

GERINOTES

SECTION ON GERIATRICS, AMERICAN PHYSICAL THERAPY ASSOCIATION

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Contact Melanie Sponholz, GeriNotes Editor
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PRESIDENT'S MESSAGE

William H. Staples, PT, DHS, DPT, GCS, CEEAA

Ellen R. Strunk, PT, MS, GCS, CEEAA



Our listserv has been flooded with questions regarding upcoming Medicare changes, so I have asked Ellen Strunk to write the major-

ity of this issue's President's Message as our expert on Medicare and government affairs (starting with the following paragraph). On July 6, 2012, the Centers for Medicare and Medicaid Services (CMS) released the proposed 2013 Medicare physician fee schedule rule that updates 2013 payment amounts and revises other payment policies. The public will have until September 4, 2012, to submit comments in response to this rule. The American Physical Therapy Associa-

tion (APTA) will submit comments on behalf of its members. Ellen will be directly participating in formatting the APTA comments to CMS. After reviewing the public comments, CMS will publish a final rule by November 1, 2012, which will become effective for services furnished during calendar year 2013. A couple of salient points are that CMS proposes to implement a claims-based data collection process to gather data about patient function for patients receiving outpatient physical, occupational, and speech therapy services. Therapists would be required to report new codes and modifiers on the claim form that reflect a patient's functional limitations and goals at initial evaluation, periodically throughout care, and at discharge. This data is for informational purposes and is not proposed to be linked to reimbursement, at least for

now. This reporting system is proposed to be implemented on January 1, 2013. Claims will be processed during the first 6 months, until July 1, 2013, regardless of the inclusion of the functional limitation codes. Beginning July 1, 2013, all claims must include functional limitation codes to be paid by Medicare.

The Centers for Medicare and Medicaid Services has been very busy this summer. Within a span of 3 weeks, they released 4 documents that will affect a large number of physical therapists in 2012 and 2013. These documents were the proposed rules for payment in fiscal year 2013 for outpatient therapy services, home health services, skilled nursing facilities, and inpatient rehabilitation facilities. Generally speaking, there were few surprises contained in these documents, but that does not mean the next few months will be quiet.

<p>2013 Proposed Revisions to the Medicare Physician Fee Schedule (CMS-1590-P)</p>	<p>As required by the Middle Class Tax Relief Jobs Creation Act of 2012, CMS proposes to implement a claims-based data collection process to gather data about patient function for patients receiving outpatient physical, occupational, and speech therapy services. Therapists would be required to report new codes and modifiers on the claim form that reflect a patient's functional limitations and goals at initial evaluation, periodically throughout care, and at discharge. This data is for informational purposes and is not proposed to be linked to reimbursement. This reporting system is proposed to be implemented on January 1, 2013. Claims will be processed during the first 6 months until July 1, 2013, regardless of the inclusion of the functional limitation codes. Beginning July 1, 2013, all claims must include functional limitation codes in order to be paid by Medicare. The therapy cap exceptions process will expire at midnight December 31, 2012 unless Congress takes action before then. The conversion factor for 2013 is projected to be \$24.7124, representing an approximate 27.3% reduction in the physician fee schedule, unless Congress takes action to prevent the cuts prior to January 1, 2013. There are also proposed changes to the Physician Quality Reporting System (PQRS) that private practitioners can participate in.</p>
<p>2013 Proposed Update to the Home Health PPS (CMS-1358-P)</p>	<p>The Home Health (HH) PPS national standardized 60 day episode rate is updated, as are the national per-visit rates for episodes starting on/after January 1, 2013. The 60 day episode rate is proposed to be \$2,141.95 for HHAs that submit quality data, an increase of \$3.43 per episode. The rule also establishes requirements for surveys of home health agencies (HHAs), and provides additional guidance and clarification to the therapy coverage and reassessment regulation. Since the initiation of the Therapy Functional Reassessment requirement on April 1, 2011, providers have continued to have questions about the timing of the visits when multiple disciplines are involved, and what visits are covered/noncovered when assessments are late. CMS responds to these questions by issuing a more narrow (or in their terms "precise") interpretation.</p>

2013 Notice for Skilled Nursing Facility PPS (CMS-1432-N)	CMS issued a “notice” for SNFs this year rather than a proposed rule, because they are not proposing any new policies related to SNF PPS. The notice updates the rates for 2013: a proposed market basket update of +2.5% minus the 0.7% productivity adjustment legislated by the Affordable Care Act for a total upward adjustment of 1.8% beginning October 1, 2012. The notice also contains a section detailing CMS’ analysis of RUG case-mix utilization patterns following the FY 2011 and 2012 changes.
2013 Notice for Inpatient Rehabilitation Facilities PPS (CMS-1433-N)	CMS also issued a “notice” for Inpatient Rehab Facilities (IRFs) this year. They are proposing a 1.9% increase to the 2012 rates . It is estimated the impact to providers will be \$140 million in increased payments to IRFs during FY 2013. The notice also includes the continued implementation of quality measures for the IRF setting.

Current as of 7/31/2012

The Medicare system--as we know it today--is unsustainable. Health care is expensive for many reasons. Fraud and abuse have taken their toll on the system, and those who are trying to do the right thing every day are struggling under the rules and regulations being promulgated to curb them. There is a flurry of activity and ideas circulating on how to ‘fix’ Medicare, but most importantly how to transform it into an active purchaser of services, rather than a passive payer. The Affordable Care Act was a major push in that direction. Whether it remains in its entirety or is picked apart in a new administration remains to be seen. Regardless, it has already had an effect and some level of change is imminent. The question for our profession is where and how do we fit in?

I think we all could agree there are a few key themes that have been weaving themselves into the language of CMS documents over the last few years. In no particular order, I want to suggest they may be: **change, function, quality, and value**. In the context of your physical therapy practice, what do these mean to you? How do you describe these 4 concepts to your patients and to other health care providers? More importantly, how do you describe them to yourself?

I find physical therapists and physical therapist assistants are challenged by this question, and generally have a hard time producing an answer. One of the qualities that makes our profession so unique and so attractive is its diversity. As a physical therapist, I can work with clients across the lifespan and in a variety of settings. But this quality also makes defining these concepts more difficult. We may base our answers on the characteristics of the patients we see or the setting we work in. We may provide

an answer based on tasks accomplished in the clinic. And for some, we may describe these concepts in terms of costs and efficiencies. The real answer probably lies amongst all of these and therein lays our biggest challenge.

Consider these definitions¹:

- **Change:** (verb) to make different in some particular; to give a different position, course, or direction to; to replace with another; (noun) alteration; transformation
- **Function:** the action for which a person or thing is specially fitted or used or for which a thing exists; any of a group of related actions contributing to a larger action--the normal & specific contribution of a bodily part to the economy of a living organism
- **Quality:** a degree of excellence; superiority in kind
- **Value:** relative worth, utility, or importance; a numerical quantity that is assigned or is determined by calculation or measurement

Our ability to define these concepts for ourselves and for our profession may be our biggest challenge over the next 5 years. But it is imperative we begin the discussion and actively shape the answer rather than allowing it to be done for us. Each of us has a responsibility to find and execute the meaning of these principles daily within our own corner of the world, rather than expecting our association or our employer to do it for us or to tell us how it should be done.

**If we don’t change direction soon,
we’ll end up where we’re going.”**

“Professor” Irwin Corey

REFERENCE

1. Merriam-Webster Online Dictionary. <http://www.merriam-webster.com/dictionary>. Accessed July 29, 2012.

EDITOR'S MESSAGE: MOTIVATION

Melanie Sponholz, MSPT, GCS



You know that wall you hit when you are starting a diet? It usually happens as the first blush of determination starts to fade, when that fridge full of vegetables starts to lose its appeal, or you “deserve” that comfort food dinner and glass of wine at the end of a long day. Maybe you can relate better to hitting the wall in your exercise routine, when you have a really bad “long run day” when you are training for a race, and you think “I am never going to be able to do this.” Both of these examples illustrate a fork in the road of motivation. If you take the path of least resistance, you can have the mac-n-cheese and cabernet or decide that you aren’t cut out to run that 10-miler or marathon. Going the other direction takes more work, you have to reach inside and find something that convinces you to stay the course, something that makes you believe it is worth it in the long run. The choice may be simple, but it is not easy. You need motivation! How do you find it for yourself? Can you help your patients find it?

Motivation is a tricky thing, because it is definitely not one size fits all. Some people are motivated well by external factors. Maybe taping pictures of bathing suits to the fridge keeps the diet on track. Maybe planning a distance run in an exotic locale, with a no-race no-trip policy does the trick. Group support may be the key for others to get through the rough patches, thus the success of Weight Watchers meetings and training groups for races. Still others can draw on past experiences for strength, remembering the feeling of accomplishment and reward when staying the course paid off. It may take a combination of all of these factors to get the job done!

As physical therapists working with older adults, we need to be master motivators. We may not be coaching mara-

thon runners, but we may be asking someone to exercise for the first time in his or her life, and for my money, that’s more difficult. I keep remembering Carole Lewis’ comment in the Master Class interview in the March issue of *GeriNotes*, when she said, “Rehab is time consuming and patient dependent, it is not ‘do it to me’ medicine.” For us to succeed in making our patients better, we need their participation. We need them to buy in to exercise and lifestyle changes, and we need them to stay bought in, even when that isn’t easy. We are up against an American culture steeped in direct-to-consumer pharmaceutical advertising, and a 12-week program of regular exercise is a hard pill to swallow!

Luckily, I think we have a lot of motivational tools in our arsenal. There are so many benefits to exercise! What if one drug could help regulate blood sugar, aid weight loss, decrease fall risk, enhance sleep, decrease constipation, slow bone loss, reverse sarcopenia, and decrease frailty? We’d all take that pill! And that pill is exercise! But our job as therapists goes way beyond the prescription. We need to use that amazing list of benefits to continuously motivate our clients to persevere to see the long-term results of what they are doing. What’s in it for them? Decreasing their medication list as diabetes or hypertension improves? Sleeping better at night? Increased ability to participate in activities that are meaningful, like playing golf or playing with grandchildren? Feeling more confident when they need to ascend a flight of stairs or walk across the parking lot at the grocery store? We have to be detectives to find out what makes our patients tick. And we have to be the cheerleaders who help them decide to take the more difficult, but infinitely more rewarding path, when they face the fork in the road.

A few suggestions from my own arsenal include: Work together to set goals not just long-term goals, but even goals for each treatment session. Make sure

you point out the progress that is happening. We are all good at seeing what we can’t do, so make sure you point out what clients can do. Hold firm the wins! Enlist help. The more people supporting and encouraging someone in their efforts the better!

Let’s help one another by sharing our success stories and motivational strategies. Please write in and share your thoughts. I will publish them in an upcoming issue, so we can all benefit from our collective experiences. The key to our success is collaboration, both with each other and our patients.

LETTER TO THE EDITOR

I would like to clarify the valuable efforts of all of contributors to the 2009 Geriatric Description of Specialty Practice. In addition to the 1996 panel of experts who developed the first Geriatric DSP, published in 1999 as mentioned in the May 2012 article: Geriatric Physical Therapy Specialty Practice: Determining the Current Status, credit must also be given to Don Backstrum, Ann Myer, Reenie Euhardy, Sue Schuermann, Bill Staples, and Jill Heitzman for their work on the 2005 practice analysis survey; without their efforts, the 2009 Geriatric DSP would not have been completed.

To address the framework for a new DSP, a practice analysis survey must be conducted to collect data to describe specialty practice in geriatric physical therapy. In 2005, the current Specialty Council at that time (Don Backstrum, Ann Myer, and Reenie Euhardy) invited Sue Schuermann, Bill Staples, and Jill Heitzman to be the Subject Matter Experts (SMEs) of the next edition of the Geriatric DSP. Over the next two years, this 6 member group developed and conducted the nationwide analysis of clinical geriatric specialty practice survey, as well as compiled all of the data, thus spearheading the effort to revalidate/revise the existing (1999) Geriatric Description of Advanced Clinical Practice (DACP).

Due credit must be given to those who volunteered their time and efforts to such a worthy and challenging task as serving as Subject Matter Experts for the 2009 Revision of the DSP. Apologies on behalf of all of the Geriatric Specialty Council; with historical documentation, at times, the details get lost in the process.

Tamara N. Gravano, PT, DPT, GCS
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POWER MOBILITY DEVICE USE PROTOCOL: A MODEL FOR FACILITY-SPECIFIC USE

Karen A Gage, PT; Michelle Bell, ST; Jessica Lawrence, MACCC-SLP

This manuscript was prepared as part of a capstone project for a tDPT program.

ABSTRACT

Purpose: The purpose of this article is to discuss the necessity of the development of a standard, evidence-based protocol for power mobility use in long-term care facilities that is proactive as opposed to reactive in approach. This article describes the evidence important to assessing safe power mobility device use in a long-term care setting as well as recommended implementation strategies. **Method:** Staff of the Maine Veterans' Home developed an evidence-based protocol with the goal of providing a uniform assessment format to assist in determining safe and appropriate usage of power mobility devices. **Outcomes:** Review of power mobility use data from 2010 indicates successful use of power mobility devices within the facility. **Conclusion:** The use of the proposed model protocol, which is being successfully used at the Maine Veterans' Home, is recommended to develop a facility specific protocol for determining safe power mobility device use in long-term care facilities.

INTRODUCTION

Medicare regulations require a face to face evaluation of patients by the prescribing physician to assess the need for initial purchase of a power mobility device (PMD).¹ However, no assessment is required for continued use. Furthermore, no guidelines for discontinuation of use of PMDs have been published. Using PMDs indoors allows those with disabilities access to facilities but can present challenges for safety to the PMD user and other residents. For some long-term care residents, a power mobility device such as a power wheelchair or scooter may be their last form of independent locomotion. Power mobility devices are known to have a "strong impact" on the user's quality of life,² but in a long-term care setting PMD use may also pose a safety risk to other residents and staff if

not operated in a safe manner.

Assessing when and if power mobility device use should be restricted or discontinued is a clinical judgment often left to the evaluating health care practitioner and there is no established standard³ with which to effectively assess safe PMD use. The only two standard tools, the Power-Mobility Indoor Driving Assessment (PIDA) and the Power-Mobility Community Driving Assessment (PCDA), are designed not to "assist the health care professional in deciding whether or not someone should have access to power mobility"⁴ but to assist in improvement of driving skills. The need for a standard assessment or protocol is obvious. With the increasing popularity of PMDs, facilities and residential settings must consider implementation of an organized program to determine use and restrictions for the safety of residents and staff.

Health care practitioners who evaluate PMD users without a standard assessment or protocol may be making a unilateral decision that is not necessarily consistent with the recommendations of other members of the interdisciplinary team.² Without a standard assessment protocol, the assessment is a best judgment based on observation. This assessment often is a reactive approach to an incident as opposed to a proactive approach. There should be an evidence-based protocol that can be adapted to individual facility needs and circumstances while addressing all the major components and influences proven to impact PMD use, used proactively to prevent potential incidents and injuries.

The decision to restrict or discontinue PMD use should be considered a clinical judgment but the decision can also be viewed as an ethical dilemma as well. A balance between resident autonomy and facility risk management (non-feasance) needs to be met; and it must be considered that the restriction of resident mobility may impact emotional and physical capabilities (beneficence).

When does the right to use a PMD outweigh the risk to other residents and staff, and perhaps less important, facility property? In a litigious society, this is a valid concern for long-term care facility administrators and owners. And, if an all or nothing approach is taken, and PMD use is banned in the facility, is administration unnecessarily restraining a resident in a manual wheelchair who is capable of safely using a PMD?

BACKGROUND

The clinical and ethical dilemmas and lack of a standard assessment tool to assess safe use of PMDs were discovered during routine quality assurance audits, and led to the development of a protocol that has been successfully implemented and used at the Maine Veterans' Home in Bangor, Maine. Prior to the development and use of the PMD protocol, a single physical therapist (PT) or occupational therapist (OT) was responsible for the decision about a resident's ability to use a PMD in the facility. The therapist often had to make a decision with very little documentation of prior and current use of PMD, and relied heavily on verbal reports from nursing and observations of PMD use in therapy sessions.

The aim of the protocol was to provide a uniform assessment format to assist in determining safety and appropriate use of PMDs within the long-term care and residential care environment. The use of this protocol has promoted a multidisciplinary team decision making process inclusive of residents and families.

MODEL POWER MOBILITY DEVICE ASSESSMENT PROTOCOL

Prior to implementation of an individual resident assessment system, the facility should seek input from residents, families, and staff to establish "rules of the road" specific to its physical plant and staff limitations. These rules of the road must be accepted in writing by each resident wishing to use a PMD within the facility.² Rules of the road should

include details for such items as which side of the hall PMD users drive, who has the right of way, how should passing be safely done, and required identification of use levels.

All facility residents, families, nursing staff, social workers, administrative staff, housekeeping and kitchen staff, activities, therapy and doctors should be informed of the rules of the road and any mandatory identification of PMD users.

The goal of a facility specific PMD use protocol should be: to provide a uniform assessment format to assist in determining safety and appropriate usage of PMDs in the specific facility campus. To facilitate success of this goal, a power mobility team should be created and charged with implementing, assessing, and monitoring the PMD protocol. Recommended power mobility team members are: Director of Nursing, Social Worker, Nurse Managers, Rehabilitation Manager, PT, OT, and Speech Therapist (ST). One of the members of the team should serve as a lead and/or point of contact for residents, families, and staff. A logical choice for lead is the Rehabilitation Manager, since they may control the flow of caseload for the PT, OT, and SLP who will be responsible for the assessment pieces of the model protocol.

The process for a full PMD assessment is initiated when the power mobility team leader is notified of residents needing a PMD assessment either through established facility referral processes or as new residents are admitted with PMD needs. The process includes education, equipment evaluation, physical and driving assessments, and ongoing monitoring of each resident.

Education

Education is an essential piece of the success of a facility specific PMD use protocol and should begin as soon as the referral is received. The PMD team leader should provide the resident a letter that includes information on the goal of the protocol, qualifications to be cleared to use the PMD, maintenance certification, continued use monitoring, appeals process, and the power mobility team contact information.

Equipment

Newly purchased or used PMDs brought into the facility should be cleared by facility maintenance or an

outside vendor to assure all parts are in good repair and all devices have an intact battery and charger. Facility and resident responsibilities in maintenance and repair of PMDs should be provided to all residents and families. Any needed repairs should be verified as completed prior to allowing the PMD to be used in the facility.

Physical Assessment

Physical assessment should include 3 areas essential to safe use of PMDs: vision, cognition, and physical functioning. The multidisciplinary team is valuable for these assessments. Vision screens are completed by OT or PT, cognition screen completed by OT or ST, and physical screen completed by PT.

Vision

Vision is vital to the safe use of a PMD. There are "strong correlations found between power wheelchair driving performance and visual perception ($p = .000$), ocular motor function ($p = .000$ and $p \leq .001$), stereo depth perception ($p \leq .001$) and alertness to the environment ($p \leq .001$)."⁶ Massengale et al⁶ in 2005 report the need for good visual perceptual abilities and visual function in order to safely use a power mobility device. The evidence supports a visual screen protocol including: visual history, acuity, peripheral vision, convergence, pursuits, saccades, visual scanning, color identification, and screening for evidence of neglect, field loss, or hemianopsia.

There are several options available to screen vision to identify the need for evaluation. Standard tools that can be completed by either an OT or PT include the Snellen chart and the Brain Injury Visual Assessment Battery for Adults (biVABA). These two standardized assessments can screen for the majority of the recommended vision areas and are readily available and cost effective.

The Snellen eye chart can be used to quickly screen; however, this alone is not a reliable indicator of driving performance⁷ and should be coupled with a more definitive screening tool such as the biVABA. The biVABA enables therapists to reliably identify deficits in visual acuity, contrast sensitivity, visual fields, visual attention, and oculomotor using standardized assessments.⁸

COGNITION

Screening initially for cognitive impairments, and then further assessment as needed, should be part of any cognition screen/assessment for PMD use. Screening cognition allows for the demonstration of the resident's ability to problem solve and use sound judgment that is necessary to the safe operation of a PMD. Various aspects of cognition are required⁵ for safe PMD use, such as executive function, memory, language, and attention.

The Mini Mental State Examination (MMSE) is a good option for cognition screening. This tool is effective in identifying "cognitive impairments in older, community dwelling, hospitalized, and institutionalized adults."⁹ It can be used to identify and assign cognitive loss and justify need for further assessment of cognition.

More extensive assessment of cognition can be performed by a speech and language pathologist or by an occupational therapist and may use several standard assessments. The Cognitive Linguistic Quick Test (CLQT) assesses 5 cognitive domains: visuospatial skills, executive function, memory, language, and attention. This formal testing has normative measures for adults up to the age of 89 years old and is a logical choice for an assessment tool in a long-term care setting.¹⁰

Another area relating to cognition that should be addressed further is judgment and decision making specifically related to PMD use. The questions should vary in complexity dependent on the resident's intention and cognition.¹¹ Author, Jessica Lawrence, MACCC-SLP, developed a brief questionnaire to help assess judgment and decision making based on power mobility safety needs specific to a facility setting. The questions included bear in mind the recommendations of Fogle¹¹ to develop questions based on intention and cognition. See Figure 1.

Physical Abilities

Several primary areas related to safe use and risk management associated with PMD use must be included in the physical abilities assessment. Areas included, but are not limited to: trunk strength, balance, gross and fine motor skills, coordination, skin integrity, sensation, proprioception, history of wounds,

- Can you state 3 safety precautions one should take when operating a power wheelchair?
- What would happen if you did not look behind you before you started backing up?
- What could happen if you hit some furniture with your power chair?
- When driving, should you be on the left, right, or middle of hallway? Why?
- If you have to drive through the parking lot, how should you face traffic? Why?
- What would you do if you were outside and your chair would not start?
- What would you do if you had a flat tire?
- What would you do if you saw you were going to run into some furniture?

Figure 1. Judgment and decision making question examples. Specific for Maine Veterans' Home, Bangor Campus.

and current equipment. These assessment procedures are standard practice for physical therapists and procedures for these assessments are widely available in the literature, such as O'Sullivan and Schmidt Physical Rehabilitation,¹² and are not repeated here.

Assessing trunk strength is important in determining if a resident is capable of maintaining an upright posture allowing for proximal stability and increased ability to use upper extremities to manipulate the controls of the power mobility device. Further assessing coordination, fine and gross motor control will determine ability of the resident to adequately manipulate the controls on the PMD.

Prevention of possible musculoskeletal issues and skin breakdown is essential and risk factors should be identified. Knowing the resident's risk associated with these issues by a thorough assessment will establish a baseline of sensation, proprioception, and also provide the current skin condition and any history of decreased skin integrity. This is key in prevention and identification of deterioration of an individual resident's physical ability to self-identify physical safety while operating the PMD.

Driving Assessment

After the physical factors: vision, cognition, and physical function have been screened and an acceptable level of performance determined, each resident is assessed for driving ability. The PIDA is recommended for long-term care residents.¹³ The PIDA assesses 30 separate activities with one of 4 scores: (1) Unable to complete task; (2) Bumps objects or people in a way that causes or could cause harm; (3) Completes tasks hesitantly, requires several tries, requires speed restriction, and/or bumps walls, objects, etc. lightly (without causing

harm); and (4) Completely independent. A summative percentage score is calculated from all items.¹³ Each facility must determine an acceptable score on the PIDA for PMD use in that facility.

The PIDA has been reported to have acceptable levels for inter- and intra-rater reliability and content validity of the individual items. This tool provides a score of driving performance at one point in time.⁴ The test is also sensitive to changes over time if the driving performance is tested at a later date. The PIDA can be adapted for use in most facilities as extra-neous sections can be disallowed in the assessment without impacting the score or validity of the test of driving performance. Facility adaptation and resident restrictions can be accounted for during the driving performance test without threatening the general reliability and validity of the tool.^{4,14}

Assigning Use Levels/Monitoring

Monitoring for safe use of PMD is imperative for continued safe use. All staff in the facility should be encouraged to report any PMD-involved incidents or unsafe use. A "traffic" ticket system that any staff member is empowered to use is ideal allowing for unsafe incidents to be logged and tracked by the power mobility team lead member. Refer to Figure 2.

Appeals

An appeals process that can be initiated by the resident or family must be implemented as part of the facility policy. Inclusion of residents and family members as well as staff on an appeals committee works to assure protection of the rights of the PMD user. This resident-centered process is able to review power mobility team decisions and provides a platform to voice resident and family concerns. Final decisions are made by representatives of all vested in the process.

DISCUSSION

The PMD protocol has been successful at the Maine Veterans' Home. The protocol was developed to balance resident's autonomy and the facility's risk management needs. In 2010 there were 7 residents using a PMD in the 150 bed residence. Of those: 6 operated their power mobility devices without restriction. During the prior 12 months, 7 had logged yellow class incidents, 2 had a red class incident requiring remediation, one

Color code system to alert all staff to any restrictions on use

- Green = independent anywhere on campus
- Blue = independent within facility
- Red = independent within unit
- Red Tag = specific restriction, read tag. The information must be covered to comply with HIPPA.

Unsafe Incidents Log

Unsafe driving incidents

- Red class: unsafe driving results in bodily injury or structural damage to facility
- Yellow class: unsafe driving noted without damage or injury

Review

- Red class: automatic suspension of driving privileges, review by power mobility team within 7 days of incident, team decision reviewed with resident with remediation/modifications as needed.
- Yellow class: 5 or more in 1 month triggers review by power mobility team, review with resident and remediation/modifications as needed.

Figure 2. Assignment of level of PMD use.

user had their PMD use discontinued. No appeals were filed to reverse staff decisions. Most importantly no injuries related to PMD use were reported after the implementation of the power mobility device use protocol. See Table 1.

The PMD protocol approach is proactive. Assessments are performed on all users rather than only after an injury or incident with significant facility damage. All assessments are evidenced-based and the process protects resident autonomy as well as facility needs. The protocol described is based on a philosophy of patient-centered care.

CONCLUSION

The benefits to using a protocol for assessing PMD use in facilities include consistency of decisions, a balance between resident autonomy and safety, and the introduction of facility specific needs based on the best available evidence on PMD use. It is recommended based on the evidence and the current successful use of the model protocol at the Maine Veterans' Home that long-term care, residential care, and assisted living facilities use the model protocol to implement a facility specific protocol for determining safe power mobility device use.

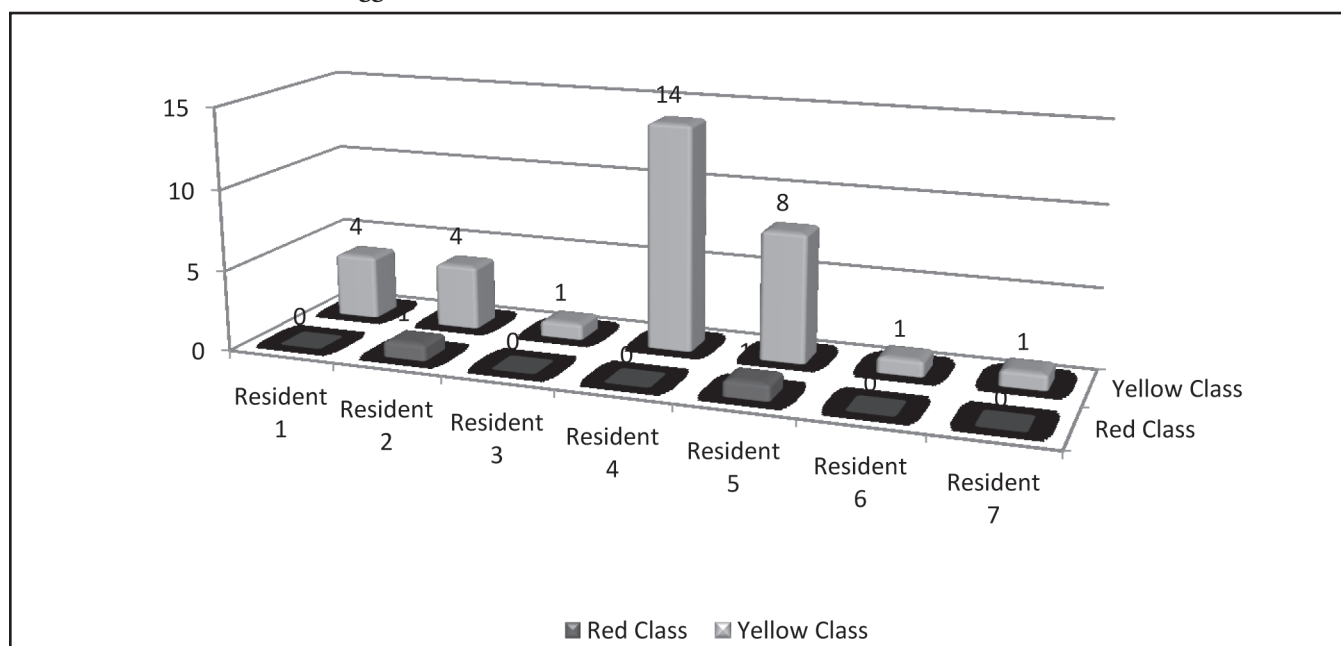
ACKNOWLEDGEMENTS

Suzanne Brown, PhD, MPH, PT, critically reviewed the manuscript. Michelle Bell, ST, and Jessica Lawrence, MACCC-SLP, contributed to the content.

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Table 1. PMD Observations Logged in 2010 at Maine Veterans' Home



Karen A. Gage, PT, DPT, RPSFC-NDT, is currently the senior physical therapist at the Maine Veterans' Home in Bangor, ME. She enjoys working with the geriatric population and has received extensive training in neurologic conditions. She recently finished her tDPT program at the University of New England where she originally graduated from in 1998. She plans to continue "caring for those who served" at the Maine Veterans' Home at the state of

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CALL FOR NOMINATIONS

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2012



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Recognize outstanding research-related activity completed by entry-level physical therapy students.

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Recognize physical therapists or physical therapist assistants for outstanding work as a clinical educator in geriatrics health care setting.

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Nominations are due October 1, 2012 and all awards will be presented at the Section Membership Meeting at CSM in January of 2013.

For additional information on the criteria and selection process for section awards, please visit the Section on Geriatrics website at www.geriaticsppt.org or contact the office by email at karen.curran@geriaticsppt.org or by phone at 866/586-8247.

PROPOSAL FOR A CLINIC BASED MODEL OF PHYSICAL THERAPIST CONSULTATION IN A GERIATRIC OUTPATIENT CLINIC

Rania Karim, PT, DPT, GCS; Patricia A. Higgins, RN, PhD; Thomas R. Hornick, MD

ABSTRACT

Purpose: The purpose of this article is to describe the role of a certified geriatric physical therapist (PT) in a geriatric outpatient clinic. **Methods:** This pilot study used a model in which a geriatric certified doctor of physical therapy (DPT) provided consultations one afternoon a week for patients in the Outpatient Geriatric Clinic at the Louis Stokes Cleveland Veterans Affairs Medical Center (VAMC). Data collection included reason for referral, DPT's interventions, and clinicians' and patients' perceptions. **Results:** Over 7 months, the DPT consulted on 25 male patients ranging from 65 to 91 years, with a mean age of 80. The majority of patients were classified into the neuromuscular category (64%) and received a home exercise program (60%). The addition of the PT consult service in the Geriatric Outpatient Clinic was well received by the multidisciplinary team. **Conclusion:** In addition to their traditional roles, physical therapists now have an opportunity to engage directly in primary care. The model described serves as an example of autonomous practice and the net result is increased quality of care, improved patient satisfaction, and increased knowledge about the profession of physical therapy on behalf of the referring clinician. The findings from this study provide support for the use of this model in settings other than the VAMC's managed care setting.

Key Words: physical therapist, physical therapist consultation, geriatric outpatient clinic, multidisciplinary

The American Physical Therapy Association (APTA) recognizes 5 professional roles: management of patients/clients, administration, education, research, and consultation.¹ The first 4 roles are well established; the fifth role, consultation, is less known. The purpose

of this article is to describe the role of one type of physical therapy consultant, a certified geriatric physical therapist (PT), in a Geriatric Outpatient Clinic.

The APTA defines consultation as expert advice in which the physical therapist "applies highly specialized knowledge and skills to identify problems, recommend solutions, or produce a specified outcome or product in a given amount of time." Autonomous practice "is characterized by independent self-determined, professional judgment and action." In a recent special interest report on autonomous practice, Hardage et al³ noted that autonomous practice has the potential to occur in all settings and professional roles.

Nationally, physical therapists serve as members of multidisciplinary teams and as consultants in specialty clinics for conditions such as Parkinson's disease, Amyotrophic Lateral Sclerosis, Post Polio, and falls. Physical therapy consultation in specialty clinics that provide primary care, however, is less used and studied. Only one publication was found that studied utilization of PT consultation in a primary care clinic.⁴ In this observational study from Norway, primary care providers (PCPs) were encouraged to use a one-time physical therapy consultation service.⁴ During the 7-month period, 59 participating PCPs requested 352 physical therapy consultations.⁴ The PCP reasons for consults varied, from requesting consultation for a specific problem to requesting consultation when they were uncertain about the benefit of physical therapy for a particular patient.⁴ The majority of consultations were for younger patients (93% were < 65 years) who presented with a problem whose duration was >1 week, with 57% of patients categorized as having problems with >12 weeks duration.⁴ Hendricks et al noted PCPs reported overall satisfaction with the PT consultation service and further, PCPs indicated

they changed their management decisions based on PT recommendations. No patient outcomes were reported.

This model of care was piloted at the Louis Stokes Cleveland Veterans Affairs Medical Center (LSCVAMC) in Ohio, a tertiary care hospital affiliated with Case Western Reserve University. Its 248 beds serve over 100,000 veterans annually. The Geriatric Outpatient Clinic at the LSCVAMC is an academic primary care clinic with approximately 100 patient visits/week. The multidisciplinary clinic team consists of primary care providers [physicians and nurse practitioners (NP), supervised medical students, residents, fellows, and allied health trainees], a licensed social worker, registered nurses, geropsychologists, doctors of pharmacy, and dietitians. Most staff members have special training in geriatrics. The patients seen in clinic are predominantly male (96%) and the average age is 85 years. New patients are seen by a licensed social worker and a psychologist, and then by a geriatrician. In July 2011, the first author, a geriatric certified doctor of physical therapy (DPT), joined the team and began providing consultations one afternoon a week for patients referred by the geriatrics team. Referrals for a physical therapy consultation could be generated by any member of the team. While this information was not formally recorded, the majority of referrals came from the NPs or the MDs. Occasionally, after performing chart reviews or listening to team members present the case, the physical therapist would initiate the consultation request.

PATIENTS REFERRED FOR CONSULTS

Over seven months, the DPT consulted on 25 male patients ranging from 65 to 91 years, with a mean age of 80. The reasons for consults varied and were often multifactorial. The history of falls/fall risk constituted the majority of con-

sult requests (56%). Other reasons centered on issues with physical activity, including decreased endurance and request for exercise recommendations (24%), musculoskeletal complaints (12%), and neurological conditions (8%). Using the APTA's practice pattern categories to organize reasons for referral, 64% of the patients' diagnoses fall under the neuromuscular category, 24% cardiopulmonary, 12% musculoskeletal, and 0% integumentary; see Figure 1.

THE PHYSICAL THERAPY CONSULTATION

Typically consults were performed either in the time period when the resident was presenting the case to the geriatrician, or after the geriatrician saw the patient. Consultations ranged in time from 15 to 45 minutes. Regardless of the patient's diagnostic category, providers most often asked two questions when making a referral:

- Should the patient be using an assistive device?
- What is the most appropriate setting for continued physical therapy?

Interventions consisted primarily of falls prevention education, functional mobility training, therapeutic exercises, and gait training. Consultation outcomes included:

- Home exercise program (60% patients)

- Recommendation for durable medical equipment (40%)
- Additional physical therapy services were requested for 44% of the patients: 28% outpatient PT, 16% home care

The PT provided multiple recommendations for many patients and entered notes into the Computerized Patient Record System.

CLINICIANS' PERCEPTIONS

The addition of the PT consult service in the Geriatric Outpatient Clinic was well received by the multidisciplinary team. A survey sent to the NPs and MDs using the PT consult services (N= 4) provided insight into their thoughts and opinions. All comments were positive and demonstrated an appreciation for the service. One clinician viewed the PT consult service as a form of triage to determine which patients need more intensive therapy. Another clinician reflected back on previous acute care experiences where the physical therapist served on the multidisciplinary team, providing their input either at daily or weekly rounds; " (I have) practiced in settings where PT is more available and have seen it benefit the patients greatly." This clinician thought the benefits of the PT consultation services also extended to the students and residents rotating in the clinic: "(I) think it is wonderful,

including for training of residents and students." All the clinicians also made reference to the benefits the PT consult service has for the patients, "appreciating the ability to evaluate patients at clinic visit," recognizing that "patients don't often want to travel for extra/frequent appointments, so this helps to gain their cooperation." Patients were not directly surveyed but clinicians stated that they received "very positive feedback from patients" and that "patient families have been very appreciative of expert geriatric physical therapy advice."

CLINICIAN REASONS FOR NOT USING PT CONSULT SERVICE

While the service is well received, the number of consults generated was lower than expected. Three main reasons were cited in the survey for underutilization. First, clinicians were concerned that PT consult would cause a disruption in the clinicians' workflow, particularly given the shortage of available exam rooms. Second, there was concern about the limitations of a one-time physical therapy consult without prompt and/or sufficient follow-up. Third, a belief was held by clinicians that certain patients fall into a gray zone of service needs. For these patients, home care PT was perceived as lacking the ability to reach appropriate intensity due to lack of equipment and/or safety issues, and outpatient PT was not feasible due to transportation issues. Other causes for underutilization of the PT consult service included: forgetting that PT was available for consults even though the PT was physically present in the clinic one afternoon a week, the futility of working with patients with severe dementia, or patients who had not benefited from prior PT treatment for the particular impairment.

DISCUSSION

Comparison of Types of Referrals

Interestingly, the reasons patients were referred for a PT consult in the geriatrics primary care clinic differed from two earlier studies. Hendricks et al⁴ reported that 97.5% of study consults were due to complaints of the musculoskeletal system. Similarly, Miller⁵ reported that when physical therapists (n=118) classified 10 of their geriatric patients, the breakdown of diagnostic categories was: musculoskeletal (71%), neuromuscular (17%), cardiopulmonary (8%), and integumentary (4%). In con-

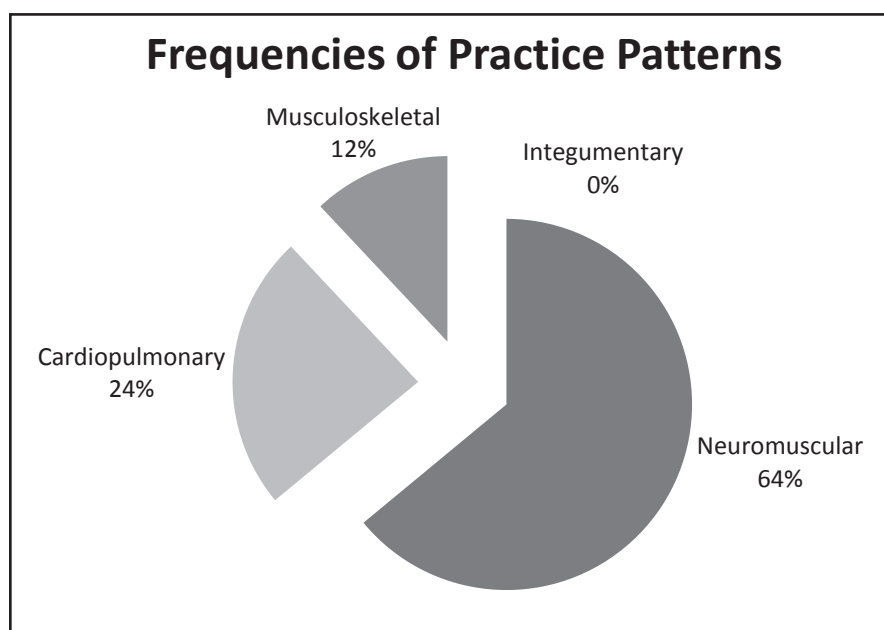


Figure 1. Reasons for referral for a PT consult in the Outpatient Geriatric Clinic according to the APTA's Practice Patterns Categories.

trast, the reasons for consult for the 25 geriatric patients in this study were categorized as neuromuscular (64%), cardio-pulmonary (24%), and musculoskeletal (12%). One possible explanation for this difference is that Miller⁵ surveyed physical therapists in all settings. Additionally, the majority of the patients were female (66.7%) and younger than the average age of the patient seen for a consultation in the outpatient geriatric clinic.

POTENTIAL MODEL OF CARE

As a managed care system, the VAMC is an ideal setting to implement a PT consult service, in part because individual services such as physical therapy and physician appointments are not individually billed. However, we think that reimbursement issues are not insurmountable, and PT consult services could be implemented in settings outside of the VA, with the net result of helping patients who otherwise may have been missed. Another potential model of care, similar to that implemented in long-term care facilities, would consist of the PT screening all new patients seen in the clinic.

In addition to their traditional roles, physical therapists now have an opportunity to engage directly in primary care. The model described here serves as one example of autonomous practice. The PT in this model is practicing according to the core values of the profession of PT and the net effect is increased quality of care, and improved patient satisfaction. The referring clinicians are also gaining increased knowledge about the profession of PT. We think that attempts to replicate this model in other settings outside the VAMC setting can only serve to positively impact patients.

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Rania Karim, PT, DPT, GCS, obtained a doctor of physical therapy from Washington University in St. Louis in 2008. Following graduation, she participated in a geriatric residency program at St. Catherine's Villa Maria in Miami, Florida. She is currently finishing a two year geriatric post-doctoral fellowship at the Cleveland Louis Stokes VA. In addition to her research on dementia and procedural learning, Dr. Karim consults on patients seen in the VA's Geriatric Outpatient Clinic and works PRN for University Hospitals Home Care.

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Thomas Hornick, MD, is section Chief of Geriatrics and Associate Director of the GRECC at ht Louis Stokes Cleveland Veterans Affairs Medical Center, and Associate Professor of Medicine at Case Western Reserve University. His career has been dedicated to providing care for older adults, with a special interest in people who have dementia syndrome.



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WHEELCHAIR STOWAWAY BAG

Colleen N. Gulick

ABSTRACT

Background: For most individuals, flying is the preferred method of travel. However, flying with a wheelchair can be extremely bothersome. People with disabilities should not be discouraged from flying. The lack of protective equipment available to the person with a disability prompted a plan to design and fabricate a prototype for a protective wheelchair case. **Purpose:** The goal was to make this prototype inexpensive, compact, lightweight, and protective. In this way users could be assured that their chair would be returned to them with all of its components and, hopefully, damage free. **Methods:** Appropriate dimensions and materials were obtained. Naugahyde and foam were used to create a roll-in zippered case with a shoulder carry strap. **Discussion:** Despite the responsibility of the airline industry for the well being of a wheelchair, financial compensation does not address the inconvenience or limitations in mobility that would result from damaged or lost equipment. Hence, an ounce of prevention could be far more valuable. **Conclusion:** Individuals with disabilities should be able to use air transportation with confidence that his/her wheelchair will arrive at the destination in the same condition it departed.

Key Words: wheelchair travel, flying with a wheelchair, disabled air travel

INTRODUCTION

Background

Craig Kennedy, president of Access Anything, a national leader in adaptive sports and adventure travel for people with disabilities, hates flying.¹ For most individuals, flying is the preferred method of travel. However, when Craig Kennedy was asked how he feels about travelling by plane he cringed and asked, "Can't we just drive there?"¹ This was a surprising answer coming from a national leader in travel for people with disabilities. An initial response might be to ask why. Why is

flying such a hassle? One can arrive at a destination in a fraction of the time without the arduous open road journey. Is Mr. Kennedy the only person with a disability who feels this way? The answer was a resounding "no." A plethora of stories, travel tip Web sites, and journal articles, confirm that flying with a wheelchair is extremely bothersome. However, individuals with a disability should have the same opportunity to use air travel as able-bodied individuals.

Steps to Flying with a Wheelchair Booking the flight

Vacations must always begin with a reservation. When travelling with a wheelchair, one is urged to reconfirm the flight 24 to 48 hours before departure and ask for "maximum assistance."²⁻⁴ There are 4 main types of wheelchairs that will need accommodation when travelling: everyday chairs, shower chairs, motorized chairs, and sports chairs. Disabled travelers are prompted to let the airlines know ahead of time the kind of wheelchair with which they are vacationing.²⁻⁴ In this way, the airlines can be best prepared to accommodate the needs of the specific type of chair. For instance, motorized chairs that use a wet cell battery need to have the battery removed by ground crew and packed in special containers for transport to comply with safety regulations.²⁻⁴ Meanwhile, everyday chairs can be simply folded and stored under the plane.

Boarding

After a person travelling with a wheelchair has successfully booked their flight, arrived at the airport, and found their gate, they can begin the boarding process. This is where the majority of hassles occur. Passengers must "gate check" their wheelchair. Gate checking allows the disabled individual to roll their wheelchair directly to the fuselage of the plane. At the door of the aircraft, they can either walk to their seat or transfer into an "aisle chair" for assistance to their seat.² An aisle chair

is a narrow straight back chair with 4 small casters. It is designed to be able to navigate the aisle of an airplane. The traveler must leave their wheelchair at the door of the plane to be stored in the luggage compartment with the rest of the checked baggage for the remainder of the flight. Accessible Journeys,² along with other sources,^{3,5} suggests that before leaving the chair, the passenger should remove the leg supports and portable seat cushions and carry these into the plane since these components do not travel well when attached to the wheelchair. To prevent loss, any removable parts should be detached from the chair and placed in a nylon sports bag. Once the chair is folded, a Velcro strap or duct tape should be used to hold the sides of the chair together. Mr. Craig Kennedy¹ states, "I have personally had major damage done to my wheelchairs on 3 different occasions." Poor treatment of wheelchairs by the airlines is unacceptable. In such a highly technologically advanced age why do people have to use duct tape and a nylon sports bag to secure a wheelchair? There must be a better a better way to solve this problem.

PURPOSE

Given the previous information regarding the lack of protective equipment available to the individual with a disability, a plan was conceived to design and fabricate a prototype for a protective wheelchair case. The goal was to make this prototype inexpensive, compact, lightweight, and protective. In this way users could be assured that their chair would be returned to them with all of its components damage free.

METHODS

The first step was to obtain the dimensions of a standard foldable wheelchair (Figure 1). Estimates of the amount of fabric, foam, and zipper length were calculated (Table 1). Naugahyde was selected as the external fabric because it is a thick, semi-weather resistant material that can be sewn using a standard sewing machine. It is typical-

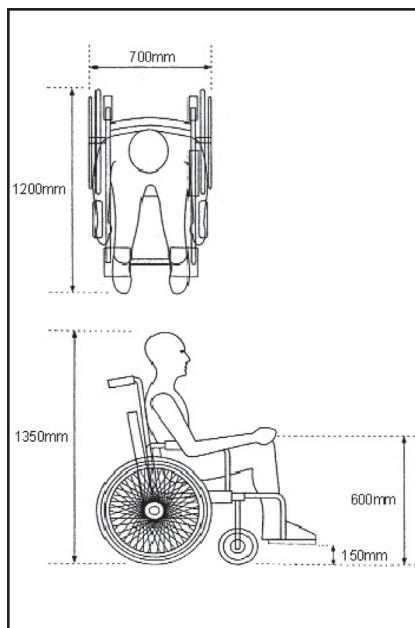


Figure 1. Wheelchair dimensions.
Source: http://www.disabledpersons-railcard.co.uk/clientfiles/Image/wheelchair_dimensions.gif

ly used for recreational vehicle coverings and automotive upholstery housings. This fabric is known for its durability and easy upkeep, making it unlikely to be ripped or punctured in travel. Naugahyde is also flexible enough that it can be folded to make the case more portable. A wheelchair pattern was created (Figure 2) by tracing the dimensions of the folded wheelchair on poster board and transferring the outline to the naugahyde (Figures 3 & 4). The design included two foam pieces inside the naugahyde exterior (one sewn on either side) that spanned the sides of the wheelchair for protection. The foam pieces are held in place via an internal

pocket but can be removed as needed (Figure 5). The case was sewn on two sides (bottom and one side) to keep its form and zippers were installed on the other two sides (top & one side). In this way, the wheelchair could be easily rolled into the bag and closed (Figure 6). The zippers were inserted from opposite directions so they would close at the same location. This afforded the wheelchair owner the opportunity to zip-tie or lock the zipper enclosure to make sure no pieces fell out while stowed. A shoulder strap was added on the top for carrying ease (Figure 7).

DISCUSSION

The purpose of this project was to serve the disabled traveler. However, this travel case is not a cure-all. People with disabilities should still be aware of their rights as passengers before boarding an aircraft. Airlines are required to uphold Federal Aviation Administration which supports the Americans with Disabilities Act (ADA) and the Air Carrier Act (ACA).⁶ In short, the ACA (enacted in 1990) prohibits discrimination on the basis of disability in air travel and requires air carriers to accommodate the needs of passengers with disabilities.^{1,2,6} Thus, when travelling with a wheelchair it may be helpful to know that according to the aforementioned acts “airplanes with 100 seats or more are required by law to allow one folding manual wheelchair onboard the plane.”⁶ Moreover, if a wheelchair is lost or destroyed, they are required to buy an exact replacement. Airlines are also required by law to have a Complaints Resolution Official who is educated in ADA and ACA requirements for travelers with disabilities, at every airport that they service.⁶ Un-

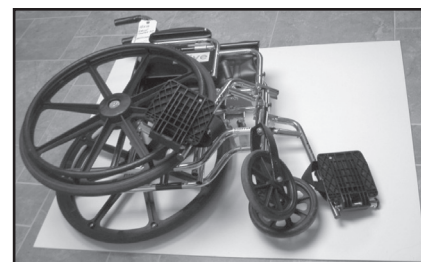


Figure 2. Wheelchair pattern.

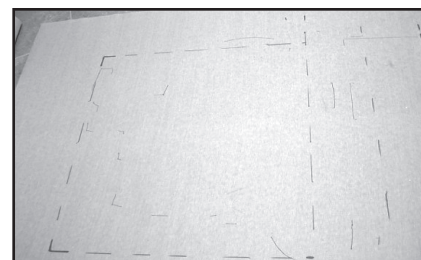


Figure 3. Transfer of wheelchair pattern onto Naugahyde.

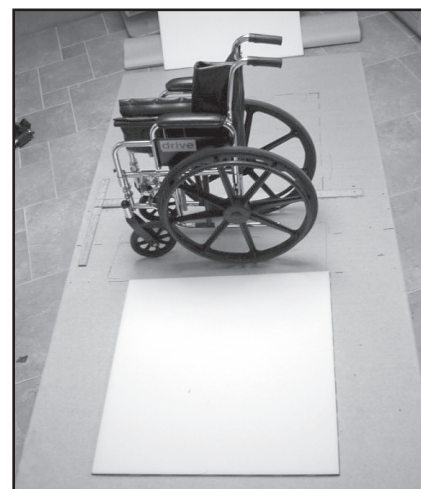


Figure 4. Incorporation of 8.5" width of folded wheelchair.

Table 1. Wheelchair Travel Bag Supply List and Cost

Item	Cost
3 yards of naugahyde @ \$14/yard	\$52.00
2 stools of thread @ \$2.50 each	\$5.00
2 — 36" zippers @ \$5.00 each	\$10.00
12" piece of hook & loop Velcro	\$00.00
2 pieces of 3" x 1/2" foam (optional)	\$00.00
2 yards of cotton liner fiber (optional)	\$4.00
2 metal rings @ \$1.50 each	\$3.00
1 carry strap	\$00.00
Total Cost	\$74.00

fortunately, there appears to be a large number of wheelchairs being damaged during air travel. Although it is not a panacea, perhaps the use of a wheelchair stowaway bag would reduce the potential for lost or damaged wheelchair components.

CONCLUSIONS

Despite the responsibility of the airline industry for the well being of a wheelchair, financial compensation does not address the inconvenience or limitations in mobility that would result from damaged or lost equipment. Hence, an ounce of prevention could be far more valuable. Individuals with disabilities

should be able to use air transportation with confidence that his/her wheelchair will arrive at the destination in the same condition it departed.

Given that this product is still in the development process, the author would like to make two requests of the reader. First, if anyone constructs this wheelchair bag, your feedback and/or

suggestions about the product would be appreciated. Second, if you are not able to construct your own bag, the author is willing to loan the current prototype. All that is requested is that you cover shipping of the product to and from your location. Correspondence can be directed to cgulick@terpmail.umd.edu.



Figure 5. Incorporation of internal foam pockets

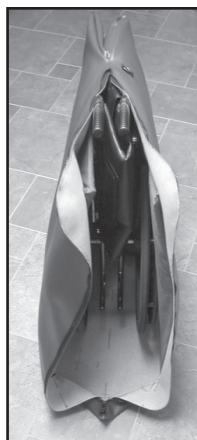
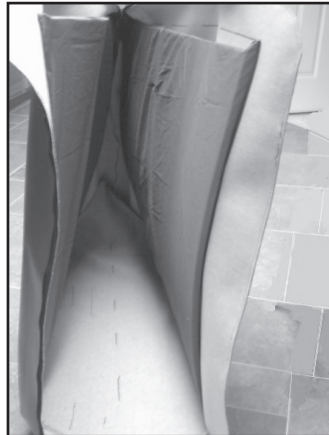


Figure 6. Wheelchair rolled into travel bag.



Figure 7. Finished product.

ACKNOWLEDGEMENTS

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Colleen Gulick is an undergraduate bioengineering major and athlete (two-time D1 National field hockey champion) at the University of Maryland, member of the honors program, and a three-time junior national cycling champion. As an able-bodied individual, she has participated in numerous Paralympic events, including piloting a tandem bicycle.

RESIDENCY CORNER

BLACKSTONE HOME CARE AND OHIO STATE UNIVERSITY PHYSICAL THERAPY DIVISION GERIATRIC RESIDENCY

By Deb Kegelmeier PT, DPT, MS, GCS and Kimberly Payne PT, MSPT, GCS

Located in Columbus Ohio, this unique geriatric residency program is collaboration between a private home care provider, Blackstone Home Care, and the Ohio State University. This collaboration allows our residents to work within a dynamic clinical environment while benefitting from the educational opportunities afforded by a top 20 physical therapy program. Resident's clinical work crosses multiple environments including assisted living, home care, outpatient, and skilled nursing facilities. At Ohio State University the resident is provided opportunities to teach DPT students within a laboratory environment. This unique opportunity hones skills in both teaching and mentoring. In addition residents can avail

themselves of the rich didactic opportunities available within the University.

Ohio State University is one of the only settings where you will find 5 residency programs including: sports, orthopedics, neurologic, pediatrics, and geriatrics. Our residents interact within journal clubs and in the teaching labs. In addition residents present a joint case study with a resident from another residency program. This past year the geriatric and sports residents did a presentation on return to sport following total joint replacement surgery. Residents from all 5 programs attend the Combined Sections Meeting with the support of Ohio State University Physical Therapy Division.

The residency program provides clinicians with an opportunity to move towards specialization in geriatrics. In addition we strive to individualize the program to assist each resident in achieving their long-term career goals. Past residents have tailored the program to further their goals towards such diverse areas as health and wellness and leadership and mentoring. All of our residents to date have passed the specialty board exam and are employed in the area of geriatrics. Residency programs are an excellent path to individual career goals as well as geriatric specialization. We encourage you to pursue a geriatric residency in the program that fits your individual career goals.

THE USE OF SPACED RETRIEVAL AND MOTOR LEARNING FOR FUNCTIONAL TRANSFERS IN DEMENTIA

Lindsay Bendler Goodman, PT, DPT, GCS and Deb Kegelmeier, PT, DPT, MS, GCS

INTRODUCTION

The number of older adults has risen, and age is the highest risk factor for dementia,¹ a disease that has been shown to impair learning and slow motor performance. Twenty to 56% of older adults report some kind of cognitive complaint, with memory loss being the most common.² In persons with mild Alzheimer's dementia (AD) with a mini mental status exam (MMSE) score of < 21, there is generally atrophy of the amygdala and hippocampal formation, which are responsible for declarative learning, also termed explicit learning. Consequently declarative learning shows the earliest and most pronounced decline in the presence of AD.

Studies show that patients with AD are able to learn and retain a motor skill, even when there is no recollection of previous learning, and this is retained across a long retention interval.^{3,4} Skill acquisition takes place through procedural learning and has in several cases included gross motor skills.^{3,5} A review of motor skill learning in AD concluded that regardless of the task used, the studies addressing implicit motor-skill learning in AD yielded positive outcomes.⁶ The individuals who have benefitted from intrinsic motor learning have had mild to moderate cognitive decline. In one motor learning trial, patients with AD (mean MMSE = 14.8) who participated in waltz lessons demonstrated skill

acquisition.⁵ In a controlled study, subjects with AD (mean MMSE = 20 ± 3.4) became more efficient with activities of daily living (ADLs) after 3 consecutive weeks of training one hour per day, 5 days per week. Training procedures included prompting and informing patients about each task to be performed. One such task was prompted, "Please, wash your hands," and the patient was given verbal and physical cues, modeling, and reinforcement, eg, "Turn on the tap." In this way, the subject went through the motion and was given an opportunity for intrinsic learning.³

Intensive cognitive training may not be sufficient unless the technique is designed properly. In a large study of

620 older adults, the use of mnemonics for memorization for one-hour sessions for 10 days was only effective in 26% of participants, which means despite their intense efforts, 74% did not see any benefit.⁷ Recent research on skill acquisition and learning in this population has been focused on a principle known as spaced retrieval. In this paradigm, individuals learn new information through implicit routes, by recalling it over progressively longer periods until it is successfully consolidated in long-term memory. The patient is given a piece of information and then asked about it 30 seconds later. If the response is correct, that time is doubled before they are asked about it again. If the response is incorrect, the 30-second interval is maintained. This goes on, doubling time when recalled correctly, until the subject has reached the 16-minute mark, at which time it is believed that the information is fairly fixed in the subject's memory. This is effective in those with no memory problems, and those with mild to moderate dementia, and has been validated for AD, Parkinson's-related dementia, HIV-related dementia, vascular dementia, and Korsakoff's syndrome.⁸

Spaced retrieval is currently used mostly for remembering daily tasks, such as what medications to take at what times, rather than functional motor skills. Similarly, while multiple studies conclude that implicit learning is effective in patients with AD, aside from the aforementioned ADL efficiency study by Zanetti,³ the majority of motor tasks used in research are simple and nonfunctional. Typical tasks include following a spot with a stylus, tracing, or reacting to a simple stimulus. While this provides a good foundation for theories of learning in AD, the clinical implications are absent. Physical therapists struggle when teaching a patient with dementia to walk safely with a new device or to effectively stand from a chair using safe techniques. A successful model is needed for teaching motor skills in the patient with memory loss. The severity of cognitive status is similar in subjects who can learn with spaced retrieval and in those who successfully learn through intrinsic motor learning, and is typical of a patient referred to physical therapy. For this reason, it is logical that spaced retrieval might be combined with intrinsic motor learning principles to become

a valid tool for training functional skills.

Using spaced retrieval for a motor task presents several challenges. One of these is to determine how practice sessions be set up to provide appropriate feedback. Spaced retrieval is a verbal call and answer, so incorporating a physical task deviates from the original paradigm. The difficulty is in what should be done during the spaced retrieval time intervals. Typically another task that is unrelated would be performed. Valuable practice time is lost and motor learning calls for numerous repetitions. In the current payment environment, this time cannot be filled with nontherapeutic activity. While it is often possible to do an alternative activity, in the case of this patient, the only reimbursable activities were transfers and gait, which both lead to fatigue and use of the lower extremity musculature. Further, these activities overlap in performance. The objective of this case study was to propose and execute a plan that incorporated spaced retrieval with uncorrected task practice during the intervening spaces to assess the benefits of this program.

METHODS

This study began with a search of motor learning and spaced retrieval literature to propose a logical training protocol. Major training and learning principles were examined for their use in the memory-impaired population. They were then combined into a program and assessed for effectiveness of learning using spaced retrieval for a motor skill.

CASE PRESENTATION

DK is an 87-year-old female residing in an assisted living apartment, with a history of Alzheimer's dementia, moderate osteoarthritis of the right knee, right rotator cuff tear, compensated congestive heart failure, transient ischemic attack, myocardial infarction, gastroesophageal reflux disease, high cholesterol, hypertension, urinary tract infection, and diabetes mellitus. She presents to physical therapy with a recent decline in functional mobility as reported by her daughter, and no complaints of pain or dizziness. She has been seen by physical therapy previously for balance, gait, and transfer training. Her therapist from these visits reports that she struggles with safe sequencing with transfers and has had limited success learning and retaining transfer training techniques.

Brief Overview of Evaluation Findings

Strength and ROM were both decreased, but within functional limits for household activities. Skin and sensation were intact. No overt neurological problems were noted.

Gait was independent but unsafe with a wheeled walker. Gait issues were addressed separately from the transfer training outlined in this case study. DK transferred from sit to stand repeatedly, demonstrating a total of 15 transfers, with two completed safely and correctly, 9 incorrectly and in an unsafe manner, and 4 were not successful on the first attempt. DK did not scoot forward in the chair, and then would attempt to come to standing, usually falling back into the chair after rising about half way. She had been instructed to scoot forward during her previous therapy but demonstrated no retention for this instruction. When cued to scoot forward in the chair, she was able to scoot forward and then rise to standing safely and independently. DK also did not use her walker correctly when approaching the chair to go stand to sit, forgetting to lock it and place it correctly. She was then at risk of falling during the transition to sitting and could not reach her walker when she next tried to get up to walk.

Functional Outcome Measures:

Timed Up and Go (TUG) = 26.5 seconds.

Tinetti score is 13 out of 28, with a score of 6 on standing balance and 7 on gait.

PROCEDURE

Framework for Fusing Motor Learning with Spaced Retrieval

Motor learning principles were combined with spaced retrieval to optimize learning of a motor task. Constant practice coincides well with spaced retrieval, in which the same verbal cues are given word for word and the session does not vary. Accordingly, DK transferred between the same surfaces, in the same room, around the same time of day. Distributed practice is ideal based on content validity since DK is an older adult with dementia, and she found transfers to be physically challenging, requiring rest periods. With spaced retrieval, this was not always possible. Early in the spaced retrieval program, cues were only 30 seconds apart, which

did not provide much time for the sit to stand motion, let alone a rest break. Training was, therefore, a mix of massed followed by distributed practice. Maximal encouragement for participation was provided, along with monitoring of signs and symptoms. The literature on spaced retrieval recommends retention of one verbal cue before adding another,³ which fit well with the motor learning recommendation to use blocked practice.⁹ As in most clinical settings, DK had many goals to address, but she was encouraged to stay focused on the sit to stand skill between spaced retrieval cues, in accordance with the blocked practice recommendation. DK performed whole practice based on motor learning reasoning, with the spaced retrieval paradigm highlighting components of the task one at a time within each transfer. Whole practice was appropriate due to the continuous nature of the sit to stand transfer. The frequency of practice for motor learning is varied and generally very high, and spaced retrieval is entirely individualized and varies to the patient's ability to progress through the program. In this case study, DK was being seen in the home health setting, where a typical frequency is 2 to 3 times per week. To maintain clinical relevance, the subject was treated twice per week.

Motor Learning and Spaced Retrieval

Initially spaced retrieval for the transfer training task was set up as it is described in the literature. DK was told to "tell me what you have to do before you get up?" She was given the cue at 30 seconds (s) x 7, 60s x 1, 30s x 6, 60s x 2, 2 minutes (m) x 1, 60s x 1, 2m x 1, 4m x 1, 8m x 1, and lastly 16m x 1. This approach was followed in the second session, at which point she demonstrated improvement in recall, but inconsistent carry-over to actual performance of the task. For the next two sessions the directions were changed to "show me what you have to do before you get up?" A correct response would be demonstrating the sequencing correctly, not just saying it. Within the guideline of spaced retrieval, she was given the cue at 30 seconds (s) x 1, 60s x 1, 2m x 1, 4m x 1, 8m x 1, and lastly 16m x 1. She performed nothing but sit to stand transfers between the armchair and bed during these sessions to enforce the motor learning aspect. During longer

intervals between cueing, she continued to perform sit to stand transfers, but no additional cues or corrections were given until the allotted time.

Outcomes

Outcome measures were taken 8 days after the most recent training session. At discharge, DK was told to transfer from the chair to the bed and back. She correctly scooted forward and locked the walker two times, there were 12 trials where she transferred successfully, but did not scoot or pulled herself up on the walker, and one trial where she was not able to stand on her first attempt. She was then retested with the therapist stating "show me what you do before you get up," and she correctly responded and did the entire transfer correctly. At this time, her TUG score has increased from 26.5 seconds to 34 seconds, and Tinetti has improved from 13 to 17 out of 28. Patient's family, who had requested physical therapy to address safe and efficient functional activities, noted that she appeared to be able to get out of her chair more easily and appeared steadier.

DISCUSSION

Final results indicated that DK could verbally identify what needed to be done to transfer safely and efficiently. While she improved in safety with her transfers, she did not show a major change in her demonstration of the chair to bed transfer during outcome testing. One possible explanation could be the repeated, uncorrected errors, which she made between longer spaced retrieval intervals during training. Ideally she would have practiced another task but this was not feasible in a clinic setting. A future study might have the subject simply sit and not practice between long spaced retrieval cues to avoid practicing incorrectly. Another solution might be to use the spaced retrieval phases when indicated, but make exception to correct the subject between cues using a different phrase, perhaps just saying "no," or "wrong," and seeing if the subject is able to self-correct. Another possible explanation might be that DK needed more sessions to obtain long term retention. It may be that spacing between training sessions also plays a key role in long term retention with a motor-training spaced retrieval program. It is noteworthy that DK learned the proper techniques and retained them over a 4 day period, when

previous therapy using standard techniques had failed. DK failed to obtain long term retention but did demonstrate greater retention and overall safety than she had with traditional therapy techniques.

DK was able to perform all elements of the transfer correctly when given the verbal cue from previous training sessions. This demonstrates some retention with her performance remaining dependent on a verbal cue. Since DK lives alone, reliance on a verbal cue is not adequate to ensure safety. More sessions may be necessary to ensure retention. If retention does not occur, it may be possible to tie the verbal cue to a picture that could be placed on the walker thus allowing the transfer of the verbal cue to a written cue that could be with the client at all times. This was not tried during this case study but may be worth investigation in the future.

Increase in time for the TUG may be attributed to the patient's fatigue the day of outcome measure testing, or it may be that after focusing on accuracy throughout physical therapy sessions she was more concerned about taking care with the transfers and gait than hurrying through them. Tinetti improvement is clinically significant, and may be attributed partly to transfer training, but also to other training sessions outside of those in this paper, which focused on gait and balance training.

Observer effect cannot be ignored in this case. When DK saw the therapist, she recalled the type of work done during physical therapy. She knew that if she performed well, she would not have to perform as many repetitions. The overall goal, however, was to make her safer at transferring when she was on her own. The only way to assess this is the nonclinical observations of her family and assisted living staff, who both volunteered that the subject looked much safer with transfers.

CONCLUSION

Spaced retrieval and motor learning were effectively paired to produce recall and retention of verbal cues for transfer sequencing. The two principles conflict about how to handle error correction between cues, allowing occasional error in physical performance of the transfer sequence, and limiting results. Further studies are needed to determine an optimal paradigm for spaced retrieval interventions with motor tasks.

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Dr. Kegelmeyer is an Associate Professor of Clinical Health and Rehabilitation Sciences within the division of physical therapy. Her teaching and research interests are in geriatrics and neurologic rehabilitation. She is also co-director of the Blackstone Home

Care and Ohio State University Geriatric Residency program.

Kimberly Payne, PT, MSPT, CDP, COS-C, GCS, is in charge of business development and oversight for physical therapy for Homecare by Blackstone in Columbus. As a board certified geriatric specialist, she is an advocate for proactive approaches towards geriatric care for their multitude of health issues. A graduate of Regis University, she has served as the state and federal legislative liaison for the American Physical Therapy Association from 2001 through 2009. Kimberly was the winner of the Meritous Service Award from the Ohio Physical Therapy Association in 2007, after Ohio gained direct access for physical therapists. She currently serves as chair of the Nominating Committee for the Home Health Section, APTA and is the Chair of the Governmental Affairs Committee of the Ohio Council of Home Care.

Lindsay Bendler Goodman, PT, DPT, GCS, is a graduate of the physical therapy program at Ohio State University and also completed the residency program at Blackstone Home Care and Ohio State Geriatric Residency. She is employed at Blackstone Home Care.



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WHAT WE DO WITH WHAT WE KNOW

Karleen Cordeau, MSPT

As the Section on Geriatrics (SOG), our Mission “*is to further our members ability to provide best practice physical therapy and to advocate for optimal aging.*”

In thinking of this mission from the Public Relations perspective, my eyes focus on two words: **members and advocate.**

In a process format it might look like this:

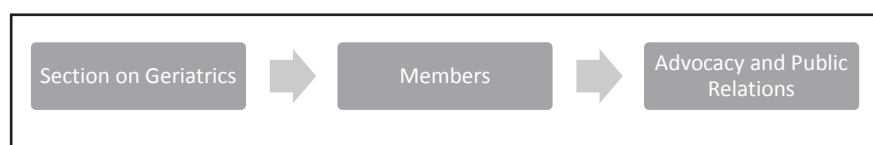


Figure 1.

By offering our members what they need in order to perform best practice for optimal aging, the SOG achieves part of its mission. With this it is hoped that our members go beyond practice and manage the flow of this information externally to share this knowledge with others. This theme information sharing flows into one of our Value Statements as well, encouraging: “*Collaborative relationships with internal and external constituencies.*” These themes are also evident in our Strategic Plan goals, including: “*Advocating for the health, wellness, fitness, and physical function needs of the aging adult,*” and “*promoting physical therapists as practitioners of choice for optimizing physical function with aging adults.*” To meet these goals, public relations efforts both inside and outside our organization encourage us to look at “**what we do with what we know.**”

The history of Public Relations began with Louis Bernays (1891 - 1995). Bernays referred to as the Father of Public Relations, has been said to be one of the most influential figures of the 20th century. Nephew of Sigmund Freud, he took Freud’s complex ideas on people’s unconscious, psychological motivations and applied them to the new field of public relations. He defined it as a management function, which tabulates public attitudes, defines the policies,

procedures, and interests of an organization...followed by executing a program of action to earn public understanding and acceptance.

Since that early definition, many definitions and descriptions of public relations have been offered, including one from the Public Relations Society of America (PRSA), which said: “Public relations helps an organization and its

public adapt mutually to each other.” The PRSA was established in 1947. The New York based organization has over 21,000 members and more than 100 local chapters. The society provides members with continuing education programs and information exchange forums, while promoting the role of public relations professionals in society. In 1982 PRSA revised its definition of public relations to read, “Public relations helps an organization and its publics adapt mutually to each other.” In 2011 and 2012, the PRSA made further adjustment to its definition, saying, “Public relations is a strategic communication process that builds mutually beneficial relationships between organizations and their publics.”

In August 1978, another organization, the World Assembly of Public Relations Associations, defined P.R. as: “the art and social science of analyzing trends, predicting their consequences, counseling organizational leaders, and implementing planned programs of action, which will serve both the organization and the public interest.”

In thinking about the global view of public relations, I was interested to know **what others do with what they know.** I wanted to choose 3 organizations/associations with a common goal of meeting the needs of their members

for the benefit of the older population.

I sought guidance from Ellen Strunk, PT, MS, GCS, CEEAA, our SOG Legislative Committee Chair. She led me to the Eldercare Workforce Alliance (EWA) for which she is the SOG representative. This group of 29 national organizations joined together to address the immediate and future workforce crisis in caring for an aging America. The EWA represents consumers, family caregivers, the direct-care workforce, and health care professionals, to propose practical solutions to strengthen our eldercare workforce and improve the quality of care. Two EWA members, the American Geriatrics Society and the American Nurses Association, came forward to offer their support with feedback. In addition to the EWA, the National Association for the Support of Long Term Care (NASL) was an organization from which I sought feedback. Although not directly supporting individuals, organizations, or associations, the companies the NASL represents provide physical therapy in post-acute care settings.

First, let me introduce you to Carol Goodwin. As the Associate Vice President of Communications, Governance and Membership for the American Geriatrics Society (AGS) Carol promotes the mission of the organization “to improve the health, independence and quality of life of all older people,” with an overall vision that every older American will receive high quality patient-centered care. This not-for-profit organization is made up of almost 6,000 health professionals. The Society provides leadership to health care professionals, policy makers, and the public by implementing and advocating for programs in patient care, research, professional and public education, and public policy. As an organization that fights hard for its mission, AGS leads two coalitions: The Eldercare Workforce Alliance (www.eldercare-workforce.org) and the Partnership for Health in Aging (www.americangeriatrics.org/PHA).

The AGS advocates its mission both

internally to members as well as externally. For its members it offers information through its Web site, a weekly list serve, a printed quarterly newsletter, and by its Annual Scientific Meeting. Outside of the AGS organization, it advocates to associations such as the Geriatric Advanced Physicians, the Practice Nurses Association, and multiple primary care physician organizations including the American College of Physicians, American Academy of Family Physicians, and Society for General Internal Medicine. The AGS also collaborates with many medical specialty societies as part of their Geriatrics-for-Specialists initiative. These medical specialties focus on disciplines such as Physical Medicine and Rehabilitation, Orthopaedic Surgery, and Gynecology just to name a few.

Building relationships with volunteer leaders and staff and sending press releases are some strategic strategies used by AGS to attract outside attention. The AGS also offers publications at a reduced rate for members of other organizations. Encouraging advocacy and relations by its members is done in several ways. Carol Goodwin referenced tools such as their *Refer-A-Colleague* program with dues discount incentives, an advocacy toolkit offered on their member's only Web site (geared specifically to public policy advocacy), and offering handouts on their Web site.

My second introduction for you is to Mr. Adam Sachs. Mr. Sachs is the public relations writer for the American Nurses Association (ANA). The ANA is the only full-service professional organization representing the interests of the nation's 3.1 million registered nurses through its constituent member nurses associations and its organizational affiliates. With its overall mission of "*advancing our profession to improve health for all*," the ANA fosters high standards, promotes nursing rights in the workplace, projects a positive and realistic view of nursing, and lobbies Congress and regulatory agencies regarding health care issues affecting nurses and the public.

The ANA educates and promotes member relations internally through their Web site and online e-newsletters, webinars, social media, bi-monthly publications, and direct emails to members about important issues. The ANA has developed tools for internal relations among members. *The Principles for So-*

cial Networking is an online social network that facilitates collegial communication among registered nurses and provides convenient and timely forums for professional development and education. It also offers potential for public education and health guidance. The ANA's *Principles for Social Networking and the Nurse: Guidance for the Registered Nurse* is a tool that provides guidance to registered nurses on using social networking media in a way that protects patients' privacy and confidentiality and maintains the standards of professional nursing practice.

For external relations and advocacy, the ANA offers members an Activist toolkit. This kit includes tips on letter writing, how to contact members of Congress, how to hold district meetings, conducting visits to Capitol Hill, and lobbying. Online pledges/commitments/campaigns/websites devoted to specific issues can be found. A Nurses Strategic Action Team makes it easy for members to keep communications open with colleagues, informs lawmakers about the position of the ANA, and keeps members informed on key bills as they move through Congress. This cross of information lets ANA's members know when contact with government officials is needed. Sachs states that "advocacy for nurses and the nursing profession is an important component of ANA's work. It is important to engage ANA's members in advocacy. With increased engagement, both ANA and the individual member are more empowered to bring about changes."

My third and final introduction is to Cynthia Morton, Executive Vice President of the National Association for the Support of Long Term Care (NASL). This United States trade association was founded in the fall of 1989 by advocates of professional medical services to long term care facilities. Although not representing health care providers directly, NASL represents the legislative and regulatory interests of over 100 companies providing ancillary products and services to the post-acute care settings nationally. This includes nursing homes, assisted living communities, home health agencies, inpatient rehabilitation facilities, independent living communities, adult day cares, hospice, and long term care hospitals. It represents its members on

health care policy and advocates for high-quality, cost-effective care.

All external relations/communications are focused on political advocacy, so internal relations with members take this route as well. The NASL offers information to its members through its Web site. Multiple tools are offered to encourage external public relations by its members. These tools include: Tips for Congressional Meetings, NASL issues briefs, How to Meet with Legislators at Home, Tips for Attending Town Hall Meetings, and Steps to Effective Involvement in the Political Process. Its Web site includes a *Guide to the Media*. This search engine offers a listing of all newspapers within a requested area for possible media outreach. In addition, federal information resources are available on the Web site. Ms. Morton states that NASL provides members with a pre-drafted letter for their Members of Congress, encourages and helps to arrange facility or facility headquarter tours for Members of Congress (for the purpose of further understanding of the business and issues), and facilitates fundraisers for the campaigns of members of Congress who are champions or supporters of their sector. The NASL also partakes in grassroots communication campaigns.

Like most associations, NASL collaborates with multiple health care organizations including the APTA. Ms. Morton lists American Medical Rehabilitation Providers Association, American Health Care Association, Leading Age, Alliance for Quality Nursing Home Care, and American Hospital Association as some health care trade associations it collaborates with. Coalitions, sign on letters, group visits to Members of Congress, group meetings with CMS officials, as well as joint advertising are a few strategies used.

After receiving all of this feedback, I went back to my question: *What do others do with what they know?* I wanted to see from a public relations standpoint how these organizations compared to just a section of a larger organization. I easily saw a difference in membership size and tried to think how this might have affected PR. There was a common theme of knowledge and desire to meet the organization's mission by each leader. Members from each organization/as-

sociation are expected to play an active role in advocacy. With this, multiple forms of communication and tools are offered to members. Tools varied but may have been based on what has been successful in the past, the audience being addressed, and the information being shared. Collaboration with other organizations/associations was important. Comparatively, I think the Section on Geriatrics is right on track with what we do with what we know! Our Section continually keeps members informed in many ways. Our members are informed via our Web site, Section news, e-blasts, *GeriNotes*, the *Journal of Geriatric Physical Therapy*, Special Interest Groups, CSM and PTAC, social media opportunities, member resources, list serve, as well as multiple avenues of education.

I then asked, what do our members do with what they know? I could not answer that question. I could repeat what many members have told me, what I have seen with my own eyes during my travels, and the wonderful inspirational stories I have read about in prior newsletters and articles. However, for me that was not enough. The PR Committee agreed and would like to get your feedback. Soon, we will be sending you an online survey. Our survey will be geared towards the PR needs and interests among our members. In 2002 a survey went out to members containing

some public relations geared questions. The SOG has offered new tools to its members since that time. This survey will allow us to look at member trends in public relations activities. It is hoped that with this sharing of information our Section can offer more tools and strategies to meet our members' needs.

With our goal of information sharing, the Committee would also like to introduce you to our Public Relations "*Evidence*" campaign. We will be encouraging members to share their public relations stories and even pictures of these activities. We would love to see your work with your community, professionals, nonprofessionals, organizations, and groups. More details to come. These steps in information gathering and sharing provide more of a cycle of communication.

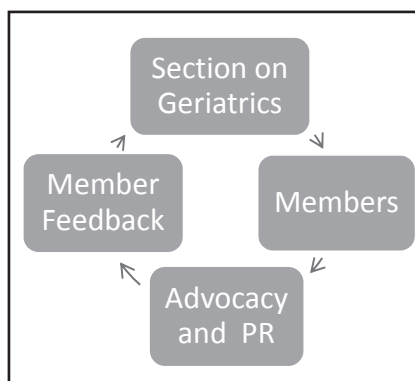


Figure 2.

This will enable us to also look into the next phase of relations: **what others think about what we say!**



Karleen Cordeau is Chair of Public Relations for the Section on Geriatrics. She is Director of Development for a rehabilitation corporation located in CT.

New health care company development, external and internal business expansion, and oversight across multiple corporations is a focus. As co-owner of The Center of Evidence, Karleen works with leading companies to encourage evidence-based interventions through custom products while still optimizing health care delivery and efficiency. She is an adjunct professor at the University of Hartford teaching health care management. She is a Practice Committee member of the Connecticut Physical Therapy Association and is the PT liaison with the states Medicare Administrative Contractor and is owner of a therapy consulting company.

A MESSAGE FROM YOUR PTA ADVOCATE

Ann M. Lowrey, PTA, Section on Geriatrics PTA Advocate

Thank you for choosing to be members of the Section on Geriatrics. There are so many opportunities for you to partake in this Section and the continuing education is outstanding. I want to invite all Physical Therapist Assistants to join us at the Combined Sections Meeting in San Diego, California this coming January 21-24, 2013. The Section on Geriatrics will have fantastic continuing education for you, along with platform presentations. There will be a members meeting where you can meet all of those who work very hard to make this Section the success it is.

I ask that you join your fellow Physical Therapist Assistants at the Town Hall meeting. Attendance at the 2012 CSM far exceeded our expectations. There will be a number of items to discuss come January as changes abound for the PTA, including the progression of the PTA obtaining a Bachelor degree as opposed to an Associate degree. If you wish to obtain further information on PTA happenings, please send me an E-mail with questions you may have or visit www.apta.org and go to the PTA page.

The Section on Geriatrics does have some areas where the PTA can be of great assistance. If you are interested in programming, public relations, mentoring new PTAs, or wish to help wherever there is a need, let me know. I encourage all of you to sign up for a shift at the Section booth in the exhibit hall. You can do this by visiting the Section on Geriatrics web page (geriatricspt.org).

I hope to meet many of you at CSM! Let me know what this Section can do for the PTA.

2012 SLATE OF CANDIDATES

Slate for 2012 Section on Geriatrics election. Those elected will take office at CSM in January of 2013. Online voting will begin in early October. Please watch your E-mail and www.geriatricspt.org for more details.

Treasurer (vote for 1): Anne Coffman, PT, MS, GCS

Directors (vote for 2):

Sarah Knox, PT, DPT, GCS, CEEAA; Tamara Gravano, PT, DPT, GCS; Myles Quiben, PT, PhD, DPT, GCS, NCS

Nominating Committee (vote for 1): Patrice Antony, PT, GCS; Mary Thompson, PT, PhD, GCS

TREASURER

Anne Coffman, PT, MS, GCS



What skills and experience do you bring to this position to assure maintenance of complete and accurate financial records for the Section?

I have served on the Section on Geriatrics Board for 9 years, 3 years as Director and 6 years as Vice President, from 2000-2009. During my Board terms, I was on the Finance Committee for 3 years which led me to be involved with the budgeting process and final decisions before presenting a balanced budget to the Board. As a Board member and previously as a committee chair, I have been involved with the Section's strategic planning for over 10 years. This gives me a strong historical perspective to understand what has happened previously in the Section and how we have funded/prioritized different goals and projects.

I also served as the Treasurer for the Wisconsin Chapter from 2000-2005. As the WPTA Treasurer, I revised the budgeting process to more closely align it to the chapter's strategic plan and also to further involve the committee chairs and Board members in the budgeting process. During this time, the Wisconsin Chapter received the APTA component award for Outstanding Financial Management.

In addition to my volunteer experiences, I served as a regional director

of operations for a large national rehab company from 2000-2002. In this position, I was responsible for the budgeting and management of over 25 skilled nursing facility contracts. This gave me plenty of experience with reading and analyzing spreadsheets and understanding the budgeting process.

All of these volunteer and professional experiences allow me to analyze financial records and ensure accuracy in maintaining them.

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

This has been one of the areas I have addressed during my first term as Treasurer. I have outlined a more detailed timeline with steps throughout the process for the Board members to communicate with their assigned committees to ensure better communication throughout the budget process. This includes the Board member sharing the Section's strategic plan and communicating with committees regarding action plans/expenses. After the Finance Committee has sent a draft budget to the Board, each Board member is to communicate suggested changes to their committee chairpersons and gather information to bring to the Board regarding impact of the changes.

How would you provide for integrity to the treasurer position and the records you maintain?

One of my first actions as Treasurer was to transfer our reserve account to a financial management firm. This ensures that our reserve funds are professionally

managed to decrease risk of financial loss. On a routine basis, switching to using WPTA staff as our executive office has resulted in much more transparent record keeping, including having the Treasurer sign all checks for payment. This was centralized and difficult to manage under our previous management contract. We also do an annual audit with Board members other than the Treasurer completing the audit. This ensures a level of oversight beyond the Treasurer and Executive Director.

DIRECTOR

Tamara Gravano, PT, DPT, GCS



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

I have a strong desire to give back to the

Section that has provided me with many outstanding opportunities to serve my profession. As a clinician and a new academic, the Section on Geriatrics has been with me from the very beginning and I have grown along with the Section. Service to the Section began early in my career. When I enrolled in a Geriatric Residency program in 2003, I met many inspiring people in the Section who served as leaders and mentors and who have encouraged me to volunteer my skills to help serve the Section. Over the years, I have had the privilege of serving on multiple committees in the Section

and in the APTA: Membership Committee Chair, Specialty Council Chair, Specialization Academy of Content Experts (SACE), Practice Committee member, Credentialing Services Council, and as a reviewer for the *Journal of Geriatric Physical Therapy*. For the last few years, I have successfully managed these roles simultaneously. Given my breadth of experience with these committees, I have a strong understanding of how the Section and its members fit into the big picture of the APTA and how to best serve the interests of our Section members.

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

My experience with the Credentialing Services council has provided a strong understanding of what is required to credential and re-credential a residency program. As a Director, I would like to promote specialization and residency education. I would seek to further the development of geriatric residencies and fellowships by helping inform potential program directors about the resources available to start and maintain a program. I support resources like grants for developing residency and fellowship programs and making didactic educational materials available online to help programs maintain high quality educational standards. After serving as an item writer on SACE and then later, as Chair of the Specialty Council, I know the process to become a Geriatric Certified Specialist (GCS) and would like to be a liaison to the Section for geriatric residency questions.

I support geriatric-specific continuing education like the CEEAA, which is coming to my institution, Marshall University, in Huntington, WV in 2013. The CEEAA is an excellent opportunity for any clinician who works with older adults and wants to uphold evidence-based standards of practice, and I would like to see more courses offered in more parts of the country to make it more easily accessible to our members.

Being Membership Chair is an exciting role that I enjoy, and I continue to learn more about our members at every conference and meeting. One of my goals is to increase student membership by offering student networking opportunities and merit awards.

I would like to see our Section work more with other professional associations that serve the geriatric community such as the National Council on Aging and the American Geriatrics Society. Similarly, we should work closer with other Sections such as Orthopaedics and Neurology to promote geriatrics. Partnerships such as these seem natural, as there is so much overlap within our goals to promote successful aging.

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

Today's geriatric practitioner is facing numerous challenges ahead. The SOG could be a valuable source of information in helping the clinician navigate the recent health care changes, and its potential impact on practice. Information such as patient advocacy resources, reimbursement and documentation resources, and professional community partnerships would go a long way towards better serving our patients and clients. The SOG continues to work to find resources for clinicians about to face the silver tsunami in our clinics and hospitals. We are nearly at the tipping point. As the percentage of our population aged 65 and older steadily increases, health care as we know it is changing right before our eyes. Unless you practice specifically with children, chances are a growing portion of your patients are older adults. Right now, it is more important than ever to promote and provide evidence-based practice, specific to the geriatric population to health care practitioners who treat older adults. We need to do a better job promoting autonomy of the geriatric practitioner and providing resources for clinicians to learn more about how to achieve autonomous practice, regardless of practice setting. As our current practice changes, we must prepare now in order to maintain the highest quality of care in the future.

DIRECTOR

Sara Knox, PT, DPT, GCS, CEEAA



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

It is an exciting honor to be nominated for the position of Director for the Section on Geriatrics. I believe that my current and past experiences in the Section, as well as in other components and at the national level of APTA, ideally position me to serve the Section on Geriatrics and its membership as a Director.

As Chair of the Awards Committee for the Section on Geriatrics for the past 4 years, I have been able to learn the workings of the Section leadership and understand the direction in which the Section is headed. I have a firm grasp on the priorities and strategic plan and believe this background would allow me to assume the role of Director in an efficient and effective manner.

A unique experience that strengthens what I have to offer the Section is my time serving as a member of the Steering Committee for the Physical Therapy and Society Summit. This experience taught me the skills of thinking outside the box, challenging our profession to go beyond the boundaries of today, and how to envision the potential of tomorrow in an ever-changing environment. This mechanism of propelling our profession forward is one that I would bring with me to the Board. We have a world of change in front of us as a profession and as a Section; I would welcome the chance to assist the Section in not only exploring these new opportunities but also driving the change that we want to see!

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

My experience on multiple boards and in various positions has provided me a diverse perspective on leadership. As a Chapter Delegate I have had the opportunity to hear the varied and insightful thoughts and ideas of numerous colleagues. These experiences have allowed me to keep my finger on the pulse of not just one Section or Chapter, but our Association as a whole. I believe this insight will be an asset to the Board if you choose to elect me to serve you in this capacity. Additionally, my experience as the Practice Chair/Liaison for two different chapters has given me the opportunity to hear the daily practice issues of clinicians from a wide variety of settings. Knowing the obstacles and

concerns that clinicians are facing will strengthen my insight when serving on the Board.

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

I believe that one of the greatest challenges facing geriatric practitioners is the present and looming work force shortage. If elected to the Board of Directors, I would love the opportunity to assist the Section in continuing the efforts towards expanding geriatric residencies and fellowships, increasing the number of Board Certified Geriatric Clinical Specialists, increasing the number of Certified Exercise Experts for the Aging Adult, and promoting and providing resources related to geriatric curriculum to PT and PTA schools. Additionally, I would love the opportunity to strategize ways of incorporating more students and new professionals into active roles within the Section on Geriatrics.

I would love the opportunity to use my passion and dedication to this profession and to our patients to serve the membership of the Section on Geriatrics. I sincerely ask for your vote for Director for the Section on Geriatrics.

DIRECTOR

Myles Quiben, PT, PhD, DPT, GCS, NCS



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

Having a wide range of clinical experience and having served at different levels with the APTA and Geriatric Section, from being an item writer with Specialization Academy of Content Experts, serving in the Geriatric Specialty Council and the American Board of Physical Therapy Specialties, I come to the Board of Directors with a broad knowledge of geriatric physical therapy practice/issues, and leadership skills. More importantly, I have a passion for geriatric care and for optimizing the quality of life and function of our elderly patients and clients. This passion is complemented with a strong com-

mitment to the Geriatric Section and its goals.

I bring a fresh perspective to the Board honed by my history of service to the profession including being a Credentialed Clinical Instructor Trainer, an active member of the Federation of State Boards of Physical Therapy, and am active at the community level. My experiences in the clinical and academic setting allow me to bring a holistic viewpoint of geriatric physical therapy practice. This viewpoint coupled with my work ethics, commitment to excellence, and enthusiasm to contribute to the growth of our practice makes me a strong candidate for the Board.

I look forward to continue serving the profession, Section, and Association in this capacity. I would be honored to have the opportunity to serve at this level and working with esteemed colleagues.

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

Geriatric education in professional programs: I believe there is much variability in the inclusion, content, and promotion of geriatrics in the PT curricula across programs. In conversations with colleagues from different states from both clinical practice and academia, there is a disconnect with the reality of the need for strong geriatric practitioners and of having a strong entry-level geriatric focus. We often hear of programs and graduates being "strong" in orthopedics or neurologic physical therapy, but rarely would you hear a strong geriatric program or focus. Are we truly responding to the societal need for geriatric practitioners and are we preparing future therapists for effective geriatric care? I would like to explore this issue further and would like to see the SOG be the impetus in initiating conversations across clinical and academic programs.

Promotion of the geriatric physical therapist practitioner: I would very much like to see the Section a more robust promotion of the geriatric physical therapist to the public, within the Association and third party payers. We need to put our stamp as the experts in the care, management, and health

promotion of older adults. I believe we need to be more visible and recognized in our contributions to healthy aging. Marketing plays an integral role to advancing this goal, and I plan to put more effort into this.

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

I believe one of the greatest challenges facing the geriatric practitioner is the lack of recognition for the identity of the PT as a geriatric practitioner of choice. We have not established ourselves as the possible points of entry of older adults into the health care system and the key role we play in health and wellness promotion for aging adults. Related to this is the challenge for the geriatric practitioner to choose the best outcome measure and intervention specific for the older adult.

I believe the SOG is in a distinct position to promote physical therapists as the geriatric practitioners, ie, that we have the knowledge and skills to effectively treat and manage a wide range of conditions and at the same time play a pivotal role in prevention through health and wellness promotion activities. The SOG can continue to boost its efforts to provide the resources to encourage evidence-based practice. In the era of increasing fiscal responsibility, we can market our role as primary care providers for elders as a cost-effective measure in the prevention of many conditions and multisystem decline associated with aging while ensuring that our aging clients achieve the highest quality of life.

The promotion of physical therapists as geriatric practitioners cannot be the principal focus without acknowledging the need for vigorous education at entry-level programs to provide the level of care needed for older adults. Inclusion of geriatrics in the curriculum can and will impact clinical preparation, practice interest, and quality of care. For the clinician, the SOG can promote a commitment to continued competence with an emphasis on the resources that provide the best possible care for the older adult.

It would be an honor to bring these activities and goals into fruition as a contributing member of the Board of Directors.

NOMINATING COMMITTEE

Patrice Antony, PT, GCS



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

Attendance at the main conferences is crucial. In my business as a care manager, I understand and embrace the business networking that is vital for growth both professionally and personally. Developing relationships with physical therapists across the country is something that I have valued and maintained in my 34 years as a practicing therapist. I also have good powers of persuasion! I find that most therapists would like to get involved, but need encouragement and support and are reluctant without that. If they feel that they will be supported and not just “dumped” into a role that they aren’t equipped for, they are more willing to serve.

What skills and experiences qualify you to serve on the Nominating Committee?

I’ve done it twice before. I’ve assisted in developing the tools and the process that is currently being used so I am familiar with the timelines, deadlines, and voting process.

Mary Thompson, PT, PhD, GCS



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

Identifying and mentoring new leaders are critical tasks for the future success of the Section. I believe the best approach is to understand what leadership means in the broadest sense and to really *know* the Section and its members. There are many leadership models. Nomination committee members need to be aware that leadership of the future is likely to look different from traditional leadership models. How can we match the leadership needs of the Section to the skills and abilities of members? For

the most part, the Section is a voluntary organization; our membership is our greatest resource. However, balancing work, family, and volunteer activities is challenging for Section members of all ages. It would be my responsibility as a member of the Nominating Committee to get to know as many members as possible through face-to-face meetings and electronic means. In addition, I think the Nominating Committee should explore the idea of a leadership bank where members interested in serving in any capacity can upload their interests, skills, abilities, and availability. In this way, we may be able to recognize and involve younger leaders or engage older members who delayed Section volunteerism due to family responsibilities but now have time to serve. Mentoring new leaders begins with succession planning. Succession planning includes clear job descriptions and opportunities for shared leadership. Leadership mentorship also involves links to resources that foster continued growth and development as a leader. Gathering leadership resources on the Section Web site may help us meet our personal and collective goals.

What skills and experiences qualify you to serve on the Nominating Committee?

My experiences related to geriatric practice, professional and postprofessional education, and professional organizational service make me well qualified for the responsibilities of Nominating Committee member. I have been a Section on Geriatrics member since 1980 and have attended every CSM since 1990. I truly enjoy getting together with Section members, new and old, to exchange ideas and network. My personal leadership journey began on a local level in the late 1980s/early 1990s, when I served on a home health advisory board and North Texas Conference, Council on Ministries, Division of Health and Welfare of the United Methodist Church. I began my involvement in the Section on Geriatrics as a newly certified geriatric specialist when Rita Wong at Marymount University suggested at CSM 1993 that I might be an item writer for the new GCS exam. Since that time, I have gained extensive experience in various roles and organizations that help therapists develop professionally.

In the Section on Geriatrics, I fostered the development of new authors and future editors as the editor for 6 years (2001-2007). As an outgoing Director, I am familiar with all our committees and have worked extensively with the Programming, Awards, Public Relations, *Journal of Geriatric Physical Therapy*, *GeriNotes*, and Research committees. As a participant in the 2012 Section on Geriatrics Strategic Planning process, I have a sense of where we as a Section are going and what human potential we need at all levels. My involvement with other physical therapy-related organization expands my network base, and has exposed me to how other organizations function. These organizations include the Texas Board of Physical Therapy Examiners; the Federation of State Boards of Physical Therapy; the Foreign Credentialing Commission on Physical Therapy; the American Board of Physical Therapy Specialties; and the American Board of Physical Therapy Residency and Fellowship Education, Credentialing Services Committee. In my role as coordinator of postprofessional programs at Texas Woman’s University, I advise physical therapists about paths that may lead to (1) ABPTS specialization, (2) contemporary practice in line with APTA’s Vision 2020 through a tDPT, and/or (3) filling our profession’s faculty shortage by preparing physical therapists to transition to the academic environment by earning a PhD in Physical Therapy. I truly enjoy helping others meet their career and professional goals and would be honored to serve the Section in this way.

CALL FOR PAPERS

The *Journal of Physical Therapy Education (JOPTE)* seeks manuscripts addressing best educational practices to prepare physical therapists and physical therapist assistants for working with older adults. Older adults represent at least 40% of most physical therapy caseloads, and their health needs promise to increase substantially over the next 20 years. Physical therapist management of older adults often requires complex decision-making as a host of internal and external factors must be taken into account. Age bias, fear of working with older patients, and difficulty recognizing and prioritizing multiple interacting factors all can impact the preparation of students for this major area of clinical practice. This special edition of , co-edited by John O. Barr, PT, PhD, FAPTA, and Rita Wong, PT, EdD, FAPTA, is intended to focus on identifying the curricular elements and instructional changes that will be necessary to ensure the provision of high quality physical therapy services for older adults.

We are particularly interested in research reports, methods/model presentations, case reports, and systematic reviews concerned with physical therapist and physical therapist assistant education. A representative, non-exhaustive list of possible topics includes:

1. Health systems and policy perspectives - What changes can we expect over the next 10 years and how do we prepare to meet these changes relative to:
 - Health policy and emerging models of care to deliver physical therapy services to older adults
 - Impact of Medicare payment policies on clinical education opportunities
 - Strategies to build the physical therapy workforce in geriatrics
2. Effective educational preparation in any of the major competency areas necessary for working with older adults*
 - Health promotion and safety
 - Evaluation and assessment
 - Care planning and coordination across the care spectrum
 - Interprofessional, interdisciplinary and team care
 - Caregiver support
 - Health care system and benefits
3. Curricular structure and content to prepare students for geriatrics
 - Strengths and weaknesses of integrating geriatrics content across the curriculum versus segregating into specific 'geriatric' units.
 - Review of basic and clinical science issues, such as genetics, regenerative medicine, etc, that need to be included in contemporary education
 - Applying clinical reasoning and clinical decision-making strategies in care of the older adult
 - Interprofessional education
 - Effective clinical education approaches and experiences in geriatrics.
 - Use of didactic curriculum to prepare students for clinical experiences with older adults
4. Ageism
 - Strategies to reduce student insecurity and fear, and to build enthusiasm for working with older adults
5. Postprofessional education in aging/geriatrics
 - Content, outcomes, effectiveness
 - Residencies and fellowships
 - Postprofessional doctoral education for physical therapists

Deadline for receipt of manuscripts via Scholar One is April 15, 2013. Please feel free to contact Dr. Barr at BarrJohnO@sau.edu with any questions. All manuscripts will go through the peer review process. This special issue will be published as volume 1 for 2014 (winter, 2014).

* Essential Competencies in the Care of Older Adults at the completion of the entry-level physical therapist professional degree, published by the Section on Geriatrics, American Physical Therapy Association, September, 2011. Can be found at: www.geriatricspt.org/pdfs/Section-On-Geriatrics-Essential-Competencies-2011.pdf

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DEVELOPED BY THE INTERNATIONAL ASSOCIATION OF PHYSICAL THERAPISTS WORKING WITH OLDER PEOPLE
AND THE INTERNATIONAL ORGANIZATION OF PHYSICAL THERAPISTS IN WOMEN'S HEALTH

INTERNATIONAL PHYSICAL THERAPY CONFERENCE

Topics on Women's Health and Aging in Men and Women

April 26-28, 2013
Boston, MA USA

Where: The Conference Center at Harvard Medical School
77 Avenue Louis Pasteur, Boston MA

Hotels: The Inn at Longwood Medical Boston
Holiday Inn Brookline

Friday April 26

Check In
Cocktail & Snack
Reception
Exhibits

Saturday April 27

Registration/Continental Breakfast
Opening Remarks
Dr. Rebecca Stephenson - President IOPTWH
Dr. Jennifer Bottomley - President IPTOP
Anne Hartstein - Massachusetts Secretary
of Elder Affairs
Overview of Aging
Dr. Marilyn Moffat - WCPT President
Osteoporosis - Dr. Meena Sran
Communications skills for therapists
working with women with cognitive
changes associated with aging
Dr. Jennifer Bottomley
Incontinence and Pelvic Organ Prolapse
and its Implications in Aging
Dr. Meghan Markowski PT
Cocktails & Dinner

Sunday April 28

Continental Breakfast
Nutrition and Exercise for
Women across the Life Cycle
Bhanu Ramaswamy
Urogynecological Surgeries
Dr. Neeraj Kohli
Sexual Changes in Older Age
Dr. Sharon Bober
Active Aging - Dr. Marilyn Moffat
Breast Cancer - Dr. Nancy Roberge



Keep checking the websites for updated information over the coming months.
www.ioptwh.org OR www.wcpt.org/iptop

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For age is opportunity, no less than youth itself,

*though in another dress, and as the evening twilight fades
away, the sky is filled with stars, invisible by day.*

- Henry Wadsworth Longfellow

Section on Geriatrics - APTA

GERINOTES

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Thinking about becoming a Geriatric Certified Specialist (GCS)?

Searching for geriatric specific continuing education?

Prefer to get your CEUs from the comfort of your own home?

The **Section on Geriatrics** is proud to release the new edition of our popular **Focus** course covering physical therapist practice in geriatrics across the practice patterns, written by a talented group of board certified specialists who are leaders in the profession. Special pricing is available for members, and for those who purchase the complete course.

The 6-monograph course includes:

Issue 1: *The Aging Musculoskeletal System* by **Karen Kemmis, PT, DPT, GCS, MS, CDE, CPRP, CEEAA**

Issue 2: *The Aging Neuromuscular System* by **Jason Hardage, PT, DPT, DScPT, GCS, NCS, CEEAA, and Mary Elizabeth Parker, PT, MS, NCS, PCS**

Issue 3: *The Aging Cardiovascular System* by **Ellen Strunk, PT, MS, GCS, CEEAA**

Issue 4: *The Aging Pulmonary System* by **John Lowman, PT, PhD, CCS**

Issue 5: *The Aging Integumentary System* by **Jill Heitzman, PT, DPT, GCS, CWS, CEEAA, FACCWS**

Issue 6: *Diabetes Across the Physical Therapy Practice Patterns* by **Pamela Scarborough, PT, DPT, MS, CDE, CWS, CEEAA**

All 6 issues are available through the APTA Learning Center at learningcenter.apta.org/geriatricssection. To learn more on how to become a GCS and to obtain a resource list visit www.geriatricspt.org, click on "About Us" then select, "What is GCS?"



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