

GERINOTES

SECTION ON GERIATRICS, AMERICAN PHYSICAL THERAPY ASSOCIATION

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PRESIDENT'S MESSAGE: ALZHEIMER'S DISEASE

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



The Alzheimer's Association (AA) has recently published their 2012 Alzheimer's disease (AD) facts and figures.¹ This can also be found as a PDF at www.alz.org/downloads/Facts_Figures_2012.pdf. These numbers are a bit scary and will challenge us as geriatric practitioners in the future. An estimated 5.4 million Americans presently have AD. Estimates see this number doubling or tripling through 2050. Alzheimer's disease is the most common form of a dementia, which also includes vascular dementia, dementia with Lewy bodies, mixed dementia (having more than one type), Parkinson disease, fronto-temporal lobe dementia, normal pressure hydrocephalus, and Crutzfeldt-Jacob disease.

So why did I choose this column to write about AD. Because we, as physical therapists, work with patients with dementia in many settings. A recent study found that physical therapy practitioners in skilled nursing facilities had nearly 50% of their case load consisting of people with dementia.² As a home health therapist, I find that about 10% of my caseload consists of people with dementia. The \$500 billion cost of informal care (about \$300 billion per year) and formal health care services (about \$200 billion of Medicare and Medicaid funds) is a chilling number. This cost will probably double or triple within the next two decades as the number of persons with dementia rises. How will we afford this increased cost, in addition to all the other health care needs?

Our patients with dementia have difficulty making sound judgments, learning new skills, executing complex motor tasks, and in the later stages, comprehending the written or spoken word. I want to urge all of you to look to advancing your practice skills and take an

advanced course if this is or will be your patient population. I hear of therapists giving up or not even starting interventions with patients because of a dementia diagnosis. Some therapists have told me that Medicare won't pay for treatment if the patient has dementia. I would say that your documentation would defend your care, as with any other patient. Carole Lewis and Keiba Shaw wrote a nice article in *Advance* defining and defending intervention for people with dementia in which Carole supplies a sample letter to defend your treatment.³

There are many specialized techniques that can be utilized to improve your outcomes. You may want to take an advanced continuing education course or spend some time with an experienced therapist to learn some of them. Additionally, practical tips to maximize success of communication with individuals with AD are found in many publications.⁴⁻⁸ To view an amazing video of how music might stimulate your patient, visit YouTube to view the following video: <http://www.youtube.com/watch?v=NKDXuCE7LeQ>.

Previously people with AD were classified as being in the early, middle, or late stages of the disease. The Alzheimer's Association has proposed a new 3 stage format for classification including preclinical AD (no outward signs or symptoms, although changes in the brain have begun), mild cognitive impairment (MCI) due to AD (mild but measureable changes in cognition), and dementia due to AD (impaired ability to function in daily life).¹ Researchers are coming close to developing biomarkers that may be able to diagnose AD well before symptoms appear. The new classification would look for treatment to begin in the preclinical stage or in MCI. In fact, Eli Lilly has developed a test that detects the presence of abnormal levels of amyloid protein in the brain, which has been approved by the FDA and will be available in June of this year. The test uses a chemical called florbeta-

pir (Amyvid), which is a radioactive compound. This chemical is estimated to cost \$1,600 per dose, and is detected with a PET scan. Sadly, no effective treatment to slow or stop AD is currently available, but if this test were to be negative, then other possible disease processes causing the dementia may be found to be treatable. Current medications have limited effect or provide only temporary changes in function, but they have not been shown to alter the course of the disease. However, some active management of the disease can improve the quality of life by decreasing stress and the burden of care. One suggestion would be to refer anyone with a diagnosis of AD to a support group. I have found this simple act to be one of the best single interventions available for the patient and the caregiver.

For now, we can encourage our clients and patients to increase their physical activity levels. In the online version of *Neurology*, researchers from Rush University Medical Center found that daily physical activity may reduce the risk of AD and cognitive decline even in people over the age of 80.^{9,10} The activity does not have to be a structured exercise program. The study showed that those individuals within the lowest 10% of physical activity intensity were almost three times more likely than those in the top 10% of activity to develop AD. Dr. Teresa Liu-Ambrose, who spoke at the ExPAAC meeting two years ago, and her research team have just published a study where they found that resistive exercise improved cognitive and brain function.¹¹ In women with MCI, 6 months of twice weekly resistive exercise training improved executive function. Other studies have linked cardiovascular disease risk factors such as high cholesterol, lack of physical activity, smoking, diabetes, and obesity with higher risks for developing AD and other dementias.¹²⁻²¹ These are modifiable risk factors and we need to be educating our patients as to the importance of decreasing these factors.

The Alzheimer's facts and figures document contains great information and statistics. Information regarding prevalence, mortality (including the fact that AD is now the 6th leading cause of death in the United States, 5th for those over the age of 65), cost of care, and a special report on those with AD that live alone can be found in this document. I would strongly recommend those of you working with this population to review this document.

Working together as geriatric clinicians allows us an opportunity for a clinical shift in this arena. Removing our stereotypes and stressing the quality of life for both patient and caregiver moves the treatment of AD forward for our clients and our practice.

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A GLOBAL PERSPECTIVE: A SPOTLIGHT ON GERIATRIC PHYSICAL THERAPY PRACTICE

Issue Editor: Jennifer M. Bottomley, PT, MS, PhD, President – IPTOP/WCPT



GeriNotes has published many articles over the years that address the growth of the older adult population in the United States and examine the countless effects

of aging on many of societal and health care issues related to policy and practice in the area of geriatrics. This focused issue of *GeriNotes* presents a global perspective of the practice of geriatric physical therapy in many of the member countries of the International Physical Therapists working with Older People (IPTOP)—a subgroup of the World Confederation of Physical Therapy (WCPT). Adapting a global perspective to the study of aging opens the door for rich intellectual discussions that will ultimately improve the quality of life for older people around the world.

Our world is aging. A major demographic shift has occurred globally that extends the life expectancy and the need for specialization in geriatric physical therapy. The International Program Center, Population Division of the U.S. Census Bureau, reports that 38 nations have at least 2 million citizens over the age of 65. It is projected that 72 countries will reach this mark by 2040.¹ By the year 2030, which is right around the corner, one in every 8 people in the world will be aged 65 years or older and the fastest growing segment of the older people in the world are the oldest old—people over the age of 80 years.² Life expectancy in some nations more than doubled during the 20th century. Not only are the numbers of older people growing worldwide, but within the next 10 years, the world will experience a historical shift in the makeup of our population as people 65 years and older will outnumber those under the age of 5 years for the first time ever.¹ This demographic shift is the result of declining birth rates, increasing life expectancy, and modern medicine, all of

which has gradually altered the age structure of societies in both developed and developing nations. Three hundred and thirteen million (62%) of the world's older population lived in developing countries in 2008. It is expected that by 2040 there will be more than 1 billion (76%) of the projected world total of people aged 65 and older in developing countries.

This dramatic growth in the worldwide older population reflects improvements in medical care, public health, and economic conditions that, for thousands of years, limited life expectancy for many. The aging of the population will have an impact on pension systems, as well as health care and social insurance programs, placing a strain on available resources. This shift also represents a dramatic challenge to existing models of health care provision. The aging of our world presents issues related to the sustainability of families, questions about financial planning for the individual and the family, and challenges to the ability of local communities and governments to provide for its older citizens. Geriatric physical therapists worldwide may see a changing role in the provision of care. In addition to providing rehabilitation services following a stroke, hip fracture, or the many diseases that we see in PT, we may see an expansion in screening and prevention programs to lessen the “illness” burden and strain on the health care systems worldwide.

In just a few decades, the loss of health and life due to chronic diseases, including cardiovascular disease, dementia and Alzheimer's disease, cancer, arthritis, and diabetes, will be greater than losses from infectious diseases, childhood diseases, and accidents.² It is a professional imperative that we, as geriatric physical therapists, consider how this major change will influence the aging process and our ability to care for older individuals worldwide. Family structures will change as the number of 4-generation families soars and the number of siblings decreases, creating greater need for care within families, with fewer persons to

provide that care. Physical therapists will play a major role in promoting independence in light of families dwindling caregiving resources.

It is likely that patterns of work and retirement will change as more people spend a larger portion of their lives in retirement, or remain in the workforce longer to decrease the strain on their retirement funds. Geriatric physical therapists may find that they are involved in vocational training and preparation for an older adults return to work. This would certainly add a new dimension to the practice of geriatric physical therapy. Additionally, the compression of morbidity and expansion of morbidity will continue to challenge us globally as professionals in the field of aging adapt to the aging of the world.

It is with this in mind that we, the country representatives of IPTOP, offer a current view of the practice of geriatric physical therapy in each of our respective countries. The compelling global demographic developments would benefit from an improved understanding of international aging. With this issue of *GeriNotes*, we introduce a new tri-annual feature column in *GeriNotes* entitled “*A Global Perspective*.” Each Global Perspective will feature a different country. Invited authors will be asked to describe aging in their country, identify the main areas of research and key researchers in geriatric physical therapy, discuss and pinpoint public policy issues, and highlight emerging issues likely to influence the aging experience in their country. We of IPTOP, hope that these articles will not only enhance our understanding about global aging but also spark international collaborations that ultimately will lead to more sophisticated research and better public policies and practices supporting older people.

This focused issue presents the practice of geriatric physical therapy in Iceland, Switzerland, Belgium, Ireland, Turkey, the Netherlands, and the UK. In subsequent issues we invite readers to contact the Editor of *GeriNotes* and sug-

gest both countries and prospective authors for future *Global Perspective* pieces. Recognizing that politics can influence how aging in a country is both understood and depicted, we encourage a holistic, well-rounded perspective of aging in each country rather than merely the view from a physical therapy base. In this focused issue of *GeriNotes*, we highlight the practice of geriatric physical therapy in the countries listed above. We welcome this rich and fertile resource, member countries of IPTOP, practitioners in geriatric physical therapy, our colleagues worldwide in providing pertinent information useful for informing practice, research, and policy regarding aging across the globe.

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WCPT: THE WORLD OF PHYSICAL THERAPY

Marilyn Moffat, PT, DPT, PhD, DSc (hon), CSCS, CEEAA, FAPTA



Marilyn Moffat is a Professor of Physical Therapy at New York University, President of the World Confederation for Physical Therapy, and a private practitioner.

THE EARLY YEARS

The groundwork for establishing the World Confederation for Physical Therapy (WCPT) was set in 1948 when physical therapists from 15 countries gathered in London to investigate the possibility of establishing an international organization to give guidance to the profession, the United Nations, specialized agencies, and international voluntary organizations sponsoring rehabilitation programs. These national representatives discussed how they might help physical therapists promote the interchange of professional and scientific knowledge, create closer links among members of the profession in different countries, and provide at an international level services for professional associations (of note—priorities for WCPT ever since).¹ The actual uniting of the world for physical therapists began with the establishment of the WCPT in 1951 by 11 founding organizations including:

- Australian Physiotherapy Association
- Canadian Physiotherapy Association
- Den alm. Danske Massageforening (Denmark)
- Finlands Medikalgymnasters Forening
- New Zealand Society of Physiotherapists
- Norske Sykegymnasters Landsforbund (Norway)
- South African Society of Physiotherapists
- Kvinnliga Legitimerade Sjukgymnasters Riksförbund (Sweden)
- The Chartered Society of Physiotherapy (United Kingdom)
- American Physical Therapy Association (United States)
- Zentralverband der Krankengymnasten

tischen Landesverbände im West-deutschen (West Germany)

The inaugural meeting of the first and only global body representing all physical therapists was held in Copenhagen, Denmark on September 8, 1951. Mildred Elson, a former Executive Director of the American Physical Therapy Association, believed strongly in the benefits of physical therapists working together nationally and globally.² She became WCPT's first President and was well aware that setting up a global body to represent physical therapy was an ambitious project, but was one that was urgently needed in a world that had been ravaged by the devastating results and war wounded of World War II and the disability from the poliomyelitis epidemics that were raging around the world. Elson knew that the magnitude of the political, socio-economic, and health problems were more apparent than ever at that time and that it was universally recognized that if peace and stability were to be attained, all must work together to alleviate the problems. Discussions with leaders of other organizations convinced those physical therapists that there was no alternative to the development of an international physical therapy organization.¹

From the beginning, setting world standards in physical therapy has been the cornerstone of WCPT. President Elson said, "We were aware of the international trends and the pitfalls ahead if nothing was done. Worldwide standards were highly desirable, but were they attainable? We thought so, but it was going to be rough going."¹

During these early years, WCPT communicated by letters written on one borrowed typewriter and by telephone calls. In 1953 the Confederation held its first international congress in London. From the time of that first London meeting, WCPT has held 15 congresses (New York, Paris, Copenhagen, Melbourne, Amsterdam, Montreal, Tel Aviv, Stockholm, Sydney, London, Washington, Yokohama, Barcelona, Vancouver, Amsterdam).

Since its inception, WCPT has provided a united voice for the profession globally. Sometimes it has spoken out alone, sometimes it has spoken out through consultations or joint projects with other global bodies, and sometimes through full collaborations with other bodies to make its voice stronger or more influential. WCPT began official relations with the World Health Organization (WHO) in 1952 and gained consultative status with the United Nations International Children's Emergency Fund (UNICEF) in 1958. The collaborative work programs with these organizations, other United Nations bodies, not for profit organizations, and other world professional bodies have aimed at improving world health.¹

The WCPT has aimed to support countries wishing to develop physical therapy education programs. In 1958, President Griffin spoke of the need for an agreed basic syllabus around the world. "World reciprocity is desired and must be the ultimate goal of the WCPT."¹ The WCPT has set the requirement for that curriculum, and it is now being followed widely around the world. Since the 1950s, WCPT has continually developed and updated guidelines on physical therapy education.

In 1959, the Confederation ratified its first set of ethical principles, which have been updated ever since. In 1960 a logo was in place for the organization, and an office was established in London with one staff person. In the 1960s, WCPT provided support to international relief efforts and projects to develop rehabilitation programs and provided WHO with details of physical therapists interested in providing services in developing countries. The WCPT was represented at major meetings organized by WHO, UNICEF, and the International Union for Child Welfare in 1961.¹

The first newsletter was published in the 1960s, and it was WCPT's main means of communicating with member organizations until the late 1990s. The WCPT began establishing a common language for the profession, and in

1963 produced its first glossary of terms commonly used by physical therapists. Between the 1950s and 1960s, WCPT grew to 27 member organizations.¹

THE 70S AND 80S

The WCPT has encouraged the international development of expertise in specialist areas of physical therapy. In 1978, its first official subgroup, the International Federation of Manipulative Therapists (IFOMT), was approved.¹ Currently the following 12 subgroups encourage the highest standards of practice internationally in their areas of expertise:

- Acupuncture Association of Physical Therapists (IAAPT)
- Association of Physical Therapists in Animal Therapy (IAPTAP)
- Association of Physical Therapists Working with Older People (IPTOP)
- Confederation of Cardiorespiratory Physical Therapists (ICCrPT)
- Federation of Orthopaedic Manipulative Physical Therapists (IFOMPT)
- Federation of Sports Physical Therapy (IFSPT)
- Neurological Physical Therapy Association (INPA)
- Organization of Physical Therapists in Paediatrics (IOPTP)
- Organization of Physical Therapists in Mental Health (IOPTMH)
- Organization of Physical Therapists in Women's Health (IOPTWH)
- Private Practitioners Association (IPPA)
- Society of Electrophysical Agents in Physical Therapy (ISEAPT)

The International Year of Disabled People in 1981 saw international understanding about the needs of people with disabilities begin to grow, and WCPT supported many of the initiatives from its member organizations.¹

The WCPT established standards by publishing international guidelines for physical therapists. Early guidelines on specialization were adopted in 1982. The WCPT has attempted to ensure democratic procedures that allow the voice of the profession in smaller countries, as well as larger ones, to be heard. The WCPT has continually supported the status of physical therapists as independent and valued practitioners around the world. In 1982, the WCPT Code of Ethics was changed to allow patients to be treated by a physical therapist without referral from a physician. The Code thus

recognized the increasingly independent nature of the profession. With this document, and others setting down principles and standards for an autonomous profession, the WCPT provided tools for member organizations to negotiate with governments and other bodies.¹

The WCPT has attempted to ensure democratic procedures that allow the voice of the profession in smaller countries, as well as larger ones, to be heard. In the 1980s, one-member one-vote principles were incorporated into the Confederation's articles of association.

The WCPT actively argued against WHO proposals to introduce multi-purpose rehabilitation therapists in the 1980s. In the second half of the 1980s, the Confederation collaborated with WHO on projects regarding physical therapy and care of the elderly and community based rehabilitation, jointly reporting on the role of physical therapy in the care of elderly people in 1989. The Mildred Elson Award was established in 1987 to recognize sustained and continuous leadership over a career and honors a physical therapist who has contributed significantly to the development of physical therapy at the international level.¹ Between the 1970s and 1980s, the WCPT grew to 42 member organizations.

THE 1990S AND ON

Until 1990, when WCPT purchased its first computer, its fact-finding, information-gathering, and information dissemination depended on meetings, personal visits, letters, and phone conversations. In 1991 it started publishing its declarations of principle and position statements, laying down a clear professional view on issues such as specialization, educational level, and use of support personnel.

The WCPT established 5 regions (African, Asia/Western Pacific, European, North American/Caribbean, and South American) in 1991 to enhance greater interaction between member organizations at regional level conferences and meetings. Regions have also encouraged the involvement of physical therapists from countries not currently represented in WCPT providing partnerships with well-established member organizations and advising them on the best means to meet internationally accepted standards.¹

Work on physical therapy and care of the elderly and community based re-

habilitation with WHO continued into the 1990s when WCPT held an expert meeting on aging with the International Institute of Ageing in Malta. The report of that meeting was published in 1993. In 1997 WCPT published guides for use by rehabilitation workers with WHO and the World Federation of Occupational Therapists. The 1990s also saw substantial collaboration with the International Rehabilitation Council for Torture Victims. New declarations of principle and position statements were adopted, including those on standards of practice and evidence-based practice.¹

Regular and instant communication with member organizations began via E-mail in 1996. WCPT's news bulletin was produced and named "WCPT News" in 1995.

In 1996, WCPT established 3 task forces consisting of physical therapists from around the world to develop an internationally agreed upon description of physical therapy, examine quality assurance issues, and investigate issues in international recruitment and education. The work resulted in a new WCPT declaration on regulation and reciprocity, a new project to gather information on education programs, and a new description of physical therapy, which has since become a standard for the profession. By 1999, the membership had agreed upon a comprehensive description of physical therapy.¹ By the end of the 1990s, membership had grown to over 72 member organizations.

THE 21ST CENTURY

With the advent of the 21st century and the information superhighways, WCPT has been the focal point of global information for the profession. But WCPT has always tried to bear in mind that reliability, speed, and access to new communications technologies varies from country to country and from location to location. And it has never lost sight of the fact that, in a global body, there would always be a vital place for face-to-face contact and seeing things with one's own eyes.

The Confederation's Web site was launched in 2001, and by 2002 it was identified as the primary vehicle by which WCPT could communicate with its member organizations, regions, and subgroups, as well as the global physical therapy community.

Consultation with members by E-mail and through the Web site became

quicker and easier, and WCPT was better able to inform key projects with expertise from around the world, unrestrained by geography. Formal and informal online groups and networks were established. Web-based forums on specialist subjects, such as the International Classification of Functioning, Disability and Health (ICF) and evidence-based practice, were set up.

An International Scientific Committee was established for the World Congress to ensure the highest standards of presentations at the meeting occurring every 4 years. At the 2007 General Meeting, WCPT admitted its 100th member organization; and at its 17th General Meeting in 2011, there were 106 member organizations.

During this decade, WCPT embarked on a major project to collect information from member organizations about the state of physical therapy in as many countries as possible—building a unique global picture of numbers of physical therapists, education, and practice areas. In 2009, WCPT relaunched its Web site, making it the organization's central information and communication resource, with an accessible and user friendly interface. The WCPT launched a monthly E-update and its quarterly news bulletin "WCPT News" also moved online and began to focus more on looking at international issues in depth, providing interviews, analysis, and features.

New declarations of principle and position statements were developed and existing ones were updated to reflect changes in the profession and health services. All policies and guidelines are fully available to all through the Web site (www.wcpt.org).

Raising the profile of the ICF and working with WHO on a collaborative program to gain greater use of ICF by physical therapists are among WCPT's long-term activities. The WCPT is also working with the WHO on projects investigating how shortages of health practitioners and migration issues may compromise initiatives to tackle the causes of global ill health. In 2010 WCPT became a member of the World Health Professions Alliance WHPA joining the international professional bodies of physicians, nurses, dentists, and pharmacists to make its voice and influence felt more widely with other professions, policy makers, and the public.

The WCPT now has a network of experts and a range of resources to support organizations looking to establish new or upgrade physical therapy educational programs. Guidelines for entry-level educational programs, faculty, clinical education, and accreditation/recognition have been adopted, and WCPT provides a means by which entry-level programs can be reviewed and judged to ascertain if they meet WCPT standards.³⁻⁷

In 2011, WCPT launched its database of experts, providing WCPT with a resource of physical therapists ready to provide input on materials in their field of expertise and to work with member organizations needing support with access to the specialists best able to help. Work also continues on the standardization of international language with a new glossary of terms published in 2011.

World Physical Therapy Day each September 8th (Figure 1) provides a prime public relations opportunity for showcasing physical therapy globally. The WCPT provides member organizations with the means to raise the profile of the profession in their own country and drive home their points to public and policy makers.

The WCPT contributed to and endorsed the World Report on Disability and endorsed the United Nations Convention on the Rights of Persons with Disabilities.

ASSOCIATION OF PHYSICAL THERAPISTS WORKING WITH OLDER PEOPLE (IPTOP)

The IPTOP was established in October 2002 and recognized as a WCPT subgroup in 2003. While IPTOP and WCPT activities related to aging adults have been ongoing, several are highlighted. The appendix contains a World Physical Therapy Day clinical area sheet on active aging that is available to all member organizations to use to inform the public during the celebration activities.

During the 2011 World Physical Therapy Congress, a discussion panel was convened to address the role of physical therapists in broad based health promotion programs (public health or wellness programs) and preventing disability leading to the question of are physical therapists playing their part? Screening for disabilities, healthy lifestyle promotion and injury prevention, identification and management of factors affecting health status and measures to prevent disability associated with chronic diseases are all part of a physical therapist's skill set and were inherent in the discussion of the panel (the power point presentation of this panel discussion is available at: http://wcpt.org/sites/wcpt.org/files/files/wpt2011-health_promotion_panel.pdf).

The IPTOP's Web site has subgroup information on physical activity. Another item of note is a joint conference

WCPT's Mission

As the international voice of physical therapy, WCPT's mission is to:

- unite the profession internationally;
- represent physical therapy and physical therapists internationally;
- promote high standards of physical therapy practice, education and research;
- facilitate communication and information exchange among member organizations, regions, subgroups, and their members;
- collaborate with national and international organizations; and
- contribute to the improvement of global health.



Figure 1. World Physical Therapy day logo.

with IPTOP and the Organization of Physical Therapists in Women's Health (IOPTWH), which will take place in 2013 in Boston.

SUMMARY

The WCPT is a confederation of member organizations. For many member organizations, the resources and day-to-day support provided by WCPT have been instrumental in their attempts to gain expert knowledge, professional status, and high quality professional education in their countries. The WCPT believes that every individual is entitled to the highest possible standard of culturally appropriate health care delivered in an atmosphere of trust and respect for human dignity and underpinned by sound clinical reasoning and scientific evidence.

It is committed to furthering the physical therapy profession and improving global health through high standards, support of information exchange, and collaboration.

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Appendix. World Physical Therapy Day Clinical Area Sheet on Active Aging

Physical therapists are exercise experts, providing services for a wide range of people to optimize their physical ability. They prescribe exercise as part of a structured, safe, and effective program. An important part of their role is to help people remain active as they age. More than any other profession, physical therapists (known in many countries as physiotherapists) prevent and treat chronic disease and disability in aging adults through specifically prescribed activity and movement.

The World Health Organization encourages regular physical activity for older adults, because it has been shown to improve the functional status and quality of life in this group of individuals (www.who.int/dietphysicalactivity/factsheet_olderadults/en/). It says that older adults should engage in at least 30 minutes of moderate-intensity physical activity 5 days a week, if appropriate.¹

This document provides information and resources demonstrating the contribution of physical therapists in keeping people active as they age, particularly their role in maintaining general health, preventing and treating cardiovascular disease, and countering joint problems. A separate clinical area sheet is available dealing specifically with cardiovascular disease.

IMPROVING FUNCTIONAL ABILITY

Older adults engaged in regular physical activity demonstrate improved:

- balance
- strength
- coordination and motor control
- flexibility
- endurance

As a result, physical activity can reduce the risk of falls—a major cause of disability among older people.² Participation in regular exercise programs leads to older adults having higher levels of functional capabilities, greater independence, and improved quality of life.³

Exercise programs can slow down functional decline. Elderly adults can, with an appropriate exercise program, be helped to achieve levels of activity that will bring health benefits, and the decline in overall function that might normally be expected with age can be substantially retarded.⁴ Physical activity and exercise are inversely associated with mortality and age-related morbidity.⁵⁻⁷

PREVENTING AND TREATING NONCOMMUNICABLE DISEASE

Participation in regular physical activity can prevent or improve many noncommunicable diseases prevalent in older adults:

- cardiovascular disease (coronary heart disease, stroke),
- hypertension (elevated blood pressure, which can contribute to cardiovascular disease),
- osteoarthritis (a disease that causes joint swelling, pain and limits movement), and/or
- osteoporosis (a disease in which bones become fragile).²

Being active from an early age can help prevent these noncommunicable diseases, and regular movement and activity can also help relieve the disability and pain associated with them.²

PROMOTING CARDIOVASCULAR HEALTH

Regular exercise in older adults has many positive effects on cardiovascular health, including increasing cardiac output, maximum heart rate, endurance, and arterial blood flow, and decreasing heart rate, blood pressure, and risk of heart disease.⁸ One study found that after 8 months of regular training, a group of 85-year-olds had increased walking speed and increased maximal oxygen uptake and decreased blood pressure. This resulted in reduced health risk and improved independence.⁹

IMPROVING JOINT HEALTH

Tai Chi exercise brings improved balanced and physical functioning to people with osteoarthritis.¹⁰ Research indicates that exercise decreases pain and increases ability to exercise in people with osteoarthritis and rheumatoid arthritis.^{11,12} Exercise decreases depression and anxiety in people with osteoarthritis.¹¹

Land-based therapeutic exercise programs have been shown to reduce pain and improve physical function in people with osteoarthritis of the knee.¹³ For people with osteoarthritis of the knee, both high intensity and low intensity aerobic exercise (stationary cycling) are equally effective at improving functional status, gait, pain, and aerobic capacity.¹⁴ Research also indicates that regular exercise by people with arthritis decreases the likelihood of developing disability by 10% and protects against functional decline.¹⁵

IMPROVING MENTAL HEALTH

Physical activity has been shown to improve mental health and cognitive function in older adults and contributes to the management of disorders, such as depression and anxiety. Active lifestyles often provide older persons with regular occasions to make new friendships, maintain social networks, and interact with other people of all ages.² (Footnote 2) Research has indicated that increased levels of physical activity reduce the risk of Alzheimer's disease. Exercise, along with cognitively stimulating activities, can reduce some of the symptoms of the disease.^{16,17}

Aerobic exercises significantly reduced depressive symptoms in people over 60.¹⁸ A regular program of aerobic exercise can slow or reverse functional deterioration, reducing the individual's biological age by 10 or more years, and potentially prolonging independence.¹⁸

FOOTNOTES

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MEET THE INTERNATIONAL TEAM

TESSIER JAN



Tossier Jan received his Bachelor of Physiotherapy graduate in Bruges (Belgium) in 1975. He is a member of the Board of Axxon, quality in physiotherapy, the Dutch wing of Axxon Physical Therapy in Belgium as well as Reference Person Fall prevention in Flanders Expertise Centre, Co-founder of the Belgian Clinical in Geriatrics Interest Group, and a Delegate for Axxon Physical Therapy in Belgium in IPTOP. From 1976 to 1988 he worked in a private practice with a colleague physiotherapist and in people's homes. Since 1988, he works a full time job in a nursing home and in a day care center in Blankenberge.

DR. FILIZ CAN



Dr. Filiz Can is a Full Professor of Physiotherapy at the University of Hacettepe, School of Physical Therapy and Rehabilitation in Ankara, Turkey. After graduation from the Hacettepe University, she has received her MSc and PhD in Orthopaedic Rehabilitation in the same University. She has published 10 books, contributed several chapters to orthopaedic and geriatric textbooks, as well as published many papers in peer reviewed journals. She has been Vice chair of working group in Advancing Health and Well-Being into Old Age in National Commission on Aging coordinated Prime Ministry State Planning Organization, and one of editors of the National Reports for National Plan of Action following Madrid International Plan of Action on Ageing 2002 developed by United Nation. She was the founding member of the Turkish Geriatric Physiotherapy Association, then working as general secretary. She

has been elected as executive Committee Member of IPTOP in 2003 and became vice Chair of IPTOP in 2006. She was the Chair of IPTOP between the years of 2007-2011.

GRAINNE WALSH



Grainne Walsh graduated from National University of Ireland, Galway with a BSc. Hons Biochemistry Major (2005), and following this graduated from Royal College of Surgeons, Dublin with a BSc. Physiotherapy (2008). She has worked in Beaumont Hospital, Dublin since graduating. Grainne has gained experience working in many areas, and is currently working in neurology and care of the elderly rehabilitation services, including acute care and day hospital services. Areas of interest include Parkinson's disease, falls and vestibular rehabilitation.

GLAUCA GONCALVES MANTELLINI



Glauca Gonçalves Mantellini is a Physical Therapist Ph.D, born in São Paulo (Brazil) who since 2002 lives in Bern, Switzerland. Her current practice focuses are the physical activities for old people with neurologic impairments and disabilities. Mrs. Mantellini is a Ph.D from the University of Campinas (UNICAMP, Brazil), who holds the Doctor Titel in Adapted Physical Activities and Master one in Sport Science. She worked almost 10 years at the Clinical Unit from the Geriatrics Department University of Bern at the Spital Bern Ziegler and is since 2010, Officer at the Group Specialized in Physical Therapy (FPG) from the Swiss Association for Geriatrics (SGG).

HANS HOBBELEN



Hans Hobbelen was born on January 9, 1965 in Best, the Netherlands. After his physiotherapy graduation in 1987, he briefly worked in Skagaströnd Iceland after which he returned to the Netherlands and start working in September 1988 in a nursing home 'de Weerde' in Eindhoven. In 1998 he started to study human movement sciences at the Maastricht University and obtained his Master of Science degree in 2001. In 2010 he gained is doctorate. In September 2010 he was appointed as senior scientist at the Dutch Institute of Allied Health Care in Amersfoort (Nederlands Paramedisch Instituut, NPI). In February 2012 he was appointed as professor in Healthy Lifestyle, Ageing and Health Care at the Hanze University of Applied Sciences in Groningen, the Netherlands. Hans is board member of the Dutch society of geriatric physiotherapists (Nederlandse Vereniging voor Fysiotherapie in de Geriatrie NVFG) and Dutch and European representative for the International Association of Physical Therapy working with Older People (IPTOP). Hans is married to Saskia van Duren and has two daughters, Marije (8) and Hanne (6) and lives in Vught, The Netherlands.

THORUNN BARA BJORNSDOTTIR



Thorunn Bara Bjornsdottir is a physical therapist who for years has worked within geriatrics with an emphasis on people with memory impairment at Landspítali, University Hospital Reykjavik, Iceland.

PHYSIOTHERAPY FOR OLDER ADULTS IN THE UNITED KINGDOM

Bhanu Ramaswamy, PT

INTRODUCTION

The United Kingdom (UK) of Great Britain and Northern Ireland comprises 4 home countries, each with unique populations and systems of health and Social Care to govern their needs. This article presents a basic overview of the changes in the UK that have occurred over the past two decades. This includes government structural changes, alteration of the roles of the governing professional bodies and the developments within the educational system, each which have impacted on delivery of physiotherapy services to older populations.

GOVERNMENTAL STRUCTURES AFFECTING PROVISION OF HEALTH

The UK is governed by the Parliament of the UK, although Scotland, Wales, and Northern Ireland each have devolved administrations, ie, the Northern Ireland Assembly, the Scottish Parliament, and the National Assembly for Wales. England continues to be governed and legislated for by the UK parliament.

With regards to health care, the publicly funded National Health Service (NHS) dominates provision, offering a comprehensive range of services most of which are free at the point of delivery. Health is a devolved issue for each country's government, with each country

having an official name for the service, eg, NHS Scotland, NHS Wales, and the Health and Social Care (HSC) in Northern Ireland. In addition to the NHS, private-sector health care is also available, sometimes funded by employers through insurance, sometimes through independent hospitals or private businesses, and also via third sector services, such as charities or churches.

The effects of political devolution over the past 10 years have been studied extensively.^{1,2} England has chosen a target-driven, performance management route with financial incentives, as compared to the more cooperative role of health care in Scotland. Wales are seen as promoting localism and public health, and 'permissive managerialism' describes the dogma of the Northern Ireland health system.

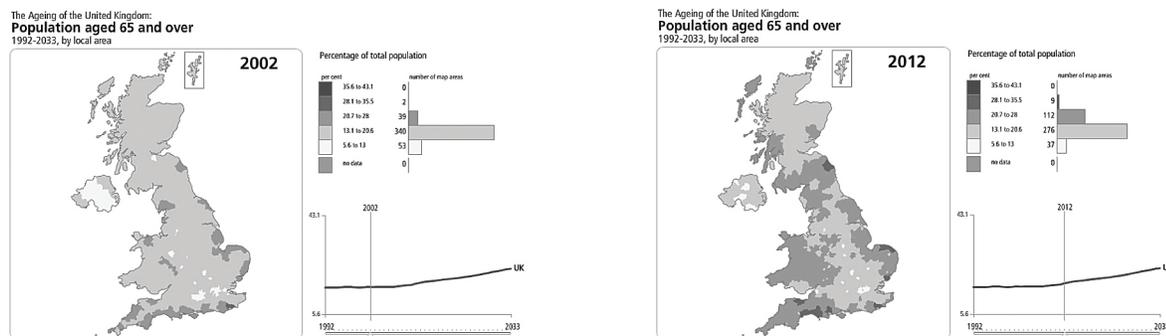
Although health care policies diverge significantly according to population needs, Smith and Hellowell³ maintain that public health policies have remained remarkably similar since devolution. They suggest that, despite 'differences in policy rhetoric,' the approaches to both health care provision and tackling public health problems remain similar across the UK nations, and that given the common economic challenges, it is likely that similarities in health care provision will remain more pronounced than differences.

The main criticism about the health services is the inability to compare data due to differing targets and measures.² The trend is that NHS England spends less on health care with fewer doctors, nurses, and managers per head of population than the devolved country health services, yet the targets demonstrate better use of the resources in delivering activity, staff productivity, and lower waiting times, noting the existence of regional differences.

Although the differences between systems make statistical comparisons difficult, the freedom of each administration to govern their own needs has provided opportunities for divergence in health provision. The physiotherapy profession has witnessed the rise in professional autonomy and the evolution of clinical leadership, such as Clinical Specialists and Consultant Physiotherapy roles, in addition to the management posts in the last decade.

HEALTH POLICY FOR THE OLDER POPULATION

UK Healthcare policy is in the process of advancement from a patriarchal, medical-model of treating 'illness' towards a model of maintaining and promoting health through the intervention of multiple professions. In 2001, a seminal document—the *National Service Framework (NSF) for Older People*⁴—was published by the Department of Health,



Growth of people aged 65 and over across the UK for 2002 (Figure 1) and 2012 (Figure 2).

with an emphasis on rooting out ageism in health care, and on integration of health and social services. The rising proportion of our older population is being charted (Figures 1 and 2) with a resultant impact on Health and Social Care resources, and with new policy including age-specific information where appropriate. There is also an emphasis on consulting the public about their needs prior to policy being finalised at Government level.

In addition to hospital geriatric ward and community work, two specific service areas developed after the publication of the *NSF Older People* document, resulting in the expansion of roles for physiotherapists. The first service area, Intermediate Care, is an integrated Social Care and Health provision with an emphasis on rehabilitation, providing a spectrum of work settings from health-led hospital based rehabilitation to the Social Service Care Home environment, with provision from visiting therapists to provide rehabilitation needs. The second age-specific development was into the area of Falls Prevention, with therapists employed into hospital front-door areas such as Emergency Units to assess and triage the older person according to his or her needs or in outpatient settings providing interdisciplinary multifactorial interventions to reduce falls and their resource-intensive consequences. Both of these areas have again resulted in the development of clinical leadership roles for physiotherapists working with older people. These roles can include an extension of scope beyond the core areas of accepted physiotherapy education, if the therapist takes additional training to gain the necessary qualifications. Such areas of extension include injection therapy, acupuncture, and the prescribing of medications. As these extended scope roles become commonplace, they begin to be accepted as normal practice.

THE ROLE OF THE PROFESSIONAL GOVERNING BODIES

The Chartered Society of Physiotherapy (CSP)

This is a member-led professional, educational, and trade union body for member physiotherapists, physiotherapy students, and assistants. The CSP aims to support its members and help them

to provide high standards of patient care. The CSP professional network for physiotherapists who work with older people is called AGILE, offering educational material and conferences, setting standards and moderating an interactive site specifically to help in the networking of like-minded therapists.

The Health Professions Council (HPC)

This is a regulatory body set up to protect the public by ensuring that its members maintain a professional standard. The HPC grants members a license to practice upon demonstration that they meet the HPC standards of training, professional skills, behavior, and health. The HPC currently regulates 13 health professions, all of which have a professional title that is protected by law. This means that anyone using the title 'physiotherapist' must be registered with the Council.

Physiotherapy Education

Physiotherapy in the UK is a regulated profession with one minimum standard of qualifying education for entry into the profession. Those who are assessed as having reached that standard are granted registration and a legal license to practice physiotherapy in the UK.

Students study on a 3- or 4-year course to qualify with a Bachelor's Degree in Physiotherapy or obtain a pre-registration MSc over 2 years. All courses are now provided through universities that advocate an academic ethos of a critical approach that promotes independent thinking and autonomous clinical practice. An issue with such undergraduate courses in terms of physiotherapy with the older population is that few provide specific older adult training as part of the curriculum; education about this age group is subsumed into condition-specific lectures. Given the rising older population and the bio-psychosocial complexities they present with, there is concern about the adequacy of this training in preparing newly qualified physiotherapists to manage all aspects of their care in a holistic manner.

PHYSIOTHERAPY PROVISION FOR THE OLDER ADULTS

In 1995, Pickles et al⁷ wrote that:

"Working with older people can present the physiotherapist with a

set of challenges unparalleled in other areas of practice. The caseload is very mixed; patients with musculoskeletal, neurological, and cardiovascular problems may all be found in a single caseload and often in the same patient. Interlinking between medical, psychological, rehabilitative, economic and social problems that all need attention is the norm, rather than the exception. Add to these the differences in presentation of disease, the unique pattern of ageing in each individual, and the varying responses that older people may demonstrate, and the complexity of the challenge is obvious."

This is still the case today with the physiotherapist expected to demonstrate clinical quality through evidence-based practice, and proof of efficient service delivery.

The main environments identified that physiotherapists work are:

- Health promotion and disability prevention programmes. For example, lecturing to groups of people at public meetings, or to people with a specific condition, eg, stroke or osteoporosis; running regular exercise classes, eg, fitness to music.
- In hospital—on the general wards or on a specialised unit for ill older people or for those undergoing rehabilitation.
- Day Assessment and Rehabilitation Units—where individuals classically require input from more than one profession and spend a day in a centre where rehabilitation is provided.
- Community—a term that includes settings such as community physiotherapy in a person's own home or at the GP clinic, regional and local outreach services, often for specific conditions, eg, neurological or respiratory conditions.
- Intermediate care, with the provision of jointly funded health and social services set up through an MDT for an average of 2–6 weeks to prevent (re)admission of older people into hospital.
- Community Rehabilitation Teams, with a longer remit of up to 12 weeks, historically funded to promote the early discharge of people post-stroke, but who now take those with or-

thopaedic and general rehabilitation needs.

- Physiotherapists on mental health teams, who can be called upon for specialist advice.
- In research institutes looking into age-related conditions and issues.
- Linked to a higher education institute⁶.

Where assessment of older people differs from that of younger people is in taking into account the differences in the body that occur with age. It is advocated that assessments and principles of therapy with older people follow suggested national protocols and guidance.⁷ AGILE have also reviewed the CSP's Core Standards, identifying which core standards and service standards have key additional areas of relevance to therapists working with older people.⁸

CONCLUSION

In the UK, physiotherapists who work with the older age group are a recognised specialism within the profession and across health care in general.

Although policy and health services are under a constant flux, especially over the coming few years following governmental changes and with our challenging economic climate, AGILE aims to be at the forefront of education and policy decisions where the older population are concerned.

For more information about AGILE, please visit: <http://agile.csp.org.uk/>

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PHYSICAL THERAPY FOR OLDER PEOPLE IN ICELAND

Thorunn Björnsdóttir, BA, BSHon's PT, MALS, BAHon's painting

Geriatrics came into being in Iceland in the 1980s and 1990s, when the first divisions of Geriatrics were established at Reykjavik hospitals. At this time, comprehensive geriatric assessment became the cornerstone of treatment, with teamwork of 5 health care professionals, ie, physicians, nurses, physical and occupational therapists, and social workers.

Physical therapists are integral participants of all geriatric work, be it in acute or post-acute care, with the most intensive work in the latter setting. The work has been extended into outpatient evaluation within a falls clinic but also into inpatient dementia units at the National University Hospital in Reykjavik. Subsequently, physical therapists have entered the scene in nursing homes, and home physical therapy for older people is now increasing. Additionally, the well

older people seek physical therapy in many private practices.

There is a course on geriatric physical therapy within the University training program for physical therapists to a BS (Hon's) degree. Several physical therapists have sought higher degrees in geriatric PT, such as master's degrees and PhDs.

The Icelandic Society of Physical Therapists working with Older People (ISPTOP) was established in 1996, originally a grass roots movement, aimed at networking nationally and internationally. The ISPTOP has a robust educational program during winter months and affects policy matters at the national level. The society has also facilitated the making of special DVD teaching programs on dementia and balance evaluation and treatment.

Currently, the ISPTOP is participating in two projects. The first is a program encouraging walking and physical activity outdoors with walking paths and benches. The other is working with the Directorate of Health on defining appropriate physical therapy standards in nursing homes and its documentation according to InterRAI NH assessment (see www.InterRAI.org). ISPTOP can be contacted through the Icelandic PT Society (see www.physio.is).

Overall, good progress has been made but more is needed both to extend coverage of services but also to meet increasing needs of old people so that they not only live longer but better.

GERIATRIC CARE AND GERIATRIC PHYSICAL THERAPY IN TURKEY

Prof. Dr. Filiz Can, PT, PhD, General Secretary, Turkish Geriatric Physiotherapy Association

PROFILE OF GERIATRIC POPULATION

Turkey is a country in Europe that has been considered as a ‘young country,’ with the population consisting of mostly young people (50% of the population is younger than 25 years). However, calculations based on the assumption that current demographic trends will continue signify that the 21st century will also be a century of aging in Turkey. It has been predicted that Turkey is going to become the second fastest aging country in the world within the next 25 years.

Following recent statistical analysis, the population of Turkey is almost 75 million and will be 88.7 million in 2050. According to the Turkish Statistical Institute projections in 2010, the percentage of older people aged 65 year and over has reached 7% of total population. The predicted rate of older people aged 65 years and over will be 9.7% of the overall population

in 2025; this rate will be up to 19% by 2050 (Graph 1). The percentage of the elderly population is 6% in urban areas, whereas it is 9% in rural areas. The main reason for this difference is migration of the young population to urban areas from the rural areas.

The elderly population counted as 4.5 million is going to be up 5.5 million in 2015, and will reach 8 million in 2025. It is foreseen that Turkey will have an elderly population of approximately 16 million in 2050. This means the number of older people is going to increase 125% within coming 25 years. Therefore 6.6 million older people are going to need daily care by care givers and/or medical staff.

Graph 1 shows percentage distributions of age groups by census years.

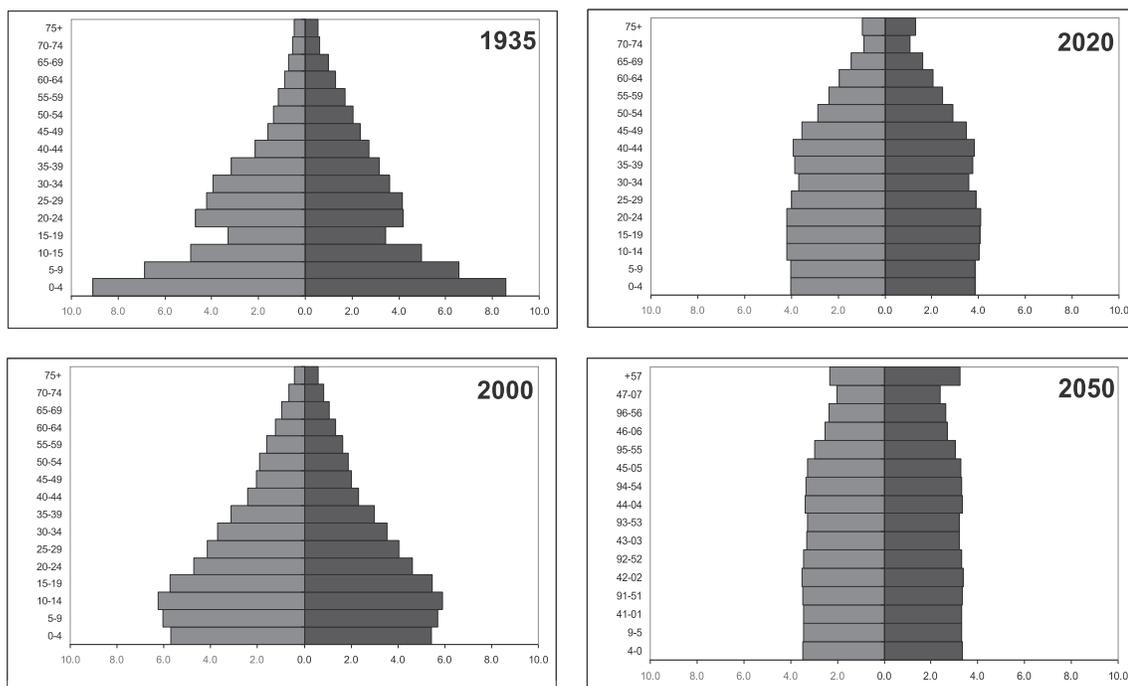
The total population is almost 75 million people and 7% of them can be classified as older people 65 years of age and over. The average birth rate is 18.3% and the aging population rate is

0.30. Beginning from 1990, a decline in ratio of gradual increase in population has begun. On the contrary, the rate of older people has increased.

Life expectancy at birth was 66 years old in 1990, increasing to 71.3 by 2006. Women have longer average life spans compared to men in Turkey, just as in the whole world. Life expectancy at birth was forecasted as 68.5 for men, and 73.3 for women, for the 2000-2005 period, and 69.1 years for men and 73.8 years for women in 2007. This difference of approximately 5 years results in a higher share of women among the overall elderly population.

On the other hand, the percentage difference between the 0-14 age group and the elderly group seems to fade around the middle of the century. The infant death rate, which was forecasted to be over 230 per thousand, declined to as low as 29 per thousand by 2000 as a result of the advancements in the maternity and child health.

Graph 1. Rate of age groups by census years and Turkish Statistical Institute population projection



Life expectancy has recorded a significant increase at all age groups as a result of the advancement of health care in Turkey. However, it is expected that together with changing age structure, the number of older people will increase and give some problems on social, demographic and economic aspects, especially in the second half of the century. There are 1.5 million people who have more than one chronic disease among elderly population. Almost 400,000 people suffer from dementia.

Regarding marital status, 86% of men are currently married, while the ratio is only 45% for women. In almost all societies, the probability of a man getting remarried when he loses his spouse is higher than that for a woman. While 53% women continue their lives as widowers, the percentage for men is 14%. The fact that the attachment between family members is still strong in Turkey arises as a distinction compared to especially developed countries. Survey results indicate that 7 out of every 10 elderly persons live in the same house, building, street, or neighborhood with their children. While no major distinction exists between genders in this respect, it is evident that the general tendency is to live with the children or very close to them. It may be considered that such preference would be quite advantageous socially and economically both for the older people and their children.

Entitlement of the elderly persons of some income becomes important in terms of economic sustainability of his or her living. Survey results indicate that 56% of the elderly population is entitled for some kind of income. However, there are significant differences between the male and female elderly population in terms of being entitled to income. While 75% of men are entitled for an income, the percentage drops down to 38% for women. Looking at the analysis on the source of income, 46% of elderly men cited their pension, while other sources cited were old-age pension and rental/interest income. Only 10% of elderly men are working. While only 6% of elderly women are entitled for pension of their own, the percentage of women who cited indirect pension as their source of income is 16%, and only 1% are still working.

LEGAL STATUS

In 1930, following the proclamation of the Turkish Republic and the imposi-

tion of the liability to protect dependent and elderly people, including building and managing homes for them, boarding homes were opened by municipalities and designated as almshouses or rest homes for the elderly, helpless people, and the poor. Various associations, minorities, and other persons have also established such facilities to offer services to elderly people. The Directorate General of Social Services was established in 1963 with the purpose of organizing all kinds of social security for poor people who are unable to work.

Article 61 of the 1982 Constitution has clearly defined the subgroups that fall into scope of Social Services, prioritizing children and disabled and elderly people who need protection, care, assistance, and rehabilitation. It issued the provision for the establishment by the state of organizations and facilities required in this respect. Upon adoption of Social Services and Child Protection Agency Law (1983), the principle of integrating social service activities under the inspection and the supervision of the state, also ensuring volunteer contributions and participation on the part of public has been taken up. Thus, the Social Services and Child Protection Agency (SHCEK) has assumed the duty of planning, managing, and controlling at local and national levels the entire systemized and programmed services with the aim of meeting the needs of specific requirement groups (family, child, disabled persons, dependent elderly, poor people, and others) who suffer from economic and social deprivation, assisting in preventing and resolving of various problems and improving their life standards. Directorate General for the Social Services and Child Protection Agency assigned with "detection, protection, care, bringing up and rehabilitation of children and disabled and elderly people who are in need of protection, care and assistance," has offered social services to older people through "Rest Homes and Care and Rehabilitation Centers for Elderly People." These social services consist of the entire systemized and programmed services designed for the elimination of physical, psychological, and social deprivations arising from the inherent and environmental conditions of the individuals and their families. The Social Services and Child Protection Agency Division on Services

for Older People has established a special law assigned with the following duties and functions:

- Arranging, monitoring, coordinating, and controlling the services pertaining to detection, caring for the protection of the older people who suffer from social and economic deprivation.
- Planning, implementing and monitoring, and coordinating the performance of activities pertaining to establish of rest homes for elderly people and other social services facilities with similar qualities in a balanced manner across the country and on the basis of requirements and their dissemination within the framework of a program.
- Organizing and ensuring the performance of the activities pertaining to protection of the elderly people in the society.
- Setting the principles, providing guidance, monitoring the implementation, coordinating and controlling of the establishment, performance and inspection the organizations to be established by public institutions, real persons, and corporate bodies for the elderly people.

The Directorate of Disabled People was established in 1997 to support the new policies and some reforms for disabled people, including older people. Regulation for private rest homes and nursing homes was introduced in 1997. Within the framework of the Law on Disabled People that come into force in 2005, provisions pertaining to older people concerning preparation of programs for early diagnosis, assessment, and treatment of disabilities of elderly people were included and the name of Division on Services for Elderly People (since changed to Division on Care Services for the Elderly People).

Although the Social Services and Child Protection Agency was previously the main organization for older people, both organizations have been working with cooperation for dependent or disabled older people. According to the new regulations at the end of 2011, the Social Services and Child Protection Agency and the Directorate of Disabled People have been taken together and established a new directorate, the Directorate of Elderly and Disabled People, which has 3 main divisions: family, children, and elderly and disabled people. This directorate has been covered by a

newly established ministry that is called Ministry of Family and Social Policies. The mission of the directorate is to have a reform package and provide new policies and regulations for older people. Thus, there is a new action plan that has been carrying out its work via meetings with the members of the core group who were selected from governmental and nongovernmental departments, civic organizations, and the universities.

INSURANCE/ SOCIAL SECURITY

As the Republic of Turkey is a social state, social insurance or social security covered by Government has been regulated and specified for the older people, as well as for all citizens, in 1982. With a new regulation in the governmental insurance system in 2006, three different governmental organizations, including home care services, were gathered under the same umbrella into one general system.

It was established that elderly people should be included in the Governmental Insurance System, due to changing social condition and the need for protection against financial risks, and that monthly income and health care assistance should be provided to the elderly people and their dependents. Individuals who have been insured for a minimum of 25 years, and who are 58 years old (for women) and 60 years (for men) become entitled to pension. Beginning from March 1997, older people who are 65 years old or over, in a dependent capacity (no relatives and no financial income) have become entitled for pension regardless of whether they have worked or been insured before. According to 2012 statistics, 265,635 older men and 510,169 older women are receiving a pension from the government. Private insurance systems are not very common in Turkey. There are 1.5 million people who have private health insurance.

CARE MODELS

Regarding the predicted statistics, geriatrics and geriatric health care would seem to be important focuses for the future in Turkey, as well as for other countries, especially European countries. Thus, the Ministry of Health and Ministry of Family and Social Policies are working on new regulations and reforms for the health care and health promotion of older people, since both ministries are in charge of geriatric care and policies.

There are 24 geriatric departments

in governmental hospitals, in addition to those in the university hospitals and private hospitals all over Turkey. According to the General Health Laws, Ministry of Health has a service for the older people. A department of Noninfectious and Chronic Diseases for older people has also been established in the Health Ministry, since there are 1.5 million older people who suffer from more than one chronic disease. There are almost 400,000 people who are suffering from dementia. Municipalities are also responsible for providing services for geriatric care, such as home help services/ service flats, day care centers, and community based care.

The Turkish Ministry of Family and Social Policies has got a strategic action plan for the period of 2010-2014 that is focused on 3 main themes:

1. promoting health and prevention,
2. home care, and
3. institutionalized care with higher standards and qualified staff.

Laws for the older people (established in 1982 and regulated many times, most recently in 2011) state that the autonomy and rights of the elderly will be respected. It is basic policy that the elderly people who are able to stay in their home should remain there for as long as possible. To help make this possible, a variety of subsidised services are provided for elderly citizens, tailored to the needs of each individual. According to the new regulations and current laws on disabled and elderly people, geriatric care can be given in various care models:

- Rest homes
- Nursing homes
- Rehabilitation centers
- Home care services
- Home help services/service flats
- Day care centers
- Community based care

According to the statistics, there are 9.5 million younger aged people, ages 55-65 years old, 4.5 million older people between 65 and 85 years old, and 0.5 million frail elderly people older than 85 years old, in Turkey. After the calculation for percentage of care for older people using formulae (0.1%), the results shows that 25,000 older people in Turkey needed to have institutionalized care or home care. This means, we need more development in geriatric care either institutionalized or home-based care.

Rest homes: There are both governmental and private rest homes. Recently, the ministry has made a regulation for establishing private rest homes, because there were various systems without standardization. Establishments offering the services of private rest homes for elderly people can be divided into 3 categories:

- establishment of associations or foundations,
- establishment minorities, and
- establishment of real person.

Nursing homes: As a total, there are 289 nursing homes in Turkey, and they are giving care services for 23,499 older people (2012 statistics). Ministry of Family and Social Policies has 102 nursing homes. Other ministries also have 6 nursing homes. Twenty services belong to municipalities, 34 institutes belong to civic organizations and foundations, and 7 of them belong to some ethnic groups. Private sector has 120 private nursing homes.

The numbers of older persons who are staying in nursing homes are detailed below:

Admission to nursing homes is acceptable for the elder people who have no economic or social support, require no long-term intensive medical care and treatment, are capable to perform activi-

Organizations	Number of Nursing Homes	Number of Persons
Ministry of family & social policies	102	9,608
Civic organizations & foundations	34	2,459
Ethnic groups	7	961
Private sector	120	5,698
Other ministries	6	2,442
Municipalities	20	2,039
TOTAL	289	23,499

ties of daily living and self-care, and have no mental illness or Alzheimer disease.

Preadmission baseline assessment by physiotherapist is not mandatory. There is no national standardized aged care assessment and aged care team yet. The assessment performed by physicians is based on evaluation of the physical, mental, and functional state of the applicant. It has not developed a valid and reliable clinical assessment method that identifies relative risk for falls or other risk factors yet.

Rehabilitation centers: Currently, there are 91 governmental rehabilitation centers for both disabled people and older patients; 21 are exclusively for older people. Seventy-eight rehabilitation centers are boarding centers, like rehabilitation hospitals, where the older people can stay overnight. Seven centers provide rehabilitation services daily for outpatient patients.

Home care: Legislation about the home care system and home visits program for geriatric patients was established in 2005 and was developed via council meetings of members of governmental and nongovernmental departments, civic organizations, and universities, during 2007 and 2009. Then, in 2010, the home care system began operation, and has been serving some pilot areas.

Currently, 538 home care teams, 105 mobile health teams, and 72 dentist teams are available. Home care teams belonging to the Health Ministry and Family and Social Policies Ministry have made 145,566 visits to 93,791 disabled and older clients. There are also 20 private companies that give home care services in 5 big cities of Turkey.

Municipalities are also in charge of home care services. Therefore, some municipal officers are giving home care services, including social care (especially services for day care, social care, social and cultural activities), assistance, and support. As an example, Ankara metropolitan municipality has given home care services for 29,444 persons since the acceptance of the home care regulation (Reports from 2010).

Health Ministry and Family and Social Policies Ministry are still working to develop new constitutions and regulation for home care services, collaborating with some governmental and nongovernmental organizations, univer-

sities, and civic organizations.

After the new regulations, home health care services included the home services below:

- Home care
- Social care
- Psychological support
- Social and cultural activities
- Home help services/service flats
- Care management, counseling, and assistance services

Home Help Services/Service Flats: Beginning in 2010, there were home help services in some pilot cities or regions, but not all provide all services yet. Very few private nonstandardized organizations or clinics provide some kind of personal and medical care yet. Home help services, such as housework, personal care (eg, bathing, dressing), nursing, administering of medication, and physiotherapy may be offered, depending upon the needs of the individuals.

Day Care: There are 5-day care centers belonging to municipals that provide for rehabilitation, basic medical care, recreational and social activities of the older people. They also give psychological counseling and guidance for some tasks. Older people can go there 5 times a week or per diem for all-day care with meals.

Community centers: These centers offer recreational and social activities, including handicrafts, some games, and other recreations. Hot meals are available. These centers are open for a wider age group. It is valuable for the social interaction and psychological support. Municipals are in charge of community center services. Six community centers or senior citizens centers have been regulated since 2009, and are giving social services to 951 persons in Turkey.

TURKISH GERIATRIC PHYSIOTHERAPY ASSOCIATION

The Turkish Geriatric Physiotherapy Association (TGPA) was established in November 2002 with 25 members. At present, there are 55 members working in university hospitals, government hospitals, nursing homes, clinics, and rehabilitation centers for the elder people.

According to the statistical analysis of Social Services and Child Protection Agency (2007), 135 physical therapists are working with older people in governmental organizations and services. There are also physical therapists work-

ing with older people in the private sector, but still very few. After establishing a new system for older people in Turkey, the importance of physical therapy and requirements of physical therapists for older people have been understood more by the governmental organizations and by the private sector. This is particularly true in the home care system. Thus, TGPA has aimed to introduce our profession to the governmental departments, policy makers, and private sectors that are working with older people. Another mission of the TGPA is to provide close collaboration with the other health professionals, both as interdisciplinary cooperation and with the other physical therapy specialists as intradisciplinary cooperation. This collaboration will enrich our skills and competence in our profession, give us an open minded concept of geriatric care, and make us more powerful to the governmental organization, policy makers, and private sector.

Our executives include the members who are specialists in various aspects of physiotherapy for older people, such as geriatric orthopedics, geriatric cardiopulmonary, geriatric neurology, prosthetics, etc, who provide interdisciplinary models in physiotherapy for older people, in addition to serving as part of a multidisciplinary team for geriatric care.

The aims of the Association are:

A) Professional:

1. To collaborate with IPTOP and WCPT.
2. To get collaborations with the similar associations and health professionals working for geriatric care.
3. To provide further education, clinical experience, and competence for the physical therapists working with older people within the interdisciplinary system on geriatric care.
4. To promote national and international research and projects.
5. To drive the society to have civic organizations for the older people.
6. To give propositions or to collaborate with the government or governmental organizations for developing new policies and regulations for the elderly.
7. To develop special (valid and reliable) assessment tools and to propose using national standard-

ized aged care assessment.

8. To design risk factors intervention program.
9. To design a model approach for rehabilitation for the elderly.

B) Social:

1. Give information and educate the community about geriatrics and aging.
2. Give stimulation to the people for preventive rehabilitation or exercises with anti-aging program.
3. Give some remarks to community, civil organizations, media, politicians, and government for establishing new concepts and organizations for the elderly, as well as about the normal aging process.

The TGPA has achieved much since it was established in 2002. Although it does not have many members, Turkish Association has done many things in many aspects, such as organizing congresses, being permanent members in core groups of the governmental councils related with geriatric care, having an active role for the new policies or regulation of the health care system, educating colleagues about the normal aging process, geriatric care and rehabilitation, encouraging colleagues to do research and to participate in congresses, stimulating the individuals for active aging, and collaborating with the other health professionals for older people.

The TGPA has organized 3 congresses, two national with international participants, and one International Congress (IPTOP congress). The third Congress of the International Association for Physical Therapists working with Older People (IPTOP) was held in Istanbul in 2006, with more than 400 participants. The congress has included every aspect of Geriatric, Gerontology, Geriatric Rehabilitation, and social policies of older people in Turkey. The program has run with 3 parallel sessions, with 3 main themes and many national and international speakers in the panels and the platform presentations. Our association has become a supportive organization in many congresses related with geriatrics. Collaboration with the other associations and health professionals (medical doctors, nurses, social workers, nutrition's vs.) in their meetings and in their congresses has enriched our vision and

made our profession and our association to be well known among the other health professionals. This has been followed by more collaboration and power for stimulating the policy makers and establishing of the new health policies for older people.

The TGPA has also a role to inform about geriatric physical therapy and educate the society on normal aging process, chronic diseases, dysfunctions, prevention of the diseases, and healthy aging. Thus, interviews and talks in some radio and television programs and in the journals have been organized. Additionally, a television program which was 45 minutes a week, with a one-year duration, has been organized with a producer. The schedule and the content of the program have been designed by our association. The program consisted of some presentations about the primary problems of the older people by given various specialists, and some basic exercises and recommendations. The program has been repeated a second year, due to having many requests from the society.

Beginning in February 2012, the Turkish Geriatric Physiotherapy Association has had close collaboration with the Turkish Republic General Directorate of Family and Social Policies, which the Ministry established in late 2011. We have had many councils, workshops, meetings, and discussion platforms with the two main governmental departments as Turkish Republic Prime Ministry Directorate of Disabled People and the Social Services and Child Protection Agency Division on Services for Older People, and more recently, with the Ministry of Family and Social Policies that resulted from the other two organizations combining in 2011.

Lately TGPA has also worked with the Health Ministry Department of Health Tourism for establishing the regulation of Health Tourism of older people, and also for pointing out the problems and difficulties experienced by older adults during travel/

Some activities of Turkish Geriatric Physiotherapy Association can be seen below.

ACTIVITIES OF TURKISH GERIATRIC PHYSIOTHERAPY ASSOCIATION:

Congress Organization:

1. 1st National Geriatric Physiotherapy

Congress with International Participants, Balçova Thermal Hotel, Izmir, 23-September, 2005.

2. 3rd IPTOP Congress (affiliated by WCPT) 3-5 November, 2006.
3. II. National Geriatric Physiotherapy Congress with International Participants (in conjunction with IPTOP), Turkish Geriatric Physiotherapy Association, Hacettepe University School of Physiotherapy, 11-13 November, 2009--Ankara.
4. Organizing Joint Congress with Ministry on 3rd National Geriatric Physiotherapy Congress with international participants "Health Tourism and Rehabilitation for Elderly," 7-9 November, 2012--Izmir (upcoming Congress)

Supported Organization for Congress:

1. 1st National Physiotherapy and Rehabilitation Congress, Hacettepe University, Ankara, -May 2007.
2. Symposium on Aging and Community Participation, The Prime Ministry Project Group for Increasing Quality of Health in Older People, 14 February, 2007.
3. Academic Geriatric Congress, 20-24 May, 2009--Antalya.
4. Academic Geriatric Congress, 26-30 May, 2010--Cyprus.
5. Academic Geriatric Congress, 23-27 May, 2011--Antalya.

Council Participation:

1. "National Action Plan for the Elder People" in state Planning Organization is to establish as a new project based on international laws and conjunctures of Europe for elderly citizens, Aging 2002-International Action Plan, April 2004-December 2005.
2. 3rd Council of Disabled People "Health Care," Turkish Republic of Turkey Prime Ministry Administration for Disabled People, 19-23 November, 2007--Istanbul.
3. 3rd Council of Disabled People "Health Care, Action Planning Meeting," Turkish Republic of Turkey Prime Ministry Administration for Disabled People, 16-17 June, 2008--Ankara.
4. Turkey-Netherlands Coloration Meeting "Health and Social Care," Turkey-Netherlands Health Foundation, Catamont Governorship, Kastamonu University, 11-12 June, 2008--Kastamonu.

5. V. Family Council, Prime Ministry of Turkish Republic General Directorate of Family and Social Research, 5-7 November, 2008--Ankara.
6. Council: "The Situation of Elderly People in Turkey and National Plan of Action on Ageing," Turkish Republic Social Services and Child Protection Agency, 17-18 December, 2008--Ankara.
7. 1st Activity of Geriatric Platform, 7 February, 2009--Izmir.
8. 2nd Activity of Geriatric Platform, 22 April, 2009--Anadolu University, Eskişehir.
9. 3rd Activity of Geriatric Platform, 15 May, 2009--İstanbul.
10. Geriatrics in Yesterday, Today and Tomorrow, Activity of Geriatric Platform, 20 March, 2009--Ankara.
11. Council of Home Care Model and Multidisciplinary Team Members Education for Geriatric Patients, Projects of Turkish Ministry State Planning Organization, June 2006-2010--İstanbul.
12. Geriatric Platform Workshop, Preliminary Commission Meeting, 19 March, 2010--Ankara.
13. Home Care Core Group Council Meeting, 8-9 April, 2010--Ankara.
14. Workshop for Guideline of Care Giver for Older People, Commission of Home Care, Turkish Republic of Health Ministry, 27-29 April, 2010--Ankara.
15. Geriatric Platform Workshop, 16-17 June, 2010--Ankara.
16. Geriatric Platform Meetings Turkish Health Ministry National Council for "Development of Health Policies for the Older People," 7-8 June, 2011.
17. Turkish Health Ministry National Council for "Home care for the patients with pulmonary diseases: Turkish program for prevention and control of chronic obstructive disease," 24-26 June, 2011--Ankara.
18. Meeting for Turkish Health Tourism Council, 15 December, 2011--Ankara.
19. Core Group Round Table, "Care Services models and Policies for older people: planning of 2012, 2015 and 2025," The Ministry of Family and Social Policies, 19 January, 2012 75.Yıl Rest Home and Nursing Home Complex, Ankara.
20. Meeting "Health Tourism for Ankara," 10 April, 2012--Hekimevi, Ankara.

Publications:

1. "The Situation Elderly People in Turkey and the National Plan of Action on Ageing, Undersecretaries of State Planning Organization" (Editors: Kırdı N, Can F, Karaduman A) November 2006.
2. "Geriatrics in Yesterday, Today and Tomorrow," Publication of Geriatric Platform, 1 March 2009, Ankara.
3. "Final Report of Workshop on Elderly Platform," 2010.
4. "Home care for the patients with pulmonary diseases: Turkish program for prevention and control of chronic obstructive disease," Report Book, Anil Publication, Kızılay, Ankara, June 2011.

Conference/Lecture as Continuing Education Program:

1. Educational courses for the staff: "Fractures in the Older People" and "General Principles of Geriatric Rehabilitation," 2002, Seyranbağları Nursing Home, Ankara.
2. Conference: "Environmental Designing in Nursing Homes," 25-26 September 2006, Afyon.
3. Educational courses for the staff: "Active Aging" and "Orthopedic Problems Seen in Older People," 6 December 2006, Süleyman Demirel Nursing Home, Ankara.
4. Conference: "Introducing Turkish Geriatric Physical Therapy Association: Background and Establishment," 16 May 2007, Dokuz Eylül University, Izmir.
5. Conference: "Matrix Rhythmus Therapie," (Dr. Ulrich Randall), 12 December 2007, Hacettepe University Congress Center, Ankara.
6. Conference: "Introducing IPTOP and its Mission, Aging World and Health Care, Geriatric Care in Turkey," 19 February 2008, Abant İzzet Baysal University, Kemal Demir School of Physical Therapy, Bolu.
7. Conference: "Principles of Geriatric Rehabilitation," Postgraduate Education Program, Gazi University School of Physical Therapy, 31 March 2010, Ankara.
8. Conference: "Geriatric Care and Introducing of National and International Associations (IPTOP)," 2011, Bilim University, School of Physical Therapy & Rehabilitation, Istanbul.

Education for the Society:

1. Speech in radio program, "Musculoskeletal problems and aging in metropolis," Turkish Radio Television, 2 February, 2010.
2. Speech in radio program, "Active aging and geriatric rehabilitation," Turkish Radio Television, 16 February, 2010.
3. Speech in television program, "Life in big metropolis and aging," Turkish Radio Television, Türk TV, 29 March, 2010.
4. Advisor and program planner: "Mavi," a television program on elderly and problems in older people and healthy aging, (45min/once in a week/ a total of 12 program).

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INTERNATIONAL PHYSICAL THERAPY CONFERENCE SUCCESSFUL AGING: MEN'S AND WOMEN'S HEALTH ISSUES ACROSS THE LIFECYCLE

Plans are being made for our next biannual IPTOP Conference in **Boston, Massachusetts – USA for April 26, 27 & 28, 2013**. I have been working with Rebecca Stephenson, President of the subgroup IOPTWH (International Organization of Physical Therapists in Women's Health) and we are planning a joint conference of IPTOP with IOPTWH in Boston, Massachusetts.

Preliminary plans include an evening reception and registration on Friday night April 26 and the full conference programming to begin on Saturday April 27 and continue through Sunday April 28. The full details of the programming will be posted on the IPTOP Web site (go to link to our site at www.wcpt.org/iptop) as this conference has the foundation in place, such as location, evening venues, and course content--and continues to evolve as the specifics are put in place. To give you an idea of the range of topics that will be presented--the focus is on aging across the life span for women and men. Specific topics include: osteoporosis, communication skills for the therapist working with dementia, nutrition and exercise across the life cycle, sexual function and aging, incontinence and its implications in aging, breast cancer (in women and men), and the role of the health promotion--active aging and prevention of disease and disability.

INTERNATIONAL PHYSICAL THERAPY CONFERENCE Successful Aging: Men's and Women's Health Issues Across the Lifecycle

Friday April 26, 2013

9:00 – 12:00	IOPTWH and IPTOP Board Meetings 3 hours at the hotels
6:00 – 9:00	Check in at Conference Center (JSM Conf. Ctr @ Harvard)
6:00 - 7:00	Reception Cocktails
7:00 - 8:00	Speaker Paula Johnson [RGS]
8:00 - 10:00	Exhibits/Vendors - Reception

Saturday April 27, 2013

8:00 – 8:30	Registration at JSM-CC & Continental Breakfast
8:30 - 8:45	Opening; Rebecca Stephenson – President, IOPTWH Jennifer M Bottomley – President, IPTOP Anne Hartstein – Secretary of Elder Affairs, State of Massachusetts
8:45 - 9:45	WCPT President Opening Remarks- Marilyn Moffat Overview of Aging Across the Life Cycle

9:45 – 11:00	Osteoporosis - Meena Sran
11:00-11:15	Morning Break
11:15-12:15	Communications Skills with Cognitive Changes Associated with Aging –Jennifer Bottomley
12:15 - 1:15	LUNCH at Conference Center/Dessert with Vendors
1:15 - 3:15	Incontinence and Pelvic Organ Prolapse: Implications Across the Life Cycle - Meghan Markowski
3:15 - 3:30	Exhibit/Vendor Break
3:30 - 4:30	IPTOP Member Meeting
3:30 - 4:30	IOPTWH Lecture [To Be Determined]
4:30	End of programming
5:30	Evening Gathering for Cocktails
6:30 - 8:00	Dinner & Guest Speaker
8:00 – 11:00	Networking & Dancing

Sunday April 28, 2013

8:30 – 9:00	Continental Breakfast
9:00 - 10:00	Nutrition and Exercise Across the Life Cycle - Bhanu Ramaswamy
10:00 – 11:00	Urogyn Surgeries - Neeraj Kohli
11:00-11:15	Morning Break
11:15 - 12:00	Sexual Changes Across the Life Cycle
12:00 - 1:00	Lunch @ Conference Center/Dessert with Vendors
1:00 - 3:00	Active Aging - Marilyn Moffat
3:00 - 3:15	Afternoon Break with Vendors
3:15 - 4:45	Breast Cancer - Nancy Roberge
4:45	Conference Closing Jennifer and Rebecca

Conference Location:

The Joseph S Martin Conference Center @ Harvard Medical School -
www.theconfcenter.HMS.Harvard.edu - Virtual Tour available
 77 Avenue Louis Pasteur, NRB Room 133 - Boston, MA 02115

The conference brochure is scheduled to be published in July 2012 – just about the time that you are receiving the special Internationally Focused *GeriNotes* issue... and the information published in this flier will also go out to the IOPTWH, IPTOP, WCPT, APTA, and SOG Web sites. In brief: the conference will be for 200 – 250 physical therapists from around the world--so mark your calendars and register early. We will be providing information on things to do in and around the Boston area for you and your family. Travel plans might include extra time to enjoy the sights of Boston, one of the most historical cities in the US... So make your plans, book your flights, and come to Boston for the combined IPTOP/IOPTWH Conference. The conference hotels are the Longwood Inn and Holiday Inn, located within walking distance to the Conference Center. We will send out a blast E-mail to all Section members, country delegates and friends once the plans are finalized with registration forms and hotel information. I look forward to seeing you in Boston.

Respectfully,
Jennifer M Bottomley, President IPTOP
www.president@iptop.org

THE DUTCH GERIATRIC PHYSICAL THERAPIST: THE SPECIALIST IN PHYSIOTHERAPEUTIC REHABILITATION AND TREATMENT FOR THE FRAIL ELDERLY POPULATION

Hans Hobbelen, PT, PhD

INTRODUCTION

The Netherlands is a small (33751 km²) yet densely populated (16.5 million inhabitants) European country. Dutch society is rapidly changing. Over the next 10 years, an increase of 55% is estimated in the 65+ age group. This increase goes hand in hand with a surge of frailty amongst the elderly population and an accumulation of chronic and complex health problems that interfere at all kinds of levels of mobility and function of elderly individuals. The trajectory of health care service for mobility and motor problems of elderly is in most cases starting with a visit to the family doctor, after which a referral towards a private practice physical therapist is written. In the Dutch system, direct access for physical therapy is possible and accounts for over 25% of the intake of patients 60 and over. In the Netherlands, most physical therapists are working in private practices. Besides private practices, they are working in hospitals, rehabilitation centers, or nursing homes. Most private practices are related to, or in close contact with, other health care providers; however, this is mostly limited to the family doctors practice and the nurses of the family doctors practice. In all other settings there is a close multidisciplinary cooperation. Complex and multidisciplinary care for frail elderly is administered at nursing homes, with often very good facilities for physical rehabilitation. In the care for patients with complex health problems in the Netherlands, a shift is visible from institutionalized care in nursing homes towards a more patient centered approach in a home-based environment. This paradigm change provides a great challenge and opportunity for health care professionals, especially for physical therapists.

EDUCATION AND POSITION

The Dutch physical therapist is educated at the bachelor level at universities of applied sciences across the country. After this entry-level educa-

tion, it is possible to specialize and gain a master degree. The geriatric physical therapist is specialized in analyzing complex movement related health problems. For example, identifying how the comorbidities and the system that surrounds the patient, like the relatives and informal care givers as well as the environment, interacts and impacts the patient on their activity and participation level. Furthermore, the geriatric physical therapist has in-depth knowledge of clinical neurology of older patients (ie, Parkinson disease, stroke, dementia) and orthopedic problems. The number of geriatric physical therapists is rising; however, it is still with only 3%, the smallest group within the Dutch association of physical therapists (KNGF).

The Dutch geriatric physical therapists are well organized, with an association (NVFG) under the umbrella of the Dutch association of physical therapists. Although it has only 670 members, the NVFG is one of the most active and visible association of specialized physical therapists in the Netherlands. It has 3 annual congresses, a journal and a monthly newsletter. The board of the association currently has 4 members: President, Marije Lubbers; Secretary, Dineke van Os; Treasurer, Ronald Valk; and Member, Hans Hobbelen.

CARE FOR THE ELDERLY

The physiotherapeutic care for the elderly is often a challenging puzzle, not only due to the complexity of interfering factors, but also due to the multifaceted and multidisciplinary approach.

The geriatric physiotherapist has a range of tools and competences to facilitate the patient in reaching their goals, like coaching and teaching skills to educate the patients, as well as the formal and informal caregivers. For an optimal result, it is essential for the geriatric physiotherapist to have thorough knowledge and awareness of the other allied health professionals involved in the patient care. Furthermore they can play a pivotal and vital role in building

a professional health care team that is focused on the needs and requirements of the patient.

With the expected increase of elderly in the Dutch society, preventive interventions to stay healthy and fit will be an important issue for the future.

The focus of the physiotherapist is on regaining mobility and independence, primarily through task-specific training. It is important to note that the training of elderly persons often yields far better results than generally is expected.

RESEARCH

In the past decade, research in physical therapy has been growing steadily alongside the growing scientific interest in ageing. The combination of physical therapy research and ageing is however still small. A large scientific initiative is the Healthy Ageing Network Northern Netherlands (HANNN), a cooperation between government, knowledge institutions, and business. The University of Applied Sciences Groningen is one of the participants in HANNN and actively involved in practice based and pragmatic research in geriatric physical therapy. Yet also in all other universities of applied sciences in the Netherlands (Leiden, Utrecht, Breda, Heerlen, Eindhoven, Nijmegen, Enschede), research in geriatric rehabilitation is growing. For example, the coach2move project in Nijmegen. The coach2move strategy is a physical therapy approach in the treatment of (pre-) frail older adults suffering from or at risk of mobility problems. This population of older adults often has to deal with complex and multiple problems. The coach2move strategy helps the geriatric physical therapist in clinical reasoning by providing an extensive, pre-structured and systematically organized diagnostic protocol. This results in a goal oriented, tailor made, and efficient physical therapy treatment, in which the patients are actively involved. The NVFG is actively participating in this and other projects in the Netherlands by financial support or by stimulating members to participate in projects if possible.

SPECIALIST GROUP IN GERIATRIC PHYSIOTHERAPY IN SWITZERLAND

G. Gonçalves Mantellini, PT

For the last 17 years, the Specialist Group in Geriatric Physiotherapy has been a constructive and active pillar for the Physical Therapists who work with older people in Switzerland. Thirty-eight physiotherapists founded this Association, which now has about 100 members. Due to difficulties joining the Swiss Association of Physiotherapy, the group became a member of the Swiss Society of Gerontology. This is an interdisciplinary professional organisation and network of people and institutions committed to research into ageing processes and involved in care and practical work relating to old age.

Our main theme is: keep mobile in your work!

The working focus is in some important areas:

- Promotion of physical therapy in gerontologic teams and inversely, raising the awareness of physiotherapists on matters of gerontology.
- Representation of physiotherapy in multidisciplinary teams and in the development of policies on working with the aged.
- Promotion of contact among specialists who work with older people.

The specific activities, based on the aims above, are regular courses, an informative newsletter, divers support for those specialists seeking to promote a high quality of service in physiotherapy, and the development of documents to be used in practice.

The *New Professional Profile of Physical Therapists Working with Older People* offers important information about those aspects of physiotherapy that are specific for the treatment of older persons. The German and French version can be downloaded at:

- <http://www.sgg-ssg.ch/cms/medialfpg/BerufsprofilOkt09.pdf>
- <http://www.sgg-ssg.ch/cms/medialfpg/profilprofessionnel.pdf>

For more information about the Specialist Group in Geriatric Physio-

therapy, you can also visit the Web site, <http://www.sgg-ssg.ch/cms/pages/en/home.php>, which is available in English.

The Health and Education Systems in Switzerland are in a constant process of reorganisation. As one of the consequences, gerontology has gained significance in our society. The Specialist Group in Geriatric Physiotherapy played a key role in the development of clinical specialisation in geriatrics, a goal of the Swiss Association of Physiotherapy.

CLINICAL SPECIALIZATION IN GERIATRIC PHYSIOTHERAPY IN SWITZERLAND

Due to major changes in the physiotherapy education system, an increasing number of physiotherapists are obtaining an academic title. For those seeking an education in physiotherapy today, the initial degree is a Bachelor of Science in Physiotherapy. In addition, several Master programs exist or are being developed. However, the vast majority of physiotherapists have a Diploma from a college of higher vocational education and training. As a result of these conditions, it is deemed necessary to formally recognize those highly qualified physiotherapists with valuable years of clinical experience and skills not seeking an academic career.

The Expert Committees of the Swiss Association of Physiotherapy have developed criteria for recognizing 6 clinical specializations, including the specialization in geriatric physiotherapy. The requirements are based on the CanMED¹ models of competence: Health professional, communicator, team worker, manager, health advocate, educator, (geriatric) expert.

A portfolio system has been developed for the documentation, collection, and evaluation of the following skills and knowledge areas:

Theoretical competence

Documentation of continuing education at advanced or master level (800 lessons).

Clinical expertise

A prerequisite for the specialization is the equivalent of 5 years of full-time clinical practice in a geriatric setting. In addition, 1200 hours for those without an academic degree, or 500 hours for those with a Master of Advanced Studies in a related field, must be documented. The requirements include:

- health professional competencies--patient related advanced clinical competence (case studies incorporating clinical reasoning, supervision by a geriatric specialist);
- educator competencies--teaching, consultation, and patient related instruction; and
- scientific competencies--participation in scientific research projects, peer review groups, and literature reviews.

The portfolio is an aid to interested physiotherapists in their career planning process.

The certification as a clinical specialist in geriatrics can be of benefit as recognition of geriatric expertise when applying for a higher position, for program development, and for interdisciplinary cooperation. In private practice the title shows specific geriatric expertise as an additional qualification to physiotherapist.

The first clinical specialists are in the process of completing their documentation for certification in 2012. After evaluating and adjusting the procedure, the definite implementation is scheduled for 2017. The Swiss Association of Physiotherapy will be responsible for the validation and registration of clinical specialists. At the present time, 3 geriatric physiotherapist candidates are compiling their portfolio for completion in 2014.

For further information contact: G. Gonçalves Mantellini, IPTOP Representative of Switzerland.

REFERENCE

- <http://rcpsc.medical.org/canmeds/CanMEDS2005/index.php>

CURRENT PHYSIOTHERAPY SERVICES AND DEVELOPMENTS FOR CARE OF OLDER PEOPLE IN IRELAND

Grainne Walsh, PT

For the first time, Ireland is approaching an era where the elderly population outnumbers the younger population. By 2030 it is expected that one in 5 Irish people will be older than 65 years of age, and over 50% of females born today will survive to 100 years old (Central Statistics Office, 2003). In response to these changes, there are a number of initiatives underway that are aimed at advancing the provision of physiotherapy services to older people in Ireland. Until recently, Irish physiotherapists specialising in geriatric services mainly worked in the acute hospital setting. A number of specialist geriatric rehabilitation units exist, offering specialist multidisciplinary team rehabilitation; however, these are mainly linked with large acute hospitals and poorly dispersed nationally. The Primary Care Strategy launched in 2001 aimed to meet 90% to 95% of health and social service needs in the community, thereby preventing hospital admission and facilitating early discharge. As a result of this strategy, many gerontology physiotherapists now work as part of large interdisciplinary primary care teams providing first contact therapy and leading the national focus on preventative medicine (Primary Care Strategy, 2001). Despite increased numbers of physiotherapists working with the elderly in Ireland, a clinical specialist physiotherapy post is yet to be developed. The lack of official clinical expertise in this field may have limited the number of physiotherapy specific initiatives developed to date. Of note however, efforts are currently underway to create new clinical specialist and advanced practitioner posts through the Clinical Strategy and Programmes Directorate.

The Clinical Strategy and Programmes Directorate was recently developed within the Irish Health Service Executive to improve and standardise patient care in a number of clearly defined areas. The Care of the Elderly Clinical Programme has set out a number of clearly defined objectives broken down into areas of quality, access, and cost. The therapy professions, including physiotherapy, occupational therapy, clinical nutrition, speech and language therapy,

podiatry and orthoptics, are involved in leading the development of these clinical pathways. The vision of the programme is first to provide standardised models for delivery of integrated care, and secondly to implement these models of care ensuring sustainability. The first drafts of the pathways of integrated care for elderly patients, from when patients present to the acute hospital setting and journey through specialist geriatric rehabilitation, have just been developed, including operational policies for members of the multidisciplinary team. The role of physiotherapy is clearly defined and is an integral part in the process flow for these integrated care plans. The development of clinical specialist roles and advanced practitioner roles are highlighted needs in this strategy. The overall aim is to reduce delayed discharges, reduce average length of stay for elderly people, reduce risk of re-admission following discharge, and improve appropriate assignment of home care services and accessibility to same (Care of the Elderly Clinical Care Programme, 2012).

Another current objective of the care of the elderly clinical programme is to reduce the number of falls in older people. Almost one quarter of Irish people over the age of 75 have fallen in the past year, and 21% of Irish people over the age of 75 have objective signs of osteoporosis (Barrett *et al* 2011). The programme plans to reduce the number of falls by implementation of the Falls Prevention Strategy that was developed in 2008. This strategy was jointly prepared by the Health Service Executive, the Department of Health and Children, and the National Council on Ageing and Older People. Dr. Francis Horgan, senior physiotherapy lecturer in Gerontology in the Royal College of Surgeons, was a member of the national steering group responsible for developing this strategy. Using research on the health impact and economic burden of fall related injuries in Ireland, the strategy developed an evidence-based approach to the implementation of multidisciplinary falls and osteoporosis prevention programmes. Physiotherapists have a key role in implementation of

this strategy by commitment to screening at risk populations and completing the multifactorial assessments outlined (Strategy to prevent falls and fracture in Irelands Aging Population, 2008).

One of the most exciting projects taking place in Ireland is The Irish Longitudinal Study on Ageing (TILDA). This €30 million project is a 10-year prospective study of the health, social, and economic circumstances of older people in Ireland. It involves 8000 people aged 50 years and over and is due to be completed in 2018. This information, when available, will be used to remodel health and social care services, including physiotherapy. Initial results published in 2011 showed some interesting features. Of particular interest are the low levels of physical activity and high levels of obesity in the older population, predicting health related problems for the future. Obesity is associated directly with age-related reduction in physical activity. Results highlighted that 75% of older Irish adults are overweight or obese, with higher incidence in males. Fear of falling was highlighted as a major factor influencing activity restriction. One in four Irish adults reports a fear of falling, with prevalence increasing from 17% in 50-64 year olds, and up to 40% in those 75 years olds and older. In particular, women were reported to be twice as likely to restrict activity, but in spite of more women reporting 'fear of falling,' there is no difference in falls prevalence between older men and women. The role of the physiotherapist in ensuring a healthy active older population has been highlighted in this study (Barret *et al* 2011).

The Programme for Government 2007-2012 made a commitment to develop a National Positive Ageing Strategy in order to 'better recognise the position of older people in Irish society.' This strategy essentially is an overarching framework for future policies, programmes, and services for the older generation in Ireland. The aim of this strategy is to highlight the changes that are needed to ensure older people are recognised, supported, and enabled to live independent full lives. In the past,

policies have focused on health and social care issues in the elderly, but this strategy seeks to ensure well-being in later life by appreciating that quality of life is influenced by a number of different factors including factors relating to people's participation in society (Programme for Government 2007-2012). A number of senior physiotherapists in gerontology and specialist lecturers were integral in developing a framework for this policy and are currently instrumental in ensuring this policy is implemented. Due to the current economic constraints, this strategy aims to direct future policies and programmes for older people rather than proposing new service developments at this time. Work on development of this strategy is continuing and is eagerly awaited by the therapy professions in Ireland.

A number of critical strategies are underway at present to advance the

gerontology service provided by therapy professions. Although many physiotherapy clinical experts exist in this field in Ireland, they are yet to formalise clinical roles. The need for clinical specialist posts and the development of the above initiatives will help bring Ireland in line with our international colleagues. Irish physiotherapists look forward to being an integral part of the process of positive and active aging for our elderly.

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- Care of the Elderly Clinical Care Programme (2012) <http://www.hse.ie/eng/about/Who/clinical/natclinprog/careofelderlyprog.html>

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- Strategy to prevent falls and fracture in Ireland's Aging Population (2008). Report of the National Steering Group on the Prevention of Falls in Older People and the Prevention and Management of Osteoporosis throughout Life. www.hse.ie/eng/services/Publications/services/Older/Strategy_to_prevent_Falls_and_Fractures_in_Ireland's_Ageing_Population_-_Full_report.pdf
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- Programme for Government 2007-2012 http://www.taoiseach.gov.ie/attached_files/Pdf%20files/Eng%20Prog%20for%20Gov.pdf

PERSPECTIVE OF BELGIUM PHYSICAL THERAPY AND THE AGING POPULATION

Jan Tessier, PT

Notes on Continuous Professional Development Activities in Belgium from the General Meeting of the European Region of the WCPT 2012:

ON REGISTRATION AND SPECIALISATION

Specialisation for physiotherapy does not yet formally exist in Belgium. However in 2010, as a first step towards specialisation, the National Council for Physiotherapy voted in favour for the creation of "special competences" or "special abilities." First of all, a list of 11 "special competences" has been approved: cardiovascular, geriatric, manual therapy, neurologic, relaxation, palliative, paediatric, psycho-motoric, pelvic re-education/peri-natal, respiratory, and sports physiotherapy. The following "special competences" have also been separately approved: cardiologic, manual therapy, neurologic, paediatric, pelvic re-education, and respiratory. The list and specific approved competences will be proposed for adoption to the Ministry of Health and their recognition has to be implemented following this decision to

be made by Royal Decree. However, the absence of a government since 550 days (on 22/11/2011) is the main burden for this implementation. The estimated time for implementation of only one on these "special competences" would be 6 years.

STRUCTURE OF PHYSICAL THERAPY IN BELGIUM IN NURSING HOMES

In Belgium, determination of the degree of dependence of the resident is made using the Katz scale. You can find explanation about the use of the Katz-scale in Belgium here: <http://www.elfri.be/katz-schaal>. Use the language you want on the site.

The residents are screened and classified according to their dependence in 4 categories. Thereafter, various personnel standards are imposed by the National Institute for Social Security and Disability Insurance (RIZIV). Here are two distinct groups of residents.

- Residents who have a score of "O" or "A" can get a physical therapist, not attached to the institution (working as an independent).
- Residents who have a score of "B," "C,"

or "CD" can get physical therapy from a therapist related to the institution.

The RIZIV determines by law how much physiotherapy (and other caregivers) must be out there in an institution.

The residents of group "1" have no physiotherapy/occupational therapy/speech therapy linked to the institution. They can ask someone for a treatment at their own expenses. Here apply the rules of nomenclature as for home care.

As of 30 residents (of the group "2"), the residents can have one FTE Physical therapy and/or Occupational therapy and/or Speech therapy, with minimum 1/3 of Physical therapy and Occupational therapy. The institution decides on the realization of the other 1/3.

All treatments are given on prescription of a general practitioner.

This is a brief description of the opportunities in the nursing homes. The task description of the physical therapist in nursing homes has not been officially described.

GLOBAL EDUCATION EXPERIENCE: PHYSICAL THERAPY STUDENTS EXPERIENCE THERAPY IN NICARAGUA AND JAMAICA

CUW DPT STUDENTS CONTRIBUTE TO “THE CIRCLE OF EMPOWERMENT”

*Cheryl Petersen, DPT, Associate Professor
of Physical Therapy*

The Circle of Empowerment is the name of a small medical clinic in a northern rural area in Nicaragua near the Pacific coast. The clinic is run by a nurse, Meg Boren and sponsored by Grace Lutheran Church in Grafton, Wisconsin. Each year physical therapy students, along with a faculty member, have spent nearly 3 weeks over Winterim working here with children with disabilities in their homes and providing services and consultation in the medical clinic. Travel to the homes of the children with disabilities is an experience itself and provides a window into the rural culture in Nicaragua. The roads are dirt and maintained only by the environment, with ruts and rocks to travel through. The homes of the families vary from one room with a dirt floor and thatched or tin roofs, to cement block with dirt or concrete floors. It is different from our culture to see how many generations live together, and how the housework is often maintained by the children, while the parents are off trying to earn money for food.

The cultural differences were described by Concordia's DPT students in the following statements:

“It is impressive to me to see how supportive the families are of each other and how hard they work.”

I was “surprised how fast the mother made his sister wash him up and put new clothes on him. The respect and pride they have in this culture is unbelievable.”

“I was also very surprised at the condition and size of the homes... It's hard to believe all of the luxuries we have compared to them!”

“His home seemed to be in the worst condition, but that did not affect the spirits of the family.”

“These people are fearless.”

The medical clinic is open 3 days a week and provides medical consultation and medication to about 5,000 people in the rural area. Nicaraguan physicians will also rotate through the clinic to gain experience in the rural setting. Concordia's DPT students spend time in the medical clinic and provide differential diagnosis, with the assistance of the physical therapy faculty member, regarding physical therapy management versus medical management of the people attending the medical clinic. Clients with neurological, integumentary, and orthopedic problems have received physical therapy consultation.

Working with children with disabilities is part of the purpose of the clinical trip, and some of the reflections on disability while viewing the situation in this 3rd world country were expressed by students in these comments:

“It's hard to have a disability living in the US, but I can't imagine the challenges a person faces living in a place with no concrete sidewalks “and paved roads.”

“It was nice to see myself rip down the walls, get past the dirt, and just embrace another loving human being. Very humbling experience.”

Spanish is the native language which proved to be challenging while attempting to communicate. During each trip, various people including one of the physical therapy students translated for us; however, communication remains frustrating for students with minimal Spanish language skills as seen in these statements from the DPT students:



Nicaragua

“The language barrier made it awkward today...”

“I found it really frustrating trying to control the session, since I couldn't speak the language...”

The mission at Concordia is not simply to educate students to become Physical Therapists, but to inspire students to “develop in mind, body, and spirit for service to Christ in the Church and the world.” This is what the Concordia tagline, “Inspiration in Action” means. Students who have completed the trips have indicated that the total experience and learning opportunities were very positive. Most have expressed the desire to return to Nicaragua or another mission setting in the future:

“I am so grateful for this opportunity and will forever cherish these experiences.”

“Awesome trip. My physical therapy skills increased as well as my whole life perspective was forever changed, and I hope I can come back multiple times on my own to work more with the extremely poor but happy and generous people of Nicaragua.”

“I love Nicaragua... and the thankfulness reminds me why I am so happy to help!”

“They are very joyful people, and I am so lucky to have spent time with them. I think I learned more from them than they did from me. I hope to come back in the future.”



The Nancy Lund Clinic, Nicaragua.

Despite the language barrier and differences in culture, students value the life changing experiences in Nicaragua. Concordia DPT students have become part of the Circle of Empowerment for people in Nicaragua.

“...every person matters, and every person should be valued. It is not OK for some to not receive basic human rights, and thanks to people like Meg, the RN in Nicaragua, this is being worked on one day at a time here in Nicaragua.”

LESSONS LEARNED IN JAMAICA

Elizabeth Olkowski, PT, DPT, GCS

When I was in graduate school at Arcadia University, enrolled in the DPT program, I had the opportunity to embark in a life altering experience. I was lucky enough to have the chance to embrace the warmth and generosity of St. Elizabeth Parish, Jamaica. It was here, that I met Dr. Brooke Riley, President of Friends of the Redeemer United (FOR U). Since 2004, Dr. Riley has been providing physical therapy to those who are unable to afford physical therapy services in rural Jamaica. In addition to physical therapy services, FOR U is very involved in community service projects including a reading initiative program in the parish in Ridge District.

In 2007, for two weeks, a fellow classmate joined me as we travelled to Jamaica to volunteer as student physical therapists. The first morning we arrived at the clinic, unsure but excited for this journey. Without the state of the art equipment that we were used to treating with, we had to think outside of the curriculum. Instead of learning how to set goals to get my patients back to playing golf, I had to think about how to set goals for individuals who had to walk a mile to get their water, or had to tend to their goats as their occupation. I felt out of my element without computerized home exercise programs to distribute, and no internet to access to see the latest treatment ideas. There were no steppers or elliptical machines, instead there we used buckets for treatment ideas and stick figures for our home exercise programs. As a second year physical therapy student, the intricacy of combining a new culture with complex patients was overwhelming. I quickly realized that no matter where you live, we all have the same musculoskeletal system. After the first day, Dr. Riley showed me that to be good physical therapist you don't

need the most expensive equipment or the latest computer programs, but instead guided us through treatments using creative clinical decision making skills acquired through education and experience.

At the end of our treatment day, we would retire back to the home of a local woman, Miss Anna. She embraced me like I was her own child. I was a long way from my air conditioned bed and long warm showers, as the Jamaican night time air was thick and my shower was quick and cold. As the week went on, those thoughts faded, and I became immersed in the community and even participated in the construction of a community center. I couldn't wait to get up the next morning to spend my day serving the community in the clinic. In addition to treating patients in the clinic, Dr. Riley manages to spend time seeing patients in their homes. I was fortunate enough to spend a few days going on home visits. I remember driving out the dirt roads into the country side and treating my first pediatric patient who had cerebral palsy. I'll never forget the smile on his face the whole time we did exercises on the physioball. His father observed the session with an eagerness to learn what we were doing, so that he could carryover the therapy after we left. This gave me a better understanding and appreciation for being a physical therapist. I went into this adventure feeling like I wasn't going be able to help or relate to the patients. I left Jamaica knowing that I made a positive impact on someone's life and gained a new appreciation for humanity.

Starting in 2009, Dr. Riley and Arcadia University began hosting a Stroke Camp at Bull Savannah Physiotherapy



Dr. Riley on a home visit.

in St. Elizabeth Parish. Each year, thousands of Jamaicans endure the debilitating effects of a stroke. The camp offers an opportunity for patients who have had a stroke to have a second chance. Patients receive a 5-day intensive physical therapy program consisting of pre-testing, 3½ days of intensive therapy, and posttesting. Expert clinicians from Arcadia University and other physical therapy programs, along with student volunteers, selflessly give their time to this organization to rehabilitate lives. Dr. Karen Sawyer, DPT, who started the clinic in 2000 continues to share her clinical expertise and is the Vice President of FOR U. She says of her experience, “You're stretched to a new shape and never return to your former size, because you can't forget what you have learned.”

I feel that in this fast paced world that we live in, it is easy to lose sight of what is really important. The opportunity I was given to travel abroad gave me a new hope in my abilities and the possibility to make those individuals who didn't have a chance, get a little bit better. To learn more about these programs please visit www.arcadia.edu/pt and www.friendsoftheredeemer.org.



Stroke Camp.

CEEAA COURSES ARE CHANGING LIVES

Since 2009, there have been over 9 series of the CEEAA offered or being offered. This has concluded in over 350 Certified Exercise Experts for the Aging Adults. What have these therapists been doing after completing this course series and have their lives been changed?

This question was put forth at the CEEAA reception at CSM 2012 and again on the CEEAA listserv. While not surprising after taking the course series, many therapists went on to get their GCS and/or mentored others in their clinic, many also began making changes in their own personal lives.

HOW HAS BECOMING A CEEAA CHANGED YOUR PRACTICE?

"The most important thing I gained was developing assessment and treatment techniques that I use every day in my practice. I feel more confident in my ability to provide justification for the interventions and the PTA's who work with me are particularly appreciative of my evaluations and treatment guidelines."

"I now use more of the functional tests to quantify muscle strength versus the manual muscle tests that did not show functional deficits. I also use the 2 minute step test for more objective measure of aerobic capacity/activity tolerance versus good, fair, poor. I am excited to find out that the literature supports resistive exercise for many populations and now push my patients harder than I used to. This has resulted in the patients being much more invested in their programs and progress as they look to "beat" their previous baseline. "

"I opened a home based cash practice that is growing steadily. My goal is to group people together according to needs and abilities in order to reinforce exercise habits. I also spearheaded a balance and falls screening during PT month."

HAVE YOU DONE ANY PUBLISHING, TEACHING, COMMUNITY PROGRAMS, ETC SINCE BECOMING CEEAA?

"I put together an inservice on Objective Tests and Measures used in Home Health and have given this inservice to many of our branch locations. I was also asked to present a discussion to a local 55+ community group entitled "Let's Get Moving: Principles of Geriatric Exercise" that was well received and brought a lot of attention to our facilities."

"I have been working with our Area on Aging to implement exercise and balance programs for community groups, frail older adults living at home, and for those aging with intellectual/developmental disabilities. I have also gotten our DPT students involved."

"I have been working with state wide initiatives on balance and fall screenings to implement in assistive living facilities."

WHAT HAS CHANGED IN YOUR LIFE SINCE BECOMING A CEEAA?

"I have become more confident in my knowledge and skills and sharing this with colleagues."

"I have begun changing my own personal lifestyle to include physical activity to keep me for the downhill slope from fun to failure-thus promoting successful aging."

"I returned to clinic practice after 12 years of being a stay at home parent and found the CEEAA course helped me make that transition. Now I am writing proposals for implementation of standardized tests, exercise protocols, and encouraging others to change their practice."

"I developed an awareness of what successful aging is and began incorporating this into my lifestyle. I will be running my first half marathon this year!"

WHAT WOULD YOU TELL OTHERS ABOUT THE CEEAA PROCESS?

"Don't wait! Take the course now as this has been the most valuable continuing education course I have taken in my 22 years of experience."

"Patients will be knocking on your clinic doors once they realize that you challenge them, get them back to their functional life, and know what you are doing."

"Your life will be changed, professionally and personally!"

So, what are YOU waiting for. Courses are coming up in 2012 and 2013. Go to www.geriaticspt.org and sign up now. Class size is limited, so sign up early.

Register Early

The CEEAA courses have limited enrollment so assure your spot today.

Minneapolis, MN

Course 1: June 23-24, 2012
Course 2: December 1-2, 2012
Course 3: March 23-24, 2013

Huntington, WV

Course 1: April 13-14, 2013
Course 2: June 15-16, 2013
Course 3: July 20-21, 2013

Kansas City, KS

Course 1: July 7-8, 2012
Course 2: August 11-12, 2012
Course 3: September 22-23, 2012

Auburn, WA (Seattle)

Course 1: October 27-28, 2012
Course 2: February 2-3, 2013
Course 3: August 17-18, 2013

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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.*

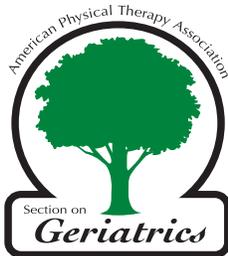
- Henry Wadsworth Longfellow

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Section on Geriatrics, APTA

2012 Regional Courses

Chicago, IL • October 20 - 21 • 12 Contact Hours

Rehabilitating Your Approach: Maximizing Outcomes in Patients with Cognitive Impairment and Evidence-Based Approaches to Cognitive Rehabilitation

Presented by: Robert Winningham, PhD

	Register on or Before 09/21	Register After 09/21
Section on Geriatrics Member	\$315	\$365
APTA Member	\$375	\$425
Non-Member	\$435	\$485

Miami, FL • December 8 - 9 • 15 Contact Hours

Manual Physical Therapy for the Geriatric Patient

Presented by: Carleen Lindsey, PT, MScAH, GCS, CEEAA

	Register on or Before 11/09	Register After 11/09
Section on Geriatrics Member	\$315	\$365
APTA Member	\$375	\$425
Non-Member	\$435	\$485

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