within pain limits.
- Passive shoulder abduction and lateral rotation aiming for 90° abduction within the first 3 sessions.
- Teach the patient gravity assisted pendular exercises to do at home.
- Pain control with heat or ice.

Intermediate Rehabilitation (2-8 weeks)

- Supervised passive shoulder exercises in supine (flexion and lateral rotation).
- Light functional exercises without causing pain exacerbation.
- Increase passive physiologic movements (not into resistance) to full range.
- Proprioceptive exercises (closed chain and open chain).

Late Rehabilitation (8 weeks or more)

- Active exercise against gravity.
- Isometric muscle work to strengthen rotator cuff muscles.
- Reduce use of sling and encourage functional exercises.
- Passive stretching if soft tissue contractions persist.
- Discharge when independent function is regained.

who received conservative treatment.⁹ Certainly, this requires further investigation. However, rehabilitation treatment is common in surgically repaired or nonsurgically treated proximal humeral fractures.

But what type of rehabilitation is best? First, it is important to recognize that many patients with proximal humeral fractures have osteoporosis and poor neuromuscular control mechanisms. The therapist, therefore, needs to provide education regarding the importance of exercise in prevention of osteoporosis and work closely with each patient's physician(s) to promote good bone health. This may also include coordination and communication with other health professionals such as a dietitian and pharmacist. Additionally, the risk of a future hip fracture is higher after a proximal humeral fracture.¹⁰ Therefore, the therapist should use the appropriate tools to examine fall risk and provide intervention strategies to prevent falls once a proximal humeral fracture has occurred. The APTA has recently offered excellent information on the many tools available in their brochure entitled, *Physical Fitness and Falls Risk Reduction Based on Best Available Evidence*.

Regarding the specific type of rehabilitation after proximal humeral frac-

tures, it is probably no surprise that there is insufficient evidence from randomized controlled trials to determine which interventions are most appropriate. However, a recently published literature review and survey done in the United Kingdom provides some interesting information.¹¹ First, there is little evidence to support use of electrotherapy in rehabilitation or for pain relief. Further, although the studies are small, it appears that exercise and joint mobilization can benefit patients with proximal humeral fractures. Additionally, recent evidence from a randomized controlled trial indicates immobilization for 3 weeks or longer provides no benefit and only delays rehabilitation.¹² The author states that early referral to physical therapy without immobilization seems to accelerate recovery by reducing pain and shoulder stiffness. The author recommends immobilization might be necessary in more complex fractures especially if vascular structures are compromised.

Clearly, patients with proximal humeral fractures should routinely be given advice, education, and an exercise program. Physical therapists are among the best trained health professionals to provide this treatment. One rehabilitation program that is based on available evidence comes from the Sheffield

study.^{12,13} There are 3 phases of rehabilitation and these are described in the table to the right.

Rehabilitation of the individual with a proximal humeral fracture will be influenced by the type of fracture, the type of repair, and the relative health of the patient, and the relationships between the patient, the physical therapist, and the physician. Early mobilization, treatment of osteoporosis, and instruction in fall prevention are important strategies. Such treatment along with the cooperation and communication between the patient, the therapist, and the physician will provide the patient with the best opportunity to attain optimal shoulder function.

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SEEKING HOME STUDY COURSE EDITOR

The Section on Geriatrics is looking for someone to serve as editor for home study courses beginning in 2009. The successful applicant will serve as co-editor in 2008, and full editor in 2009.

The Section on Geriatrics produces one home study course per year, usually consisting of six monographs. The editor's duties include: overall planning for the home study course, selection of topic(s) and an author for each monograph, ultimate responsibility for the content and quality of each monograph. Support is provided by the SOG office and the managing publisher. Honoraria for the editor includes: \$500/monograph while co-editor, \$1000/monograph while editor.

The application deadline is 10/1/2007, but we may need to extend that deadline.

If you are interested, you can view the job description and application form at www.geriatricspt.org, by clicking "About Us." We will remove the job description from the webpage as soon as we stop accepting applications.

Questions? Please contact the SOG office, jessicasabo@apta.org.

EXERCISE AND DEPRESSION IN OLDER ADULTS

Kelsea Lundquist, SPT; Nora J. Francis, PT, OTR, DHS

This article is a follow up to the Linking Evidence to Geriatric Practice in Physical Therapy Student Education article that was published in the January 2006 edition of GeriNotes. That article described how one physical therapy education program provides opportunities for students to link geriatric professional literature to practice within a course that presents special issues in providing physical therapy care to older adults. One of the course objectives is that students will be able to analyze the professional literature on selected topics that are relevant to providing physical therapy care for older adults. This objective is addressed through the assignment of a Geriatric Physical Therapy Topics Paper, which is designed to provide students with an opportunity to examine and analyze current professional literature on topics that are especially applicable to providing care for older adults.

The students are provided with a list of 19 potential topics that are presented in the form of a clinical question. Students select and research the identified topic and write a paper that includes: (1) a brief introduction of the topic and its importance to the care of older adults; (2) an in-depth, specific discussion of the topic; (3) a discussion of the implications of the researched topic on the physical therapy management of the older adult client; (4) and suggestions for future research.

The following is a Geriatric Physical Therapy Topics paper submitted by Kelsea Lundquist who researched the clinical question, "What is the role of exercise in the management of depression in older adults?"

INTRODUCTION

Older adults face a number of changes in their health as they age, and depression may or may not accompany these changes. Depression is a major health problem and should not be viewed as a part of the normal aging process. Older adults are at a higher risk for depressive symptoms due to factors in their lives such as loss and grief, social isolation, medical illness, and caregiver burden. Although the risk and incidence of depression is higher, it is often more difficult to diagnose, as these patients tend to not report symptoms of mood or depression to their primary care provider, and they are more likely to describe their symptoms as physical complaints.¹ It has been theorized that exercise decreases depressive symptoms in older adults, and many studies have been done to test the hypothesis. As a result of these studies, there is a general agreement that exercise can significantly decrease depressive symptoms in older adults. Thus, encouraging older adult patients to exercise may decrease current depressive symptoms or the risk of developing depression.

THEORIES

There are several theories behind how exercise affects depressive symptoms in older adults. The social stimulation hypothesis posits that physical

activity allows for social interaction with others thus providing a social support network.² Another theory is that neurobiological mechanisms occur with physical activity, including changes in brain monoamines, which have an antidepressant effect on depressive symptoms.³ Finally, another theory is that physical activity has a positive effect on self-esteem and self-efficacy secondary to changes in health and physique that result from an active lifestyle.⁴ It is quite possible that there is no one correct theory for the reasoning behind exercise and its effects on depression because depression is a highly subjective experience that most likely differs for each individual.

TYPES OF EXERCISE

One question that researchers have explored is whether there is a difference in the reduction of depressive symptoms with the type of exercise that a person chooses to engage in. Motl et al³ compared low intensity aerobic exercise with low intensity strengthening and stretching exercise and examined the outcomes over a long period of time. They measured the depression symptoms using the Geriatric Depression Scale (GDS) and the physical self-esteem of participants using the Physical Self-Perception Profile, and measurements were taken at baseline, 6, 12, and 60 months after beginning a 70-day exercise regimen. They

found that both groups had significant reductions in depression symptoms over time, and these changes were not significantly different between modes of exercise. The effects on depressive symptoms continued to decrease for a sustained amount of time, indicating that exercise has a significant antidepressant effect on the elderly that is long term.³ In another study, older adults underwent a 10-week progressive resistive training (PRT) program and were compared to a control group that simply received advice. The PRT group had greater decreases in depressive symptoms (GDS scores), but the difference was not significantly different than the control group.⁵ The results of this study may be influenced by the way that the PRT group engaged in exercise. For example, it was not specified whether the exercise program was in a group or individual setting, nor was it specified whether there had been any objective changes in overall strength or function in the subjects. Blumenthal et al did a similar study focusing on aerobic exercise, and also showed that depressive symptoms decreased significantly after 4 months of a walking/jogging exercise program.⁶ This exercise group met for group exercise and subjects exhibited changes to their overall fitness as measured by a graded exercise test. Based on the literature, it can be determined that the type of exercise does not make

a difference in the reduction of depressive symptoms in older adults. This fits into the model that many factors that result from physical activity are involved in reducing depression, whether it be the increased social support, increased physiological fitness, or increased self-esteem. The type of exercise does not play a significant role in contributing to those factors, however, when prescribing an exercise regimen to an older adult patient, these factors should be considered and will greatly increase the likelihood of adherence and effective treatment of depressive symptoms.

ANTI-DEPRESSANTS

The most common treatment for depression in any age group is antidepressant medication therapy. However, 30% to 50% of patients do not respond to treatment.⁶ The effectiveness of antidepressants may be even lower in elderly patients because adherence is often low and there are often negative attitudes regarding the stigma of taking an antidepressant or the fear of certain side effects. Givens et al⁷ explored older adults' attitudes towards antidepressant use through interviews. Interviewees revealed many reasons why there are negative attitudes toward antidepressants including fear of addiction, reluctance to relate depression to a medical illness that medication can affect, belief that antidepressants will prevent natural sadness that has important meaning, and prior experience with medications.⁷ Older adults often take numerous medications for a variety of concurrent health problems, and may experience problems with adhering to all medications due to forgetfulness or fear of adverse side effects. As stated earlier, older adults rarely complain to their doctor of problems with mood or other depressive symptoms because they do not see them as medically relevant information. Given their lifestyles and social situations, grief is a common emotion, and older adults may not see this as something medication can change, nor do they wish to become numb and not experience natural sadness that occurs with grief and loss. For older adults, antidepressant therapy often poses more of a psychosocial issue than a medical one.

So then, the question is can exercise have the same or better effects on depression for older adults who tend to have

such aversions to antidepressant therapy? Blumenthal et al⁶ not only looked at the positive effects of aerobic exercise, as mentioned earlier, but they compared the aerobic exercise group to a medication group who were given selective serotonin reuptake inhibitors only. There was also a third group that had a combination of exercise and antidepressant therapy. All subjects in this study had been diagnosed with major depressive disorder (MDD). The outcome measure for depression was the Hamilton Rating Scale for Depression (HAM-D), and all groups had significant decreases in HAM-D scores throughout the course of a 16-week treatment. Interestingly, all three groups had significant enough decreases in depressive symptoms to be no longer classified by DSM-IV criteria as having MDD.⁶ The results of this study suggest that exercise is equally effective as medication in the treatment of depression, thus should be considered an option for treatment before, or perhaps in conjunction with, antidepressant therapy.

EXERCISE DEPRESSIVE SYMPTOMS

The current literature supports exercise as an effective means to decrease depressive symptoms in older adults. Physical therapists can be very effective in providing this treatment because of the extensive knowledge in the area of exercise prescription and wellness promotion. Therefore, it is extremely important for physical therapists to be able to recognize signs and symptoms of depression, especially since these patients do not often directly express complaints of problems with mood. More often complaints will be referred to as somatic complaints that may or may not fit with the current problem for which they seek physical therapy. When addressing patients that are depressed, psychosocial skills should be employed, and it should be emphasized to the patient that depression is not a normal sign of aging and can be treated. Given that there are many factors underlying how exercise improves depressive symptoms in older patients, a physical therapist needs to take into account each of these factors when prescribing an exercise program. Considering group-based programs, find-

ing out what functional activities the individual enjoys, and taking objective measures of strength or aerobic capacity to measure overall fitness improvement are all examples of factors that should be taken into account. Because it does not make a difference whether an individual engages in an endurance or strengthening exercise program, activities that are enjoyable to the individual are important to consider in choosing a program in order to ensure adherence. The goal of decreasing symptoms of depression will be more easily met if the individual enjoys the process of participating in the exercise program. Finally, it would be important for the physical therapist to discuss treatment with the patient's primary care provider about prescriptions and share thoughts on the effectiveness of antidepressant therapy for older adults.

FUTURE RESEARCH

This topic has been highly studied to date, however there are suggestions for future research that may further provide evidence that will assist treating patients that are at risk or demonstrate depressive symptoms. There have been many studies on both patients with and without diagnoses of depression and their responses to physical activity. It would be interesting to conduct a qualitative study to examine whether there are positive or negative attitudes towards physical activity in either population. This would give a good idea of the ease or difficulty it would be to motivate these patients and convince them that exercise is an effective method of treatment. We already know that there is a negative attitude towards antidepressant therapy, and among a population that is at such a high risk for depression there may be overall negative attitude towards physical activity as well. Another suggestion is to further explore the factors that underlie how physical activity affects symptoms of depression. This would take several studies to quantify the physiological and biochemical factors as well as the social support theory and self-efficacy theory. Self-efficacy and self-esteem have been used as outcome measures in several studies in addition to depression scales, so this topic would not need as heavy as an emphasis in future research.

Finally, it would be interesting to qualitatively explore the attitudes and beliefs that physical therapists have towards the incidence and treatment of depression within the elderly population. This would provide an idea of how it is currently being managed and whether physical activity is a common prescription used in the clinic.

CONCLUSION

There is overwhelming evidence to support physical activity in older adults as a treatment for depression. Older adults are among the highest at risk for developing depressive symptoms due to life changes as well as physical changes. Depression is not a normal process of aging, and efforts to effectively treat it in the aging population should be taken very seriously. Physical therapists are among health care providers that can emphasize the importance of physical activity for this population of patients to increase both physical and mental health. Physical activity may have multifactorial effects including increases social supports and networks, changes in monoamines in the brain that increase mood, and increased self-esteem and self-efficacy. Encouraging physical activity in older adult patients is important in decreasing the risk of developing symptoms of depression or decreasing current symptoms.

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APTA APPOINTED GROUP POOL VACANCIES FOR 2008 POSTED ONLINE

Components and individual members are encouraged to submit names for the APTA Appointed Group Pool. When recommending individuals for appointment, members may contact Suzie Callan in APTA's Governance Department at suziecallan@apta.org, who will in turn send a communication describing the Appointed Group Pool and the appointment process. Members who have an interest in serving on an appointed group themselves should submit a Biographical and Consent Form online. The form must be submitted by January 1, 2008, for consideration by the Board for appointment at the March 2008 meeting. A list of the current vacancies is also available online.

Section on Geriatrics members who apply are encouraged to notify us at geriatrics@apta.org. This will afford us the opportunity support your appointment, to help ensure that aging/geriatric issues are represented in appointed groups.

More information: www.apta.org, click "Membership and Leadership," "APTA Leadership," and "Committees."

USING CLINICAL SCENARIOS TO FIND EVIDENCE FOR GERIATRIC PHYSICAL THERAPY PRACTICE

David Scalzitti, PT, MS, OCS

Clinical scenarios related to geriatric physical therapy practice have been added to the Hooked on Evidence website. These scenarios are for management of patients with a number of conditions which affect older adults, including deconditioning, falls, fractures, and osteoporosis, and were developed by a group of expert physical therapist clinicians and researchers.

The scenarios can be accessed in Hooked on Evidence by clicking the link titled Search Clinical Scenarios and are indexed according to the type of Preferred Practice Pattern and conditions they represent. As an example, a clinician who is interested in using interventions that can improve gait speed in patients after a hip fracture would go to the drop down lists and select musculoskeletal as the practice pattern, fractures in older adults as the condition, and the scenario titled older adult with a femur fracture (Figure 1). After selecting the appropriate scenario, a description of the scenario, a reference list, and an outcome list is then displayed (Figure 2). The scenario provides a one paragraph description of a typical patient with the condition and includes text in bold to identify key findings from the examination. The reference list includes articles that relate to these key findings, is organized by study design type, and includes a hyperlink to an extraction of the article, which presents additional information on the participants, interventions, and outcomes of the study. Figure 3 presents a sample view of an individual article extract. Note that an extract provides a link to the PubMed abstract which may further link to full-text of the article. Full-text of an article may also be available through APTA's Open Door at www.apta.org/opendoor.

A list of outcomes related to the clinical scenario is accessed by scrolling to the bottom of the page and allows a

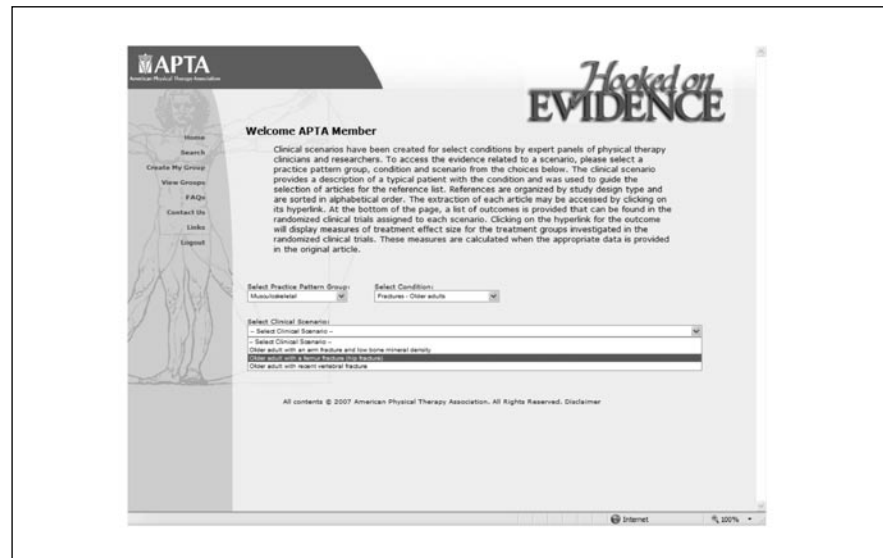


Figure 1. Example of the drop down menus to access a clinical scenario using the Hooked on Evidence website. Note that the scenarios related to older adults are currently listed among the Musculoskeletal, Neuromuscular, and Cardiovascular/Pulmonary practice patterns.

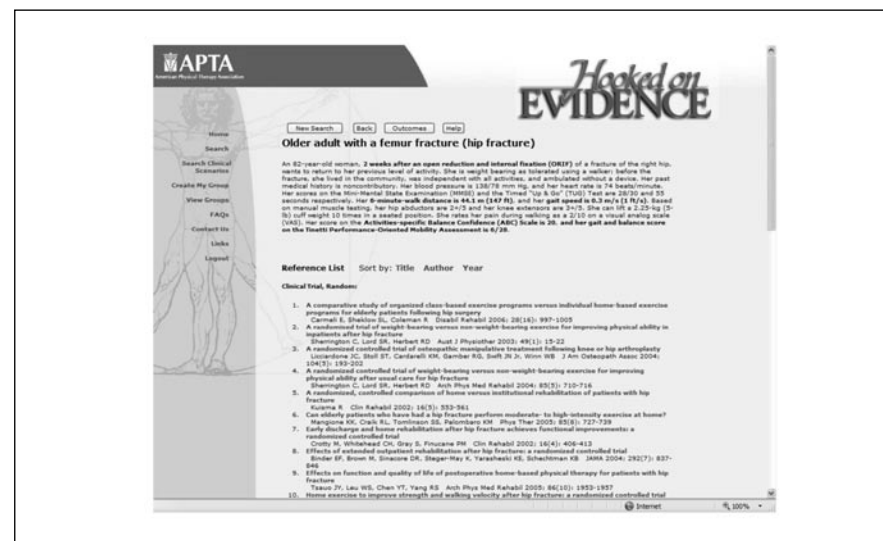


Figure 2. Example of the display of a clinical scenario within the Hooked on Evidence website. A one paragraph description of a typical patient with the condition is provided and includes text in bold to identify key findings from the examination which are used as inclusion criteria for the studies provided in the reference list. A reference list ordered by study design type follows the patient description.

clinician to view results from multiple studies (Figure 4). Clicking on the hyperlink for the type of outcome, such as gait, pain, functional limitation, etc. displays measures of treatment effect size for the treatment groups investigated in the randomized clinical trials for the scenario. These measures are calculated when the appropriate data is provided in the original article. Treatment groups are categorized according to the type of procedural interventions using the framework of the *Guide to Physical Therapist Practice*. For outcomes measured on a continuous scale, the standardized mean difference is calculated as the measure of treatment effect size. For outcomes measured on a dichotomous scale, an odds ratio, risk ratio, and number needed to treat are calculated. Definitions and guidance in interpreting these measures is provided throughout the website, including a section of frequently asked questions and help buttons. In cases where more than one study compared similar types of interventions and outcomes, a measure of pooled treatment effect size is calculated and displayed (a pooled standardized mean difference for continuous outcomes and a pooled odds ratio for dichotomous outcomes).

Returning to the earlier example, a clinician would click on the gait hyperlink in the outcomes section to access a summary of the randomized clinical trials that reported appropriate data for this outcome. Figure 5 demonstrates graphs of some of the studies indexed for this scenario. Quickly, looking at the graphs a clinician can see studies where one treatment group was more effective than the comparison or where there was no difference in effectiveness between treatment groups. In Figure 5, there is one study where the graph of the standardized mean difference and its confidence interval is to the left of 0 indicating that the intervention was more effective than the comparison in improving gait. The user of Hooked on Evidence can then click on the link to the article extract for more information on the participants, specific interventions, and gait outcome reported in the study.

A unique feature of these clinical

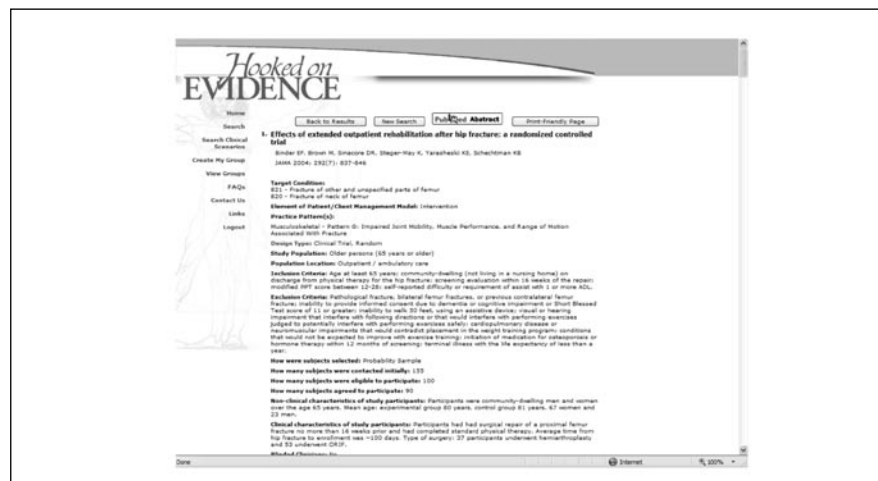


Figure 3. A sample view of an article extract in Hooked on Evidence. Each extract presents in a standard format information on the study's methods, characteristics of the study's participants, the interventions studied, and the outcomes of the interventions.

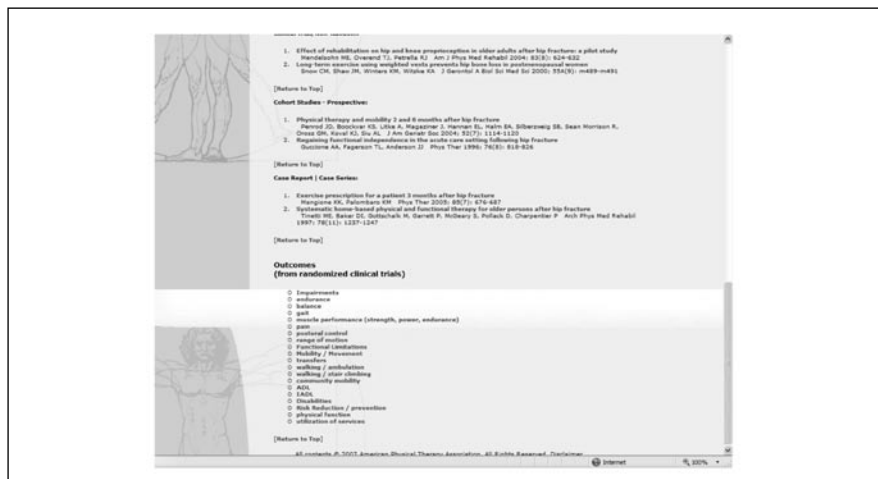


Figure 4. Example of the display of outcomes from a clinical scenario. Clicking on the hyperlink will display measures of treatment effect size for the treatment groups investigated in the randomized clinical trials indexed in the scenario.

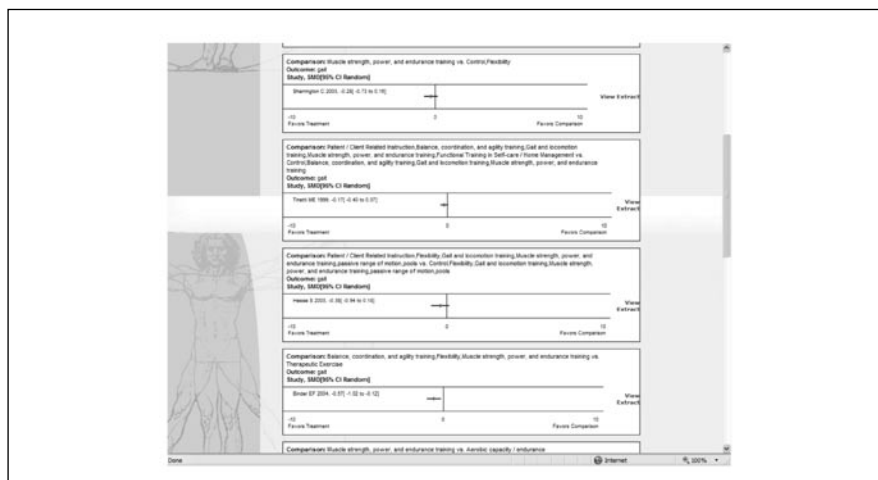


Figure 5. Example of graphs of treatment effect size from a clinical scenario in Hooked on Evidence. Measures of treatment effect size whose 95% confidence interval does not include 0 suggest a difference in the effectiveness between two treatment groups compared.

scenarios is the ability for the evidence to be updated as new studies appear in the literature. Hooked on Evidence allows for appropriate articles to be added to the scenarios as soon as the article is extracted into the database. In contrast, published systematic reviews may take years till an updated version that incorporates new evidence appears in press.

Hooked on Evidence may be accessed at www.hookedonevidence.org and is a benefit of membership in APTA. Questions and feedback regarding the scenarios can be sent via e-mail to hookedonevidence@apta.org.

The work of Cathy Ciolek, PT, GCS;

Sandy Ganz, PT, PhD, GCS; Kathleen Mangione, PT, PhD, GCS; Peter Normandt, PT, CRNP; and Anthony Walker, PT in developing the scenarios is greatly appreciated. The assistance of the Section on Geriatrics Exercise Task Force in the provision of lists of appropriate articles is acknowledged.

David Scalzitti is an Associate Director of Research Services for APTA and is responsible for management of Hooked on Evidence. Prior to coming to APTA, David was a clinical faculty member at the University of Illinois at Chicago. He has



published on the topic of using evidence-based practice and clinical practice guidelines and has served as a member of the editorial advisory panel for the Physical Therapy journal's Evidence in Practice feature. He may be contacted at davidscalzitti@apta.org.



CSM 2008 NASHVILLE, TN FEBRUARY 6-10, 2008



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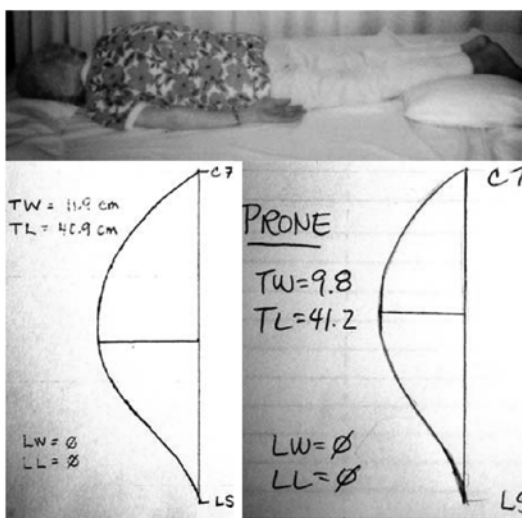
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- Appropriate Patients
- Importance of Monitoring Kyphosis
- Validity
- Reliability
- Practicality
- Assessing Change Over Time
- References

C: Equipment List

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GLOBAL PERSPECTIVES IN GERIATRICS, EDUCATION, AND REGULATION

World Confederation for Physical Therapy 2007

Neva F. Greenwald, PT, IPTOP Representative

WCPT OVERVIEW

The air was full of excitement and anticipation as the World Confederation for Physical Therapy (WCPT) meeting in Vancouver began in early June. I had the wonderful opportunity and privilege to interact with physical therapy colleague acquaintances from earlier international experiences and meet many new practitioners during several types of conferences, meetings, and social events. Networking experiences were great and the educational/scientific presentations thought provoking. WCPT, 2007-“Moving Physical Therapy Forward” attracted around 3,500 delegates from about 80 countries for a variety of workshops, symposia, and presentations (over 1600 presentations) on issues impacting physical therapists around the globe.

MOFFAT ELECTED WCPT PRESIDENT

During the WCPT Association General Meeting, just prior to the beginning of the Congress scientific and educational event, Section on Geriatrics member, Marilyn Moffat was elected President of WCPT. Her term is for 4 years. Congratulations to her!!!!

We look forward to her leadership. She certainly will have a very busy 4 years and will be leading WCPT in some new directions identified by the organization in Vancouver.

THE INTERNATIONAL TRAVELER

Like many others attending the meeting, I had a travel delay and spent one night in route at the Houston airport due to inclement weather. I was lucky to obtain a stand by seat and arrived in time to participate in all meetings. Others were not so lucky and with all of the new security regulations many individuals from other countries could not get the appropriate travel documents. One therapist from Afghanistan could not get

needed documents and did not arrive until the postconference course held by the International Society of Educators in Physiotherapy. He had assistance from many physical therapy colleagues and friends with some of these individuals actually hand carrying needed documents for him to the Pakistan and Afghanistan border. Such dedication, determination, and commitment are not often encountered.

IPTOP AND EDUCATION

The International Association of Physical Therapist Working with Older People (IPTOP) activities were an important part of my responsibilities and activities at the meeting. Our subgroup had a festive booth complete with balloons, a poster, and handouts throughout the meeting. Attendees learned about the Section on Geriatrics through bookmarks and a brochure. US representatives to IPTOP, Nancy Prickett and yours truly, were responsible for the festive balloons, pens, poster, and SOG information. Jess Sabo was very helpful in getting the brochures designed.

A very informative session on geriatrics internationally occurred in panel discussion presented on Sunday as a preconference offering. The take home messages were that the older population continues to grow rapidly with the most surges in developing countries where issues such as sanitation, communicable diseases, and food supply contribute to the health care issues facing older people. Nancy Prickett (USA) discussed the diverse issues facing patients/clients and physical therapy practitioners in North America and the Caribbean.

IPTOP BUSINESS MEETING

Representatives from 10 IPTOP affiliated countries and individuals from 7 other countries were present. There are a total of 15 affiliated countries representing over 8,000 physical therapists

in IPTOP. Ten people from the US were in attendance at the association general meeting including SOG President, John Barr. I was honored to serve as the IPTOP voting representative.

Olwen Finlay, outgoing IPTOP President summarized the accomplishments of the fledgling group during the initial 4 years as a WCPT subgroup (Barcelona 2003 – Vancouver 2007). Among the highlights was the fact that the group has held meetings in Dublin, Ireland (2004); Melbourne, Australia (2005); and Istanbul, Turkey (2006) in conjunction with the special interest groups in those countries. Other accomplishments included: production of a logo, establishing organizational structure, offering low affiliation fees, producing an electronic newsletter, and establishing a web page on WCPT web site. She paid tribute to the Chartered Society of Physiotherapy for seed funding and the



Marilyn Moffat presents Sandra Mercer Moore a plaque in recognition of her years of service to WCPT.

American Physical Therapy Association, Section of Geriatrics for banking services. She thanked Brenda Myers, WCPT Secretary General; Inger Bröndsted, WCPT Vice President; and Sandra Mercer Moore, WCPT President for their support and advice.

Elected to positions for the next 4-year term were: Felix Can (Turkey), President; Jennifer Bottomley (USA), Vice President; Jill McClintock (UK), Secretary; Neva F. Greenwald (USA), Treasurer; Amanda Squires (UK), Newsletter Editor; Bhanu Ramaswamy (UK), European Regional Representative; No representation from South America and Africa; Jeannie Delaney (Australia), Regional Representative; Asia Western Pacific and the North America and Caribbean Region is represented by the IPTOP Treasurer. Jennifer and I are honored to have been elected for service in IPTOP and proud to represent the SOG.

Action items during the business meeting related to enhancing communications and extending appreciation to those who assisted the organization during the past 4 years. The group voted to send certificates of appreciation to those countries who had shared congresses with IPTOP. As the email list for the association is updated 3 mailings for each country will be requested to facilitate communication.

WCPT AWARDS

Three members of the IPTOP executive were honored by WCPT during the meeting. Nancy Prickett (USA) received 1 of 7 International Service Awards presented at the Awards Dinner. Amanda Squires (UK) also received one. This was the inaugural year for the awards and the IPTOP group was pleased to have members of its executive honored. Both Nancy and Amanda deserved recognition for their IPTOP work and other international activities. Nancy has had previous service as a



Olwen Finlay, outgoing IPTOP President; Nancy Prickett; Dr. Sandra Mercer Moore, outgoing WCPT President; and Amanda Squires, newly elected IPTOP Treasurer.



New WCPT President and Section on Geriatrics member, Marilyn Moffat with representatives from the European region.

physical therapist in India. In addition, Olwen Finlay, IPTOP President, received 1 of 6 WCPT International Leadership Awards during the WCPT Association General Meeting. Finally

Dele Amosum (Africa), a participant in the first physical therapy international course on geriatrics/gerontology (1993) and an original facilitator of IPTOP, was recognized for his international service in enhancing physical therapy services in Africa.

IPTOP recognized the best poster and the best presentation in the area of gerontology through presentation of an IPTOP globe statute (Table). Recipients were selected by the WCPT academic committee and prizes presented at the

Table. Poster and Presentation Award Recipients

| | |
|---------------------------------|--|
| Joao Marcos Dias, Brazil | Muscle Co-Contraction During Walking: Comparisons Between Young and Elderly Women |
| Shelly R. Graham, Canada | Adapt Via Telehealth: A Multidisciplinary Approach to Educating Urban and Rural Patients Waiting for Hip and Knee Arthroplasty |

closing ceremony. WCPT 2007 was also the first time that any subgroup recognized excellent presentations and posters. At the IPTOP business meeting, it was agreed that this was a very fitting way to recognize research in gerontology/geriatrics, good PR, and should be continued.

WCPT

Interestingly, both the WCPT opening and closing keynoters were US educated physical therapists who have been practicing in Canada for some time. Martha Piper, physiotherapist and researcher, provided attendees with an inspiring message and challenge for the next decade to focus on 5 basic factors— (1) “hope, (2) nerve to accept that some of what is done may not be efficacious or cost effective, (3) hard work, (4) a strong sense of self, and (5) a sense of interconnectedness” for the next decade. Susan Harris summarized the 3 days of the conference in a very fitting manner with statistics of the event (number of attendees and presentations in each category) and reflections on the wonderful opportunities for networking that occurred during the meeting. She encouraged members to attend the next meeting in the Netherlands—2011.

OTHER MEETING EVENTS

My first and last conferences were both with physical therapy groups not presently formally affiliated with

WCPT. Both groups are addressing issues with important implications for future practices in physical therapy.

INPTRA—The International Network of Physical Therapy Regulators met for one day to discuss some regulatory issues related to advanced scope of practice, to understand the role of regulators in various countries, look at frameworks for continuing competence, and to facilitate international cooperation and collaboration on issues of mutual interest. At this second official meeting, the group adopted a discussion paper on the organizational purpose and establishing a continuance of the network with a steering committee for management. The issues which received attention were the shortage of health professionals, how shortage influences regulation, and what roles various organizations play on the national and international scene. What impact does the world situation have on standards and mobility across jurisdictions as rapid organizational change and the expectations for health care services evolve.

ISEP—During the WCPT Congress, the International Society of Educators in Physiotherapy held a business meeting and voted to explore subgroup membership in WCPT. During a two day post congress meeting

at the University of British Columbia, educators shared a variety of educational experiences and techniques being used in many parts of the world. The setting provided an excellent atmosphere for networking. There was also further discussion on WCPT subgroup membership its importance in having a voice on educational activities globally.

SUMMARY

The week at Congress in Vancouver was a time of learning, sharing, and recognizing accomplishments in every area of physical therapy practice. IPTOP has gotten off to a great start as a subgroup during the past 4 years and received recognition from other components of the international community thanks to the affiliated individuals and organizations.

It is difficult to put into words the excitement, the information sharing, the cultural experiences, and wonderful networking that occur during international meetings. The Congress and associated meetings were a memorable experience that will continue to impact physical therapy practitioners for the next several years and create many enduring friendships and collaborative projects.

Now is the time to begin looking forward to participation in the next WCPT Congress scheduled for 2011 in the Netherlands.

CALL FOR VOLUNTEERS

Why do We Want Volunteers?

Browse the website. Read the Journal. Look through our course offerings or newsletter. Everything produced by the SoG has been created by volunteers. You ARE the Section on Geriatrics. We welcome your interest in getting involved, and invite you to read about available positions.

Visit www.geriaticsppt.org, and view our Volunteer Opportunities (click on members).

WELCOME NEW SOG LEADERS AND VOLUNTEERS

As always, we are truly humbled by the time and effort that volunteers give on behalf of the Section on Geriatrics and the population we serve every day. A big thank you to all past, present, and future volunteers who do so much to advance and improve the profession and practice of PT for aging adults! If you are interested in becoming involved, or in contacting one of the below volunteers, you'll find everything you need at www.geriaticsppt.org.

Balance and Falls Special Interest Group Chair – Judy Daniel, PT, MS, GCS

Judy has been appointed to serve as the Balance and Falls SIG Chair through CSM 2009. Judy is passionate about sharing information related to Balance and Falls with Section members. If you have information you can share with Judy about your B&F program, reimbursement related to B&F, recent research or articles, consumer education resources, etc, please get in touch with her!

Membership Chair – Leon Bradway, PT

Leon currently resides in Edgewater, MD. He serves as the Director of Clinical Support Services at the Naval Health Clinic, Annapolis. Some of his early goals will be executing a membership campaign and improving our booth.

PR Chair – Kerri Bednarcik, PT

Kerri will be overseeing our PR and Marketing efforts from her home in Yardley, PA. She is a Clinical Specialist in charge of Education & Staff Development for Genesis Rehab Services. Kerri will be overseeing development of a marketing plan for all Section materials (courses, products, etc.), as well as the writing and distributing of press releases for release to national and local media. **PR Chair is a new position in our Section, and Kerri will be looking for committee members. If you are interested, visit the volunteer opportunities page at www.geriaticsppt.org.

PTA Advocate – Jean Reynolds, PTA

Jean joins us from Maitland, FL, where she works as an Adjunct Instructor at Seminole Community College and is a staff PTA at Orlando Regional Healthcare. Jean will be working to expand current Section projects to benefit PTAs, and working to create new resources just for PTAs. If you are a PTA and have an idea for a resource that would be helpful to you, please get in touch with Jean! You can contact all Section officers from our website, www.geriaticsppt.org.

Finance Committee Member – Susan Griffin, PT, MS

Susan will be analyzing our finances from her home base in Burlington, WI. She is the lead instructor in a PTA program there.

ACEE (Advanced Clinical Exercise Expert for Aging Adults) Committee—co-chairs Marilyn Moffat, PT, PhD, DPT and Dale Lynn Avers, PT, DPT, PhD

Our co-chairs from New York will be working to establish a series of courses on exercise to be offered by the Section on Geriatrics. There should be more information available on this project this fall. Good luck, Marilyn and Dale!

Regional Course Leaders

Regional Course Chair Missy Criss, PT, MS, GCS is working to expand the Section's annual regional course offerings, and has recruited four Regional Course Leaders to help make this happen. Each leader will be offering a course in their region in 2008, and 1-2 courses in their region each year after that. We are very pleased to welcome our four Regional Course Leaders, and are excited about their work! If you would be interested in having a course at your facility, feel free to contact our course leaders.

West Regional Course Leader – Mike Studer, PT, NCS

Mike works at Northwest Rehabilitation Associates in Oregon. He has served before as the Vice President of the Neurology Section.

Central-West Regional Course Leader - Vicki Gines, PT

Vicki is a Rehab Supervisor in home health, and the owner of "50 Plus Fitness." She works at North Kansas City Hospital.

Central-East Regional Course Leader - Danille Parker, PT

Danille hails from Muskego, WI and is a faculty member at Marquette University. She also works part-time as a PT in the subacute setting.

East Regional Course Leader - Bruce Wassung, PTA

Bruce is the Director of Medical Rehabilitation and a PTA at Easter Seals Greater Hartford Rehabilitation Center.

TAKE A TOUR: YOUR NEW WEB SITE GOES LIVE!

Lucy Jones PT, GCS, MHA, SoG Web Chair

Your Section on Geriatrics WebConnection, www.geriaticspst.org, has never looked better! We have worked to improve the look and organization of the site, and will continue to expand and update the resources available there. Please consider taking the following tour to familiarize yourself with this fantastic tool from the Section on Geriatrics.

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 - ✓ View, print, and copy our patient education brochures. Direct your patients here to read frequently asked questions about geriatric PT, and information about what a PT does. Click on "Find a PT" to sign up and be included in APTA's online database for consumers!
- Need a juried, peer reviewed article for your continued information?
 - ↳ Click "Publications," and "*Journal of Geriatric Physical Therapy*"
 - ✓ You'll be looking at the current copy of the Journal (available to Section members only). Click "Journal Archives" to view full-text of issues back through 2001.
- Would you like the poster "What to do when you fall?" for your clinic or office? How about the new instructional video, "Kypholordosis Measurement Using a Flexible Curve?"
 - ↳ Click "Online Store" on the left, or under "About Us."
 - ✓ View all for-sale items using our secure online order system, with discounts for Section members.
- Interested in getting more involved in the Section on Geriatrics?
 - ↳ Click on "Volunteer Opportunities" in the sub-menu under "Members."
 - ✓ View our current vacancies, and download an application packet. Don't see anything that interests you? Review our list of committees (click "Committees" under the "Members" sub-menu), and e-mail us at geriatrics@apta.org to let us know where your interests lie.
- Need continuing education units at reasonable prices?
 - ↳ Click "Education"
 - ✓ View all available home study and regional courses, as well as geriatric-related conferences being held by other organizations.
 - 👉 You can help! Are you aware of outside conferences that aren't on our website! Please let us know, so that we can advertise them. Having PT representation at multi-disciplinary conferences benefits us all.

The Web Committee will continue to improve the website: would you like to be apart of this great endeavor?
Click on "Volunteer Opportunities" under "Members" to apply for a web committee position, or contact
Web Chair, Lucy Jones, PT, GCS, MHA at lhjones@aol.com with your questions!

SOG WEBSITE: GRAD STUDENTS GIVE KUDOS

Marilyn Miller, PhD, PT, GCS

INTRODUCTION

How do you get busy graduate students to spend some quality time with the APTA and the Section's websites? To facilitate students interest in the web site they were given an assignment to assess the value of the SOG website in relation to their future practice as part of a Geriatrics course at the California State University, Fresno. Because current students prefer to be in control of their destiny, open-ended questions were chosen to stimulate thought, reflection, and freedom of expression. The students had the assignment from the first day of the course, and had the freedom to complete the task any time during the course of the class.

ASSIGNMENT

Review the APTA SOG website and answer these questions:

1. How could you use this website in your PT practice?
2. List the types of content you could find on the APTA SOG website.

STUDENT RESPONSES

Student responses to question 1: How would you use this site? included:

- "To advocate and provide the best practice in PT for optimal aging by..."
- "One other important contribution from this website that is valuable to a physical therapist and future clinician like myself is access to Geri-Notes and current articles in the Journal of Geriatric Physical Therapy. The site not only provides information for practicing clinician and student, but also provides information for the general public. I thought that this section educated individuals who are unfamiliar with the practice of physical therapy on the qualification that we hold and the types of conditions that may lead to a functional limitation that we can help to improve. Along with the things listed above, the

other portion of this site access that is very important in my physical therapy treatment for the geriatric population is the CMS homepage."

- "In the GERIE link, it provides Power-Point presentations in both English and Spanish about Health Information...In another section, 'Patient Education' provides access to forms about the following issues...These two links are great assets to the health professions...The work has already been done...This is a very important role as a physical therapist is to be an educator. Educate...in their lingo, not confusing medical jargon...As a physical therapy student. I learned about the many resources that are available at just this website alone...I will definitely use these resources to [prepare] for my culminating presentation."
- "There is an education link for clinicians that display upcoming seminars and courses. Within this same link there is also a geriatric resource library...obtain information about advanced clinical practice and offers assessment tools. A link can be used to find clinicians that are GCS, with the advantage of searching for them by state and city. This would be an important resource for the consumer to find a specialist in their area."
- "This website is very user friendly and frequently links back to the main APTA homepage...I think that this website will be a valuable resource as a PT because I will likely see geriatric patients. The website will be a convenient way to stay on top of new research and information regarding treatment for the aging individual. I can also use the website to stay current on new Medicare changes...Overall I think that the SOG website will be a favorite link on my computer so I can quickly and easily stay on top of all that is current and changing in PT for geriatrics."
- "SOG should be saved under 'favorites'...it provides an abundance of information. Basically you name it and somewhere within the site there will be a link to redirect you for further information. It's a win-win situation to have this site as resource since it addresses patient concerns by providing information, in addition to information directed to the professional clinician."

STUDENT RECOMMENDATIONS

- "I have to be honest. It took me a while to find the 'honey pot' of geriatric information from the APTA homepage. At first I kept going to the contact information of the elected representatives and thinking - - there must be more than this! Being more thorough, I found the website link to the SOG home page. I don't know why you cannot get to this page by 'searching' on the APTA homepage. What I found was a wealth of information at SOG page."
- "The only aspect that I thought could be modified is the size of the print, it was small and may be difficult to read for the older adult. At least the pages specifically for the consumer could have larger font for ease of use."

One of the goals of the Geriatrics tract is to link together content from the multitude of other PT content courses. In the philosophy from K. Patricia Cross' educational strategies as articulated, "In search of zippers." I ask students to draw information from their intervention specific courses to compare and contrast with what we know about aging for adapting these therapeutic interventions. As from Cross, adult learners learn and retain best when they have a "hook to hang things on," much like the action of a zipper.

Using question one, the guidance in the question suggests a website can be used to enhance or affirm practice. Question two requires the psychomotor act of listing, in the hopes that a memory formed may draw the student back to the SOG website for specific information. Use of the website also becomes a Section membership recruitment tool.

A third question: "What could the site do differently?" was specifically not included because, when asked this in the past, the commentary lost sight of the usefulness of the website, and focused predominately on the imperfections of any website from the eye of the end-user. It was anticipated that unsolicited recommendations would emerge if there were issues that were particularly distracting and this indeed did occur.

The SOG has come a long way from the early days when the BOD was debating the value of creating a website to the current sophisticated product that can be a definite asset to students and clinicians. Those who are involved in education are encouraged to use the ideas in this article and share information garnered from students with *GeriNotes* readers.



Marilyn Miller is a member of the faculty in the Physical Therapy Department at California State University, Fresno, and a past PTA Program Director. She has been active with the SOG since the 1980's, serving on Cultural Diversity Committee, Task Force on Clinical Residency, and in various offices: Delegate, Vice President, Program Chairman. Her pilot research with the TibTrainer will be published in the November issue of the Niigata

University for Health and Welfare Research Journal. She can be contacted at mem@csufresno.edu.

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SECTION ON GERIATRICS 2007 SLATE AND CANDIDATE STATEMENTS

All Section on Geriatrics (SoG) Members will receive a ballot in the mail in September. Ballots are also posted online for you to print and mail in. Ballots must be postmarked October 17, 2007 or earlier in order to be counted. We appreciate every member's participation in this year's election, and thank all of our candidates for their willingness to serve the SoG!

Director (Elect 1)

Greg Hartley, PT, MSPT, GCS
Mark Richards, PT, MS

Delegate (Elect 1)

Cathy Ciolek, PT, GCS

Secretary (Elect 1)

Linda Eargle, PT, DPT, Med
Rubye Kendrick, PT, MS, GCS

Nominating Committee (Elect 1)

Carol Schunk, PT, MS, PsyD

Candidate Statements

The Section on Geriatrics (SoG) candidates for office were invited by the Nominating Committee to provide a candidate statement by answering several questions within an 850-word limit. Below are the candidate statements and biographical information provided by each of the candidates.

DIRECTOR

1. What creative and innovative ways do you propose to increase communication among Section leadership and grass roots membership?
2. What financial planning do you think needs to be done over the next years for the Section?
3. What three agenda items would you like the Section to accomplish while you are on the Board of Directors?
4. What is the greatest challenge facing the geriatric practitioner and how can the Section help?

GREG HARTLEY, PT, MSPT, GCS



Residence: Miami, FL

Credentials/Degrees: Greg Hartley, PT, MSPT, GCS is a doctoral student in the PhD program in the Department of Physical Therapy in the Miller School of Medicine at the University of Miami. Greg received a master's degree in physical therapy from the University of Miami in 1990 and board certification in geriatrics in 1999.

Employment: St. Catherine's Rehabilitation Hospital and Villa Maria Nursing Center in Miami, FL

Section Membership: 15 years

APTA Membership: 19 years

Activities, SoG: Board of Directors, 2005-2008; Chair, Task Force on the Development of Geriatric Clinical Residencies, Jan. 2003-present; Chair, Advanced Clinical Practice Committee, 2007-2010

Activities, other Sections: Member, Education and Health Policy and Administration Sections

Activities, APTA Chapter(s): Delegate to APTA House of Delegates for ALPTA, 1999-2001; Chair, Practice Committee, ALPTA, 2000; District Coordinator, ALPTA Governmental Affairs Committee, 1999-2001

Activities, National: Member, APTA Consultant Group on Continued Competence, 2007; Member, APTA Residency/Fellowship Education Focus Group, 2006; Member, APTA Clinical Residency and Fellowship Program Credentialing Committee, 2005-2009

The Section on Geriatrics has become one of the most important Sections within the APTA, serving the fastest growing segment of the American population. The decisions of its Board of Directors over the coming years will prove to be important actions for many years to follow, having an impact on the direction of the Section as it continues to move into the spotlight of physical therapy for our aging generations. As the Director of the first APTA credentialed post-graduate residency program in geriatrics, and Chair of the SOG Task Force for Residency Development, I have a keen interest in preparing physical therapists to become not only specialists in geriatrics, but providers of state of the art geriatric physical therapy, confident in primary care decision-making as a point of entry into the health care system. With that comes a greater responsibility, not only within the leadership of the APTA and the SOG, but from all of its members. Members must be fully informed as to the potential of our future role, especially in the Medicare population. This movement away from "allied health care provider" to "primary health care provider" will be among physical therapy's defining moments. The opportunity to help guide the Section and the profession toward this future is humbling.

Increasing Communication: Communication between Section leadership and the membership is of paramount importance. With the popularity of electronic forms of communication, it could hardly be any easier these days. Furthermore, the Section's publications do an excellent job of getting information to those who may not have access to computers. I would suggest formal chat rooms between Section members and leaders, discussing a variety of topics of interest to Section members. These sessions could serve to inform members about the Section as well as generate interest in Section activities. The state liaisons are the Section's link to Chapter/Regional meetings. In-

formation from each Chapter/State (of interest to the Section) could be shared annually. *GeriNotes* and/or the website could publish updates from state liaisons on a regional basis quarterly (NE, SE, SW, NW). Regional courses could be tied to Chapter meetings (benefiting both parties, and increasing the Section's activities locally). This kind of grassroots involvement is often the best way to find out what is on the minds of members (and non-members alike) who may not be able to attend national meetings. Regular columns in *GeriNotes*, such as "Policy Talk," have proven to be a valuable contribution. These columns, as well as the list serve, are great tools to keep members informed of the countless changes that occur in CMS, and they should be supported and continued by the Section.

Financial Planning: As physical therapy, and particularly geriatric practice, moves into the forefront of healthcare; potential members should be aware of the benefits of membership. Membership is the single most important factor in budgeting for the Section. The accomplishments of the Section, as well as its planned future direction should be shared with PTs and PTAs who are not yet members; particularly students and new graduates. The Section's strategic plan should prioritize increasing membership. Contacts should be made with schools who teach geriatrics in their curriculum, and exposure to the Section should begin there.

Agenda Items:

1. Postprofessional education: Create guidelines and content for advanced practice including postgraduate residency education for PTs, and advanced proficiency programs for PTAs. Focus on evidence-based practice for all settings, with an emphasis on quality of care, professionalism, and accountability.
2. Create "partnerships" with PT and PTA educational programs to:
 - a. Generate a list of programs interested in conducting clinical research and assist in linking them with clinicians and clinical sites also interested in expanding our contribution to evidence-based practice.
 - b. Increase local exposure of the SOG and generate interest in its activities.
3. Expand regional course offerings to include on-going courses, offered at least once a quarter, in rotating parts of the country, and taught by Section experts in:
 - a. Medicare Reimbursement and Documentation
 - b. Health Promotion and Disease Prevention
 - c. The PT's Role in Chronic Disease Management
 - d. Primary Care in Geriatric Physical Therapy

Greatest Challenge: The biggest challenge facing the SOG is direct access under Medicare. Along the road to this end, we must be prepared as clinicians, as a Section, and as a profession to become primary-care providers. This will not be an easy road, as the very nature of our relationships with facilities and hospitals, administrators, and physicians will be challenged. However, these obstacles can be overcome through public relations/marketing, local/community involvement, advancement of clinical skills (specialization, DPT, residency programs), and our continued contributions to clinical research. This means

we, as members of the Section that represents clinicians treating the fastest growing and most politically powerful group in the US, must become involved in this process at some level. The SOG and the APTA are moving in the right direction towards this goal. As a member of the Board of Directors of the SOG, I would make certain that we continue on this path over the years it will likely take to overcome these barriers.

MARK RICHARDS, PT, MS



Residence: Champlin, MN

Credentials/Degrees: BA and MS in Physical Therapy

Employment: AEGIS Therapies

Section Membership: 22 years

APTA Membership: 22 years

Activities, SoG: Current- Task Force on Exercise; Task Force on Alternative Models of Care Delivery, 1998-2001; Multiple Presenter at CSM

Activities, other Sections: Current member of Oncology Section, past member of Orthopaedic Section

Activities, APTA Chapter(s): Multiple Presenter at various state conventions; Contributor, Ethics Committee, Peer Review Committee, and MN State Board of PT

Activities, National: Multiple Presenter at APTA national meetings

Increasing Communication: The Section has done a good job of providing general communication to our members through the SOG periodicals. Additional opportunities are: (1) Using the listserv, which is a very cost-effective way to disseminate Section news and opportunities, (2) Requesting Section member input on key issues through e-mail/on-line surveys and specific requests for feedback, and (3) E-sharing of the SOG strategic plan, action items, and budget to keep our members apprised of the status of Board and committee issues and actions.

Financial Planning: The life-blood of the Section is membership and we must provide increased resources to the Membership Committee. While the Section has other sources of revenue, the greatest return on investment are the dollars spent on increasing membership. Every reasonable, fiscally responsible effort must be made to increase the size of the Section. Regarding membership efforts and all other areas of Section business, on an ongoing basis, we should examine spending to insure we are prioritizing our expenditures wisely and are getting the desired return. Also, the Section must always look for cost savings opportunities. I believe the Section has been prudent in this regard but operating expenses must always be scrutinized. The focus should always be on reducing overhead while maximizing member benefits.

Agenda Items:

1. I will work to increase Section efforts to recruit and retain physical therapy geriatric practitioners. Today, the number of older adults is growing exponentially while we as a

profession are struggling to find enough clinicians to treat them. This divergence may threaten quality of physical therapy care. Increased efforts should be made to reach out to therapy students, and experienced clinicians, to show them the wonderful therapy outcomes and personal fulfillment that comes from treating older adults. Also, bringing more clinicians into geriatric practice will contribute to Section membership.

2. The Section is working to promote physical therapy clinicians as the go-to, exercise experts for older adults. Toward that end, I will promote Section efforts to provide clinical education to the geriatric practitioners to enhance their knowledge base. The Section must continue efforts to support and expand the geriatric specialist certification, CSM and National meeting course offerings, Section sponsored CE, the efforts of the Task Force on Exercise, and all other educational programs related to older adults.
3. I believe the Section must have an increased role with APTA Government Affairs and Reimbursement. Stronger efforts must be made to repeal the Part B cap. The exception process is only a band-aid on illogical and unfair legislation. Collectively, the Section membership has a large voice and a more organized effort will allow our voice to be heard. Our combined efforts should also be directed toward advocating for fair and adequate reimbursement including efforts to receive payment for routine therapy assessment and wellness services for seniors provided by qualified practitioners. Finally, the Section should actively support efforts by APTA Government Affairs to advocate with CMS on behalf of ALL physical therapy practitioners to be able to participate in the Physician Quality Reporting Initiative. The number of approved quality measures relevant to PT is very limited and since most of the Section members work in skilled nursing facilities, they are currently precluded from submitting information due to the program structure currently in place.

Greatest Challenge: The greatest challenge facing the geriatric practitioner is the great need for our therapy services and not having enough clinicians to provide those services. We must have a sufficient number of PTs and PTAs to treat the ever increasing number of older adults and those clinicians must be prepared to provide effective, high-quality therapy at all levels of the continuum of care. Doing so will position us well to continue to fight for fair and adequate payment for our services.

DELEGATE

1. What do you perceive as the most important interpersonal skills that are needed by the Section Delegate to the APTA House of Delegates?
2. What is the greatest challenge facing the profession in terms of geriatrics at this time?
3. What experiences would you bring to the position of Section Delegate that make you a strong candidate for this position?
4. What methods of communication would you utilize to "feel the pulse" of the Section on Geriatrics members on relevant RCs?

CATHY CIOLEK, PT, GCS



Residence: Wilmington, DE

Credentials/Degrees: PT, GCS (pending DPT in Aug 2007)

Employment: University of Delaware Neurologic and Older Adult Physical Therapy Clinic

Section Membership: 15 years

APTA Membership: 19 years

Activities, SoG: Listserv Moderator, 2000 to present; Nominating Committee 2002-2005 (Chair 04/05);

Secretary, 1999-2001; Program Committee, 1997-2004; State Liaison 1995-2002; Geriatric Clinical Educator Award 2006; Presidents Award 2006; Lynn Phillipi Advocacy Award 2001

Activities, other Sections: Member Section on Health Policy and Administration, 2001- present; Member Neurology Section 2004- present

Activities, APTA Chapter(s): President, DE Chapter 2002-2006; Delegate 2002-2006; Chief Delegate 2000-2002; Membership Chair 1996-2000; Continuing Education Coordinator 1998-2003, 2005

Activities, National: APTA Advisory Panel on Practice 2002-2005 (Chair 04/05); Hooked On Evidence Geriatric Clinical Scenarios 2006-2007; APTA Member Representative to the Technical Advisory Panel for Strive Task Force 2005-2007

It is an honor to be slated by the nominating committee to run for the office of Delegate. If elected, I will strive to do my best in serving this Section as Delegate to the APTA House of Delegates and the other duties that are assigned to me in this role.

Interpersonal Skills: The House of Delegates is the highest governing body within the American Physical Therapy Association. It has been my privilege to represent my state chapter in the House for 7 years. During that time, I learned the unique role that the Section Delegates play in bringing forward issues that are of significant concern to that particular area of practice.

Our previous Delegate, Kathy Brewer, was an excellent role model. She was able to bring forth several motions that related to geriatric physical therapy, an effort that included collaborating with other Section and chapter delegates to expand the scope of these motions to make them applicable to all practicing PTs, as well as negotiating with opposing groups to find common ground, thereby moving our issues forward. The role of Section Delegate is one of negotiation and problem solving, sometimes on the spot, while representing the PTs, PTAs, and students who chose to practice with older adults.

Greatest Challenge: As members adapt to the changes in our profession associated with Vision 2020, many therapists do not feel that vision applies to their practice. Our greatest challenge is helping our members understand how to apply the core tenets of our professional vision; Professionalism, Autonomous Practice, Direct Access, Practitioner of Choice, and Doctor

of Physical Therapy. I truly understand that this shift in our profession is not easy. However, it is where we are moving as a group. I would like to see our Section members challenging ourselves by assessing where we meet the vision and where we all need to develop more to move the profession forward.

Every physical therapist is capable of practicing at this level. Many already do! I see therapists and assistants who are so dedicated to the care of their older clients, who go above and beyond every day to maximize their patient's quality of life. I see passionate leaders of our Section who give time and energy to create important support services to enhance our members practice and learning opportunities. All practicing PTs need to understand and determine how best to apply the principles of life long learning to promote professional growth and work to adopt the tenets of the vision. These tenets are independent of practice setting and can be strived for whether you work in a SNF, hospital, home health, outpatient, or other setting.

Experiences: As I stated previously, I have served as a chapter delegate for 7 years, 3 years as a chief delegate in my state. I was privileged to be mentored by delegates from my neighboring chapters (in the North East) who helped me understand the workings of our House of Delegates as well as members of the Small States Caucus. These leaders truly "walked the walk" in preparation for the House, demonstrating year round governance and how to work with other groups to build consensus to see a motion through to the end. I value the friends I have made while serving as delegate, even when we disagreed on the issues.

The other role of the SOG Section Delegate is to serve as a member of the Board of Directors. I valued serving on the Board in the past and working with the Board when I was a Committee Chair. The Section Delegate will also be having responsibilities in serving as parliamentary consultant for Board and member meetings. I am a "rule follower" and look forward to sharing my knowledge of "Roberts Rules" with the Section membership to facilitate actions by the Board, as well as maintaining our Section Bylaws.

Methods of Communication: To best represent the SOG membership, I would be asking for feedback and comments from the membership and Board of Directors/Committee Chairs. Decisions in the House sometimes have to be made with little notice to changes in the wording, so I would not seek directives to specific language. However, I would love to hear from members who have opinions on the issues, to be able to represent their point of view. I plan to use the listserv as a method of posting some of the issues and asking for feedback. This is our best method for rapid communication-responses can be directly to me or to stimulate discussion.

The Section Delegates are not voting-your chapter delegates represent you in that area. However, Section Delegates can speak to issues either for or against. I hope you will consider me for the opportunity to represent PTs, PTAs and students who practice in geriatrics.

SECRETARY

1. What experiences would you bring to the position of SOG Secretary that make you a strong candidate for this position?
2. The SOG is a member driven organization, how do you feel the communication is between the membership and the Board and vice versa? How could it be improved (if necessary)?
3. What is the greatest challenge facing the profession in terms of geriatrics at this time?

LINDA EARGLE, PT, DPT, MED



Residence: Cullowhee, NC
Credentials/Degrees: PT, DPT, MED
Employment: Western Carolina University
Section Membership: years >10 years
APTA Membership: 41 years
Activities, SoG: Health Promotion and Wellness Nominating Committee 2004-present; Member of Cultural Diversity Committee

Activities, APTA Chapter(s): Chair, SC Public Relations Committee, 1986-1991; Chief Delegate for SC to APTA 1987, 1988-89, 1990-91, 1992-93, 1994-95; Co-editor of SCAPTA NEWSLETTER, 1996; Nominating Committee 1995-97 and 2002-2005; Quality Assurance Chair 1997-99; Delegate, 1986, 1998 and 2000-2001; Special Olympics screening, November, 2001; Chair, SC Bylaws Committee, 1991 – 94; Chair, Finance Committee 2003-2007; History committee member 2006-present

Activities, other Sections: Education Section: Clinical education SIG program committee member

Activities, National: Commission on Accreditation in Physical Therapy Education, 1995-1998; Executive committee Fall 1996-Spring 98; APTA Panel Chair Fall 97-Spring 1998, On-site evaluator and Reader-Consultant to newly developing programs, 1988-1995, 1998-99. Central panel, appointed to Criteria Revision Group for PTA criteria, Jan. 1999; Commissioner appointment term Jan 99-June 2000, and July 2000-2004; Trainer for APTA Clinical Instructor Credentialing 2002-present; APTA PTA Awards Committee: 2007-2010

Experiences: Being slated for this position is an honor. The Secretary responsibilities include: maintaining and disseminating accurate, timely minutes of meetings to the membership and the Board, maintaining an accurate record of the membership roster, and managing the election process. I served two terms as Secretary for the Carolina Clinical Education Consortium and several terms for community organizations.

As a member of the SOG Board of Directors, the Secretary has major leadership role that requires working with others to achieve SOG goals. I served nine years on the Commission on Accreditation for Physical Therapy Education on both the

physical therapist assistant and central panels. My leadership skills were further developed as secretary and chair of the Carolina Clinical Education Consortium, as a member of the SC Chapter Board of Directors, as SC Chief Delegate, and as a member of the SC Chapter Nominating Committee during two separate terms. I enjoy the opportunity to lead; I work effectively in small groups. The opportunity to serve the SOG would be an honor and privilege.

As a Section member, I regularly attend the CSM Business Meetings, contribute to the work of the Health Promotion and Wellness SIG, and participate on the Committee on Cultural Diversity. I've been an active member of the Section for more than ten years. I agreed to be slated for candidate for secretary because I feel a responsibility to the Section and I have both the time and energy to devote to the position since I will retire from full time practice in 2008. As a member of the South Carolina chapter, I would add a geographic perspective not currently represented on the Board.

Communication: The SOG has multiple methods of communication that are effective. I particularly appreciate the format for the business meetings, the Section listserve, and the information provided in *GeriNotes*. Board liaisons, to the SIGs and committees in which I participate, regularly attend meetings, and communicate via email between meetings.

Electronic asynchronous communication is one method to encourage those who don't attend the Section meetings to participate. Such opportunities include: (1) an online discussion board or a separate listserve to request member responses to specific questions and/or Section goals, (2) a listserve or discussion board for each chapter to enable chapter liaisons to strengthen communication between the Section and individual Chapter members. As we increase electronic communication, the SOG must be cognizant of members who do not use or are hesitant to use electronic communication. Inclusiveness of such members might be accomplished through *GeriNotes* summaries of the topics from the listserves and/or resources to learn to use electronic communication.

Greatest Challenge: I see three challenges for the profession: (1) encourage student physical therapists and physical therapist assistants to value older adults and the opportunities of geriatric practice, (2) encourage physical therapists and physical therapist assistants to become active participants in APTA, and (3) improve public utilization of direct access to physical therapy for health promotion and wellness as well as to improve impairments and functional limitations. I believe that by addressing student education, the other two goals will more easily occur.

One way to attain the goals of the SOG is to expand the way in which we educate and inspire students to value a geriatric practice. The SOG regularly scheduled CSM program for students to learn about geriatric practice provides insight and inspiration to those who attend. I suggest sending email announcements to each PT and PTA academic program to make them aware of this program and other SOG CSM programming, including the SIG meetings.

For the majority of students who do not attend CSM, activities that reach from the SOG to the classroom could be strengthened. The SOG sponsors a contest that encourages students to design consumer brochures related to various aspects of geriatric practice. The 2005 report from the Task Force on Promoting Physical Therapists as Exercise Experts for the Aging Population, available at <http://www.geriaticspst.org/pdfs/ExerciseTaskForceReport-Sept05.pdf>, included several strategies to educate students about physical activity and exercise for the older adults. Other possibilities, to inform students about geriatrics and the SOG, include a formalized process for a geriatrics Section member and/or Chapter liaison to offer presentations on geriatric practice, making the CSM programming available to students in a MP 3 format, and/or providing academic programs with learning activities such as an online scavenger hunt for students to become familiar with the SOG web pages. The future of the profession is exciting as we consider ways to inculcate patient management of the older adult across the continuum of care into student academic experiences.

RUBY KENDRICK, PT, MS, GCS



Credentials/Degrees: BS Physical Therapy, University of Texas Health Science Center, Galveston, TX; MS Health Care Management, University College, University of Maryland, College Park Maryland; Certified Geriatric Clinical Specialist

Employer: Rehab Pro

Residence: Tyler, Texas

Section Membership: 20 years

APTA Membership: 33 years

Activities, SoG: Minnesota State

Liaison; Secretary, Board of Directors

Activities, other Sections: Member, Home Health Section; past member, Section on Clinical Electrophysiology and Wound Management

Activities, APTA Chapter(s): Currently- Treasurer, East Texas District, Texas Physical Therapy Association; Previously- MN Chapter, APTA: Board of Directors, Peer Review Committee, Geriatrics Functional Outcomes Committee, Membership Committee, Delegate to the APTA House of Delegates

Experiences: I have been honored by the opportunity to serve as Secretary since 2005. Being in the role and familiarity is probably the most significant reason that I am a strong candidate for the position. The skill set learned from previous experience as Secretary in another organization transferred well into this role; however, I've had to sharpen those skills even more to ensure that I fulfill the responsibilities of the position. Good communication and organizational skills are crucial and having now been through the basic "learning curve" of any new job, I have identified the strategies that lend to efficient and effective operations and providing accurate information. I make myself available by volunteering at the booth during CSM as much as possible and I thoroughly enjoy the interaction with members and nonmembers, answering questions

and promoting the benefits of belonging. It's great to hear "yes, I'll join the Section" from a non-member, or "how can I get more involved" from a current member after I've engaged them in discussion. I can relate to many clinical issues because I'm still treating patients everyday also.

Communication: The Board values ideas and input from the membership. The member's meeting is the primary venue for face to face interaction between the membership and the Board. It is a central element in that not only is it a great social event with a superb meal, but a number of crucial activities occur at the meeting, such as: the membership is updated on status of charges made to the Board and other pertinent action items; roundtable discussions are facilitated by Board members regarding selected topics to obtain feedback and solicit ideas and to allow questions/answers about general issues impacting practice; volunteer opportunities are highlighted. As a member driven organization, it is imperative that members not only hear reports and follow up information but it is also important that they feel they are being heard. We must ensure continuance of this two-way dialogue between the leadership and membership. I was very excited about the decision to add the "morning chat" opportunity at the Section's booth at annual conference last year because it provided an additional opportunity to meet members, field questions, hear about ideas and concerns, etc. Our website and the listserv are other avenues for communication. We are in the process of redesigning the website so that it can be a better resource tool and provide more collaborative opportunities for clinicians regarding current research and evidence based practice, in addition to keeping members updated regarding Section news. Even with all of the great tools we have in place, we must continue to assess and reassess the effectiveness of our systems. In spite of the advancement of technology, not all members have internet access or choose to utilize it as their primary mode of operation. Therefore, *GeriNotes* is the tool available to all and can be used to keep the membership informed. Expanding the role of the State Liaison to Section of Geriatrics Advocates to the States is also a great move as the change in responsibilities will enhance communication and hopefully increase member involvement.

Greatest Challenge: Our Vision is that the physical therapist will be the practitioner of choice for achieving optimal health, wellness, fitness, and physical function for the aging adult. The greatest challenge falls under the umbrella of practitioner of choice. There are many underlying components in this arena, such as: (1) Marketing/public relations —Numerous non-physical therapists are encroaching in our area of expertise and consumers don't know who we are and why they should choose us to help with movement and function problems. I've participated in 2 community health fairs recently and experienced first hand the lack of awareness of the services we provide. Every therapist should be encouraged to promote physical therapy at a local level and tools should be provided to facilitate this process, (2) Recruiting and retaining PTs and PTAs to work with older adults, (3) Ensuring that clinicians have access to evidence based practice information and that they are able to translate evidence into practice so that thorough and effective treatments are provided, (4) Advocating for adequate reimbursement for

our services. Our mission is to further our members' ability to advocate and provide best practice physical therapy for optimal aging. We must continue to move forward with identifying and implementing strategies that accomplish this mission. It requires leadership, mentorship, and involvement of all members. It would be an honor to continue to serve as Secretary for another term and help promote attainment of our vision and mission.

NOMINATING COMMITTEE

1. Please describe what attributes you value in a candidate. Do you see the need to look at the balance in the Board composition when determining the slate?
2. Recognizing the need to develop new leaders within our Section, how can the nominating committee play a role in encouraging members to become involved in the SOG activities? (ie. Serving on committees, running for office, working with the various SIG's, etc.)
3. What skills and experience do you have to enable you to serve on the nominating committee?
4. How can a member of the nominating committee identify qualified individuals that represent the geographical and practice diversity of the Section on Geriatrics?

CAROL SCHUNK, PT, MS, PSYD



Residence: Bend, OR

Credentials/Degrees: PT, MS, PsyD

Employment: Central Oregon Home Health and Hospice

Section Membership: 25+ years

APTA Membership: 37 years

Activities, SoG: Current Editor *GeriNotes*; Chair- Education Committee; Chair- Government Affairs Committee; Joan Mills Awardee- 2007

Activities, other Sections: Board of Directors- Private Practice Section; Board of Directors- Education Section; Nominating Committee- - Private Practice Section; Program Committee- - Private Practice Section & Education Section

Activities, APTA Chapter(s): Current OR Ethics Committee Chair; President; Reimbursement Committee Chair; Chief Delegate

Activities, National: APTA Board of Directors; APTA Ethics and Judicial Committee; APTA Benefits and Liability Committee; Task Force for Vision 2020

Candidate attributes/Board composition: Attributes for office will vary depending upon the responsibilities required by the office. However there are common qualities we should consider for leaders in our Section. Those who lead should have some experience in component activity, be it on a committee or in an elected capacity. This would be reflective of their ability to work with others, communicate, be organized and be dependable. I also would look for those who are forward think-

ers, who have an understanding of not only where the SOG is but where the SOG can go to meet the needs of the members and of older adults. Times are a changing in health care and we want our leaders to put the SOG in the most progressive front ranks.

Encouraging member involvement: Often people are approached to run for an office but indicate that the timing is not right in relation to other commitments in their life. These people should be put into a data base and supported through the years with lesser responsibilities such as serving on a committee or in a SIG. By following this group, when the time is right for them to emerge, we will be right there. At SOG meetings we have sign ups for those interested in committees, we need to expand that to the regional level. We now have regional people who can assist to identify those who show the

interest and the capacity for potential leadership and participation at all levels.

Experience: I have served as a committee member and a chair of the Private Practice Section Nominating Committee so I understand the function and responsibilities. I have been active in the Section for over 20 years so know many members. My position as Editor of *GeriNotes* has allowed me an additional venue for getting to know members.

Diversity: I think you identify individuals who are interested and qualified, then you look at the composition of the Board and attempt to provide diversity in practice settings and geographically. The most important issue is finding those who want to serve, identifying their practice setting, and geographic location is easy.

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- Practice/Services
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- Fall Prevention—*Celinda P. Ewitt, PT, PhD, GCS*
- Health Promotions in Geriatric Care: The Collaboration Between Physical Therapy and Public Health—*Kathryn K. Brewer, PT, GCS, MEd*
- Exercise Prescription for Older Adults—*Dale Avers, PT, DPT, PhD and Patrick VanBeveren, PT, DPT, MA, OCS, CSCS*
- Successful Aging: Biopsychosocial and Environmental Implications for Physical Therapist Practice—*Mary Thompson, PT, PhD, GCS*

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