GERINOTES

SECTION ON GERIATRICS, AMERICAN PHYSICAL THERAPY ASSOCIATION

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Contact Melanie Sponholz, GeriNotes Editor
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PRESIDENT'S MESSAGE: WHAT'S IN A NAME?

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

A busy, but worthwhile and invigorating Combined Sections Meeting has just wrapped up in San Diego. Your Board of Directors has been working hard to progress on the ambitious goals we made for the Section at our retreat in Milwaukee last summer. The strategic plan is available to the membership at www.geriatricspt.org. "What's in a name? That which we call a rose by any other name would smell as sweet." *Romeo and Juliet (II, ii, 1-2)* When Shakespeare wrote those famous words spoken by Juliet, he was reminding us what matters is what something is, not what something is called. However, a name is something of vital importance to an organization. It can tell others who we are, what we are, and what we do. Does the name make a brand or does the name ask a question?

After much research, I challenged the Board that the Section on Geriatrics officially investigate and thoroughly consider changing our name to "Academy of Geriatric Physical Therapy." This name would be similar to current terminology used in other health professions. The motion passed unanimously. Our bylaws require a membership vote at our next member meeting. There will be no formal member's meeting at annual conference, so the vote will be taken next February at CSM in Las Vegas. The Board would welcome any comments until that time. Please send comments to geriatrics@geriatricspt.org.

A primary interest in making this name change is to better brand **who** we are. A Section is a piece of something, in our case the APTA. While that will not change, we strive to be more recognizable. For me, every time I engage someone outside the APTA, I first have to explain what a Section is and what we represent. The most used term for health related groups that deliver education, promote excellence in practice, and advocate on public policy issues is an academy. Two examples of this would be the American Academy of Physical Medicine and Rehabilitation, and the American Academy of Family Physicians.

So what is the process of changing our name?

STEP 1

Read the organization's bylaws to determine whether or not we may change the name of the organization and under what conditions. We must follow the procedures in the bylaws to change the name. A name change will require a vote of the members, as this is a change to the bylaws (see below). That requirement will be fulfilled by holding a vote of the members present at the annual (CSM) meeting. In order to do this, there is a certain announcement requirement (30 days).

Current bylaws:

ARTICLE I: NAME

The Section on Geriatrics of the American Physical Therapy Association, hereinafter referred to as the Section, shall be a section of the American Physical Therapy Association. ***We will still be a section of the APTA, just a new name.***

ARTICLE XIV: AMENDMENTS

A. These Bylaws may be amended at the Annual meeting of the Section by a two thirds (2/3) vote of members present and voting, providing that notice of the proposed amendments has been given to the Section membership at least thirty (30) days in advance of the meeting at which the amendments are to be considered. ***That meeting would be CSM in February 2014.***

Proposed change to bylaws via amendment: The Section on Geriatrics of the APTA shall hereafter be referred to as the Academy of Geriatric Physical Therapy.

STEP 2

Do a search to determine if any other organization is using the name. ***This has been completed.*** **www.geriatrictherapyacademy.com** ***was the only company closely named to our proposed change. This group is a continuing education company.***

STEP 3

Notify the state in which you are incorporated (Virginia) once we have officially changed the organization's name (if we choose to do so). Read the rules regarding corporations in Virginia to determine whether or not our nonprofit's articles of incorporation and/or bylaws need to be amended and resubmitted to the state after you have changed the name. These directions can be found on the Secretary of State's Web site. The cost is $25. **No requirement for bylaws to be amended or resubmitted.**

STEP 4

Notify the IRS of the name change. Read the IRS 501(c) (3) code (which is how the Section is currently coded) as we are a tax-exempt organization. We need to determine whether or not our nonprofit's articles of incorporation and/or bylaws need to be amended and resubmitted after a name change. ***They do not***. Any organization that files an annual Form 990 must notify the IRS of a name change. This can be done when filing our next annual report.

STEP 5

Notify the organization's membership of the official name change. Update stationery, business cards, Web site, Facebook page, logo and any other marketing, promotions, and advertising

materials we use. Notify vendors, such as your accountant, bank, office building, electric company, and other organizations with which you work. There will be some cost here, but we can use "old" letterhead etc. until exhausted.

STEP 6

Perform a Google or other Internet search of our organization under the previous name to see if we need to contact any groups promoting your organization. Many Web sites have nonprofit databases in which we are listed. ***I have checked Guidestar.org where we are currently listed. We can easily make changes to this database if we do change our name.***

This was by no means the only issue we addressed at CSM, but very important to the membership. The Section has pledged significant funds to the Foundation for Physical Therapy, including $25,000 to the Moffat Geriatric Research Fund and $25,000 to the new Center of Excellence. At the 35th Anniversary Member's Meeting, we celebrated with cake and an excellent array of appetizers. The awards ceremony preceded the meeting where Ellen Strunk was awarded the President's Award for distinguished service to the Section; and Greg Hartley was presented with the Joan Mills Award, the highest award the Section bestows. Dave Pariser, our APTA Board representative, was fondly remembered and will be missed after his unexpected passing in January, just a week prior to CSM. Speakers from the Foundation, APTA Board, APTA Nominating Committee, PTNow, Annual PT Evaluation Committee, along with Section updates and reports filled the celebratory evening.

I would like to thank the following people for their dedicated service to the Section. Bob Thomas and Mary Thompson, Directors; Michelle Lusardi, Editor *JGPT*; Mike Studer, Chair Balance and Falls SIG; Kathy Brewer, Chair Nominating Committee; Tamara Gravano, Specialty Council; Carol Knudson, Co-chair Reimbursement/Legislative Committee; and Sara Knox, Chair Awards Committee. I want to welcome Myles Quiben and Sara Knox as new Directors on the Board, and Mary Thompson to the Nominating Committee. I also wanted to take the time to thank our Gold Sponsors: Aegis Health Care, Fox Rehabilitation, and Genesis Rehab Services.

EDITOR'S MESSAGE: SELLING GERIATRIC PT

Melanie Sponholz, MSPT, GCS, CCEP, CHC

When it comes right down to it, we are in a service industry. I had the opportunity recently to spend some time as a clinical mentor to a sales and marketing group who work to increase referrals to rehabilitation professionals through physician outreach. We talked about why physicians should refer to physical therapy (PT), and about what PT has to offer older adults with some of the most common impairments and chronic conditions. However, I think maybe I got the most out of the meeting, because it jolted my neurons out of their usual pathways and got me thinking about something new. I have spent a lot of time thinking about regulatory affairs lately, with all of the impending Medicare changes: the therapy cap, the Manual Medical Review process, the looming Multiple Procedure Payment Reduction. Clearly the reimbursement system for those of us treating older adults is going to continue to pose challenges to providing clinically excellent care. And these proposed reductions and restrictions are coming into effect in the midst of a major change in who the "older adult" is. The boomers who are becoming Medicare eligible every day are vastly different than the older adults that most of us have treated thus far in our careers in geriatric therapy. These new older adults are super active, and they are going to need therapy for reasons that would make a Medicare auditor's stomach turn. Imagine trying to find the medical necessity in the ability to walk 18 holes or run a marathon. Anyway, I am going somewhere with all of this. It got me thinking about the likelihood that all of us will need to become better sales people ourselves, if we want to continue making a living doing what we love. We will need to convince insurers that our services impact cost in a positive way (even cut costs through proactive health care) and are worth reimbursing, and convince our patients that what we have to offer is worth writing a check when the insurance company won't.

I recently read an interview with Lois Vitt, PhD, Founding Director of the Institute for Socio-Financial Studies, who explained that most people fall into one of 4 categories in relation to what they find valuable: Personal-values people, social-values people, physical-values people, and financial-values people. By looking at what makes each type tick, maybe we can find some insight into how to promote the services we offer:

The personal-values person is the type who is happiest spending on self… the type with custom golf clubs or a closet full of shoes. I think the pitch here is pretty easy. The health and wellness we can deliver is unmatched. Heck, a great exercise prescription can keep you out of the hospital or get you into your skinny jeans! I know patients who started PT after an illness or injury and continued to pay privately long after insurance benefits were exhausted, because they loved the way they felt and looked after regular sessions with their physical therapist.

The social-values person is most likely to buy for others. This could apply to our services in a couple of ways. First, when discussing paying for services with an older adult, we may face resistance, because they want to spend on their children and grandchildren, not themselves. However, what we do can absolutely benefit their families and their savings. Living as independently as possible, for as long as possible means avoiding the costs of hospitalization and institutionalization. It also means the ability to be actively involved with family and friends. We may also market to the social-values inclination of older adults' families or powers of attorney who may be involved in their health care decisions. The strength, vitality, and increased safety that can result from effective PT intervention are certainly things worth buying for a loved one.

To explain our value to physical-value folks, we can emphasize the way healthy activity engages the senses. Whether it's hiking, running, swimming, or even creating something pleasing to the senses, like a beautiful garden or a renovated room, we can help ensure that the ability to achieve enjoyment of these experiences. My own father recently underwent elective knee surgery and PT to prolong his ability to trail run, an activity that is invaluable to him.

Finally, there are those driven by financial values, who relish saving, investing, and getting good deals. We might lump insurers into this category, along with many individual spenders. Here we need to demonstrate the pure value of what we do. We need to devote time and energy to further studies demonstrating that effective PT keeps people at home, out of doctors' offices, hospitals, and skilled nursing facilities. This is the kind of evidence that will appeal to these bottom-line spenders.

Overall, we need to be shaken out of the complacency that patients will be delivered to our practices and accompanied by generous insurance benefits. Over the next few weeks, pay attention to health care marketing you see around you. You will hear and see ads for hospitals, physician practices, plastic surgeons, sports orthopedic surgery groups, and a few of our peers. Everyone is vying for a piece of the pie. We need to be active participants in the development of health care and reimbursement trends. We need to take pride in our skills and elevate the profile of our profession. This is essential to our growth and financial viability in the years to come.

SERVICE LEARNING AND THE GERIATRIC POPULATION IN PHYSICAL THERAPY EDUCATION: A STUDENT PERSPECTIVE

Brian Faries, SPT; Sean Asp, SPT; Nick Dwyer, SPT;
Julie Hartmann, PT, DSc, GCS; Brad Gleason

When we first began our graduate education in the Doctor of Physical Therapy program at Gannon University in Erie, Pennsylvania, we were surprised to find an entire portion of the curriculum of classes dedicated to service learning and community health initiatives. We must admit that the concept of service learning was new to us, but were informed that service learning is an essential component needed for accreditation by CAPTE, the Commission on Accreditation in Physical Therapy Education, and it aims to integrate community service with instruction and reflection in order to enrich learning, teach the importance of a commitment to social responsibility, and benefit local communities.

THE TWILIGHT WISH FOUNDATION

It was in this curriculum that we first were introduced to the Twilight Wish Foundation, a wish granting organization dedicated to needs of the elderly population. Twilight grants wishes to the deserving elderly, ages 68 and older, who earn less than 200% of the poverty level annually, or who live in a nursing facility.[1] As classmates, we had always shared an interest in geriatric physical therapy, and felt that it is a patient population that is easily neglected and underserved. However, not only did this organization strive to serve a population for which we harbor a certain compassion, but it also fulfills needs that we could be certain would be greatly appreciated. For these reasons, we agreed to work with the foundation for our Capstone Project, an assignment in our program requiring us to commit at least 60 hours of community service to a local organization. Before getting underway, however, we needed to learn more about Twilight's history and its mission.

The Twilight Wish Foundation was established in 2003 in Doylestown, Pennsylvania, by founder Cass Forkin. After seeing several elderly women counting their loose change in order to pay for their meal at a restaurant, Forkin felt compelled to pay their bill anonymously, and their appreciation for this act of kindness served as the inspiration for the founding of the Twilight Wish Foundation. Since its inception, Twilight has continued to expand, granting wishes in 38 states and opening 7 local chapters throughout the country. In 2011 alone, Twilight was able to grant 90 wishes in accordance with their mission of honoring and enriching the lives of deserving seniors. Wishes that are granted can fall under one of 3 categories: simple needs, such as obtaining dentures, hearing aids, computers, or food; living life, which could include a night out with a spouse or attending a sporting event; and celebrating a life, which encompasses requests for family reunions or recording of a life story.[1,2]

OUR WORK WITH TWILIGHT

After learning about Twilight and its involvement in the elderly community, we were excited to begin working and to see how we, as student physical therapists, would be able to assist the organization in its mission to honor and enrich the lives of deserving seniors. We wouldn't have long to wait, as we were soon informed that a wish had been approved for granting in the Erie area. Francis, a 77- year-old Army veteran residing at the Pennsylvania Soldiers' and Sailors' Home for veterans in Erie, had requested to play one last round of golf. Though he was an avid golfer earlier in life, medical and transportation issues prevented him from golfing on his own, and he wanted one more opportunity to play the game that had brought him so much enjoyment. We set to work and were able to help coordinate the event, by networking with a local golf shop to obtain a donation. Frank's drive may have lost a few yards, and his putter some of its touch, but we only needed to look at his face to see how happy he was and that our time and efforts had been well spent. His endurance allowed him to only play 3 holes that day; however, his repeated gestures of appreciation and thanks were testament to the impact of what these wishes mean.

Our second opportunity to assist in the granting of a wish was no less rewarding. Evelyn, an 80-year-old Air Force veteran and retired nurse, had requested to spend time with a golden retriever, a breed of dog that had brought her so much joy throughout her life. Evelyn, now on continuous oxygen therapy, was rarely able to leave her house anymore due to her medical condition. However, working with Twilight's Erie chapter, we were able to collaborate with Therapy Dogs United, and a home visit from Daisy, a golden retriever and certified therapy dog, was arranged. Someone looking in on the scene that day might have seen something rather commonplace, an elderly woman just sitting and petting a gentle dog, scratching its ears, its back, its belly. But to Evelyn it was so much more; it was a chance to enjoy the familiarity of a loving companion while reflecting on the lives of other dogs that had made such an impression on her life.

In the end, we learned that while physical therapists undoubtedly have specialized knowledge and skills to offer the geriatric community (such as our safety skills, ability to network within the community, and previous clinical experience interacting with elderly individuals), often all that is required is time in order to make a significant positive impact in the life of an elderly person. We have been privileged over the last few months of our physical therapy education to work with the Twilight Wish Foundation and play a small part in helping it achieve its vision of making the world "a nicer place to age, one wish at a time."[1] We also feel that our service learning curriculum has impressed upon us the importance of social responsibility as future physical therapists. In a day and age when other health care professionals seem to be putting up barriers between them and their patients, physical therapists live on the "front lines" of patient interaction. As such, we are in a unique position to affect change in our local communities, especially in the geriatric population.

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Sean Asp, Nick Dwyer, and Brian Faries were students in the Doctor of Physical Therapy program at Gannon University at the time this article was written. Sean now works as Clinical Director for Integrity Physical Therapy in Elyria, OH. Nick is employed as a staff physical therapist at Legacy Physical Therapy in Bradenton, FL. Brian is currently employed as a staff physical therapist at UPMC Hamot in Erie, PA.

Brad Gleason is the Operations Director of the Center for Intelligence Research Analysis and Training (CIRAT) at Mercyhurst University in Erie, PA. He is the administrator for the Washington, DC / Baltimore High Intensity Drug Trafficking Area. He is also responsible for coordination of contracting and grant writing for CIRAT. He is the Co-Director of the Erie County chapter of the Twilight Wish Foundation.

Julie Hartmann is the ACCE for the Doctor of Physical Therapy program at Gannon University in Erie, PA. She is course coordinator for the Foundations in Geriatrics course and a faculty participant in the Community Health Initiatives course sequence. She maintains clinical hours in home care. She is the Co-Director of the Erie County chapter of the Twilight Wish Foundation.

HEALTH PROMOTION AND WELLNESS SIG: CALL FOR VOLUNTEERS

The Health Promotion and Wellness SIG is seeking volunteers to assist with the development and promotion of health and wellness research updates. No experience needed!! You can contribute by writing a short summary of one or more articles on one of our many topics.

See the SIG Web site for our research updates at:
www.geriatricspt.org/special-interest-groups/health-wellness/sig-health.cfm

Contact Lori Schrodt to volunteer or for further questions at:
lschrodt@email.wcu.edu

ERRATUM

Apologies to *GeriNotes* author, Shawn Arrington DeVol for a misspelling that occurred in the title of her article that appeared in the Volume 20 No. 1 January 2013 issue of *GeriNotes.* The correct title of the article is, A Multidisciplinary Fall Management Program Design Using Home Health for Elderly Residents with Dementia Residing in an Assisted Living Setting. Again, we apologize for the error.

GRAVITY ASSISTED SEATING: PREVENTION OF WHEELCHAIR RELATED FALLS IN LONG TERM CARE

Betsy Willy, PT, MA, CWS

INTRODUCTION

Fall related injuries continue to be a quality improvement focus of the National Quality Forum Quality Measures.[1,2] A significant number of falls in long term care facilities occur from wheelchairs. In the past, the industry has addressed this problem using restraints and personal alarms. Falls from wheelchairs can be significantly reduced without use of restraints or alarms, through appropriate attention to the biomechanics of the fit of the chair and using gravity to assist in maintaining stability in the chair during the performance of dynamic and static activities. This article addresses application of this principle to the general population served by long term care facilities.

Assigning wheelchairs to newly admitted residents often falls to nursing personnel who have little or no training in wheelchair fitting. In many homes, referral to therapy for wheelchair fitting does not occur unless the resident has complicated neurologic tone or orthopedic issues or has experienced a recent fall from his/her chair. Therefore it is essential that key nursing personnel as well as therapists understand the basic principles of wheelchair seating. Nursing needs to be able to recognize inappropriate seating, fit chairs for the non-complicated resident, and know when to refer for a therapy consult.

Falls from a chair occurs when the individual:

- attempts to rise from a chair unsupervised,
- becomes agitated and impulsive,
- overreaches toward the floor or to the side,
- rocks center of gravity beyond the base of support,
- fails to lock their brakes during transfers, and/or
- slides into sacral sitting and then onto the floor.

TWO FINGER AND MARBLE RULES

Therapists should make a concerted effort to teach nursing and other caregivers to apply basic biomechanical principles to ensure comfort and good fit when assigning wheelchairs. The application of the two finger and marble rules instill a visual image. These rules work well when seating most residents. More complex residents should be referred to therapy.

- To prevent sliding into sacral sitting: The thighs should be level with feet resting flat on the floor or foot pedal support. If an imaginary marble would run downhill off the knee when placed on the thigh, the seat is too high.
- To ensure good trunk support: There should be no more or less than two fingers width of space between the hip and the inside of the wheelchair arm panel.
- To reduce pressure per square inch and increase the base of support: There should be no more than two fingers width of space between the back of the calf and the front edge of the wheelchair seat.
- To prevent falling forward out of the chair: The resident's nipple line should not fall in front of the front edge of the wheelchair seat as they bend forward. This will ensure that the center of trunk mass remains within anterior/posterior the wheel base (base of support) of the chair during reaching activities.[3]

UNSAFE RISING FROM CHAIRS

As humans, we have a physiologic need to move. We all move away from pain and toward comfort. Poorly fit chairs contribute to discomfort that can be relieved by changing positions. Anticipating the need to move, and providing many opportunities for optional seating and position changes, is critical to prevent a resident from initiating an unsafe transfer by himself. Boredom itself is relieved through movement and the seeking of alternative stimulation. It is essential to meet the need through anticipation of the response and interceding before the fall occurs.

FALLING FORWARD FROM WHEELCHAIR

When the seat is too high and the depth is inadequate, the seated resident will experience falls forward out of the chair when reaching for objects on the floor. This problem can be eliminated by:

- lowering the chair seat either by changing the wheel positions or through use of a "hemi," "super-hemi," or youth sized wheelchair.
- increasing seat depth to prevent the nipple line from falling in front of the chair seat when bending forward. This will maintain the center of mass of the trunk within the wheel base.
- using gravity to assist in stabilizing the pelvis, by dropping the back of the seat and raising the front of the seat. Some therapists call this "dumping the seat." Change the wheel positions, placing the back wheel in the top axel position and the front castors in the lowest hole on the castor stirrup. For those who use their feet to propel the chair, the chair frame must be low enough to allow the feet to rest flat on the floor. This may require starting with a chair with a lower frame.[3]

KYPHOSIS

The resident with significant kyphotic back deformity will also fall forward as their head and upper trunk or center of mass is in front of their hip joints. These individuals usually demonstrate significant sacral sitting due to the mechanics of the back deformity. These folks are often placed in recliner chairs increasing the pressure on the apex of

their kyphotic back curve and sacrum.

The principles for seating individuals with kyphotic back deformity include:

- tipping the chair seat by changing the wheel positions as described above. This helps achieve a vertical position of the face to reduce hyperextension of the neck during social interaction and swallowing.
- providing a total contact back support by removing the back upholstery of the chair and replacing it with a moldable or stretchable back that conforms to the shape of the individual. This reduces points of high pressure while maintaining an upright sitting position.
- ensuring that the chair frame is low enough to allow foot propelling for independent mobility.
- addressing pelvic obliquity as needed to provide lateral stability and comfort.[3]

Figure 1. Seating for kyphotic back deformity.

SACRAL SLIDING FROM THE CHAIR

Use gravity to prevent a person from sliding into sacral sitting by lowering the back of the seat and raising the front of the seat. The use of wedge cushions and dycem can be eliminated by angling the wheelchair seat, lowering the whole frame as needed, and increasing the chair depth as appropriate. Use of a recliner wheelchair simply increases the slide angle making it more likely that the individual slip out of the chair unless the feet are jammed against raised footrests. Tipping the chair seat eliminates the need for the recliner wheelchair.

DEFINITION OF A RESTRAINT

As defined by CMS's Minimum Data Set 3.0 Section P, "physical restraints are any method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body."[4] The practical interpretation of this definition of a restraint is a device that 'restrains' the individual from doing something that they could do without the device. Angling the wheelchair seat and lowering the frame does make it more difficult for the resident to rise independently from the chair. If the resident is dependent in their transfer activity, lowering and tipping the seat angle does not fall under the MDS (minimum data set) definition of a restraint. However, if this intervention prevents the resident from performing an activity that they could do from a standard wheelchair, it must be documented as a restraint, care planned, assessed quarterly, and have a physician's order and permission of the POA or resident.

There has been a great deal written about the dangers of restraint use.[5] Through experience, we are aware that personal alarms rarely prevent falls,[6] they only reduce time of response to a fall. An alarm is meant to alarm you. Your trained response when an alarm sounds is to leave the area of risk, not to sit back down, and quietly wait for someone to turn off the alarm. Alarms contribute to noise pollution. Noise pollution contributes to sleep deprivation, agitation, and aggression from other residents, as well as fear withdrawal and embarrassment of the alarmed resident. The goal is to reduce fall risk without resorting to the use of restraints and alarms.

MORBIDLY OBESE RESIDENTS

Not only do the morbidly obese residents require wider wheelchairs, but the seat itself needs to be deep enough to properly distribute the pressure under the thighs and prevent the individual from sliding off the front edge of the chair. The girth of the thigh brings the feet up off the floor requiring a lower wheelchair frame to achieve level thighs and fully supported feet if self propelling with their feet.

These folks tend to accumulate large fat pads behind their pelvis and across their abdomen below the diaphragm. The fat pad behind their pelvis pushes the pelvis forward in the seat, necessitating a deeper seat. The natural low back curve and lack of bulk behind the shoulders results in a reclined position of the upper body. The arch of the low back causes back pain that can be relieved through proper support for the low back curve and posterior shoulders, and a more upright sitting posture. This chair seat could also be tipped to allow gravity to assist in preventing a slide if proper support is inadequate to provide comfort and safety.

It must be kept in mind that this upright position may compromise effective mobility of the diaphragm from the upward pressure of the abdominal fat pad. Assess the pulmonary response of these residents and provide a more reclined position with adequate low back support as needed to maintain appropriate oxygen saturation.

Figure 2A. Incorrect seating of bariatric resident.

Figure 2B. Seating the morbidly obese individual.

SEATING FRAIL RESIDENTS WITH SIGNIFICANT CONTRACTURES

Opportunities for socialization, stimulation, and position changes for significantly debilitated residents with hip and knee flexion contractures present a real challenge. There is a high risk of progression of the contractures, pain from positioning, and pressure ulcer development from inadequate pressure redistribution.

In the past, nursing home staff has tried to accommodate the needs of these residents through the use of "Geri chairs" or reclining wheelchairs. Even with pillow support of the hips and knees, residents' legs will rotate to one side or another, painfully twisting the low back and assuming a "wind swept" position. It is difficult to achieve pressure relief as the heels dig into the support surface and the sacrum and coccyx rest on the unforgiving surface of the chair.

The use of the "Geri chair" can now be eliminated by substituting the manual "tilt in space chair." Reasonably priced manual "tilt in space" wheelchairs, now available through several different manufacturers, have multiple adjustable features to allow seating to accommodate the restrictions of the resident. Maintaining a 90° angle of the seat to the back of the chair and tilting, not reclining the chair, allows for multiple positions to promote safe feeding, social interaction, and alternative positioning to the bed. Neutral rotation of the pelvis can be achieved if the chair accommodates the knee contractures and allows the feet to position under the front edge of the chair seat. However, it remains a challenge to find good foot support in this position for feet contracted in a plantar flexed position.

PACING IN THE CHAIR

Pacing activity of an ambulatory resident with dementia can be considered a form of vestibular self stimulation. The need for this movement stimulation does not immediately cease as their balance deteriorates, and it becomes necessary to discourage independent ambulation.

Meeting this need to move through multiple movement activities can reduce the risk of unsupervised rising from the wheelchair with resultant falls. Activities or restorative programs that include use of stationery rockers, gliders, assisted walking, opportunities to stand and stretch, and stationery recumbent bike exercise can be offered intermittently throughout the day. Rock and go wheelchairs are now available for unsupervised safe independent mobility. Success in managing this high risk faller is based on recognizing this behavior as a neurologic need and providing timely interventions that meet the drive for almost constant movement.

COST EFFECTIVE MANAGEMENT OF SEATING RELATED FALLS PREVENTION

Optimizing the use of current wheelchair stock requires that the right residents are in the right wheelchairs. As you analyze your facility's needs, start first with a wheelchair shuffle to fully use the chairs you currently have.[7] Make a list of residents who have equipment needs that are not being met. Prioritize those with a history of falls.

It has been this author's observation that most nursing homes have done a good job of providing extra wide chairs as needed, but are lacking chairs with extra depth. Wheelchairs in use today have multiple positions for the front castors and back wheels. Some have adjustable back height. You will recognize these chairs by the extra back upholstery hanging below the back edge of the seat. Ordering one or two specialty chairs per month will help you achieve the variety you need to meet the needs of your population.

Department of Health Surveyors will hold the facility itself responsible for meeting the safe seating needs of their residents, regardless of the reimbursement agent. Work with Hospice and your HMOs for appropriate financial support. Overcome the resistance of the family who brought an ill fitting chair into the facility. Keep in mind that "the buck stops here," and the liability for injuries from falls related to poor wheelchair seating lies with the nursing home administration. So long delays, due to attempts to find alternative funding, place the facility as well as the resident in jeopardy.

SUMMARY

Seating is an ever changing arena as new products become available. Provision of appropriately fit, well maintained, comfortable seating is only one intervention in fall prevention. Rising unsupervised from a wheelchair is body language that says, "I need something that you did not anticipate, and I'm going to take care of that need myself." It helps that the chair fits and is comfortable, but in the end, fall prevention requires that staff know the habits of their residents so well that they anticipate and meet their needs before the fall occurs. This requires a truly dedicated staff, ongoing vigilance, and a supportive team effort.

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HAITI REVISITED

Lucy Jones, PT, DPT, MHA, CEEAA; Chuck Gulas, PT, PhD, GCS

Life in Haiti remains difficult following the earthquake, flooding, and cholera outbreaks. Resources are scarce and slow in reaching those in need. There is no postal service in Haiti, rendering transportation difficult, and impairing the delivery of needed items. The health care is scattered, but there are pockets of health clinics that serve those within their local reach. Various nonprofit agencies provide health services. Haitians are charged for services, and most are unable to pay for them. There are different rates for care depending on location.

The rehab program at Albert Schweitzer Hospital in Deschappelles, Haiti, is doing well, with two Haitian physical therapists (PTs) and 6 rehab technicians trained by the Health Volunteers Overseas program and the physical therapy volunteers serving there. The health care community now meets in Port au Prince periodically to help coordinate services and decrease the duplication of programs. After the earthquake, everyone wanted to provide as many services as possible to those in need, and the meetings stopped, thus leaving limited coordination.

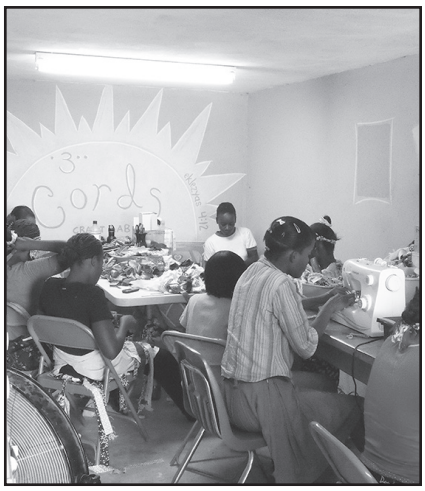
VENTURING BEYOND OUR BORDERS

Landing in Haiti was an adventure in itself. From the air, one can see pockets of the bright blue "tent cities." Once on the ground and out of customs, pandemonium ensued as baggage was unloaded on one side of the terminal, just outside of customs. It was a free for all to retrieve luggage, piling our belongings together. We brought a backpack carry-on with our personal items, and each of us brought two large suitcases with donated items for the Mission of Hope (MOH), our destination. Finding the MOH driver calmed some anxiety; however, exiting the airport was not for the faint of heart, as we were approached from all sides by people asking if we wanted a ride and wanting to grab our bags to take them to their cars. Next was the MOH bus for the 45 minute ride to Titanyen and the MOH center. People were everywhere, some waiting on the street corners for the "taptap." This is Haiti's informal bus service, made up of small pick-up trucks or vans with people jammed inside, riding on top, or hanging off the sides. It was an accident waiting to happen. Blue tents were everywhere. We were instructed not to take pictures of people, since we were not to appear as tourists documenting their suffering, but volunteers to assist with improving the situation, one person at a time.

The bus ride was slow and bumpy, negotiating pot holes, rocks, and cracks in the highway, remnants of the earthquake. The strikingly calm rural countryside emerged, with the bay to the east and mountains to the north. We arrived at a walled compound, where an armed guard was posted to deter thievery and ensure a safe environment for the orphanage, hospital, school, prosthetic clinic, food distribution centers, staff housing, and 1000-seat community church. As the gates to the complex opened, we heard celebratory singing from a wedding conducted in the church near the entrance. Despite the odds, joy continued here as did family celebrations. Our bus became silent, and we were spectators to the fact that life continues with rejoicing and celebratory days. Life has moved on despite bleak circumstances and surroundings.

THE CLINIC SUSTAINED

The MOH health clinic was open 10 to 3 Monday to Friday, staffed with 3 Haitian LPNs and one RN, two volunteer physicians with commitments for one year, and two volunteer RNs (one to serve in the wound care area, and one as a coordinator for the program). There were no PTs in the clinic, but a series of volunteer PTs to assist with the pediatric cases in the orphanage, medical and rehabilitation needs, and the prosthetic clinic. They had a cottage industry, "Three Chords," recently enlarged to accommodate 28 women and a full time Haitian coordinator. This was started as a way for those women with earthquake injuries, amputations, and displacement, to earn a living post-earthquake.



3 Chords, the cottage industry and occupational therapy center.

The prosthetic clinic was staffed by two technicians. It was a rectangular room with parallel bars, equipment for prosthetic revisions, various sized prosthetic feet, supplies, and a wall of shoes. A monthly visit from a prosthetic group in Puerto Rico allowed for fitting, adjusting, and measuring for new prostheses and revision of existing ones. The physical therapy provision was sporadic, with one week and two week assignments. The clinic had a registration process, a requested payment of one Haitian dollar, and a triage nurse taking blood pressure, weight, and basic medical history. It was after this process that individuals saw the Advanced Practice Nurse or physician, who would then send them to the prosthetic/physical therapy clinic. There were also visiting dentists to accommodate dental needs.

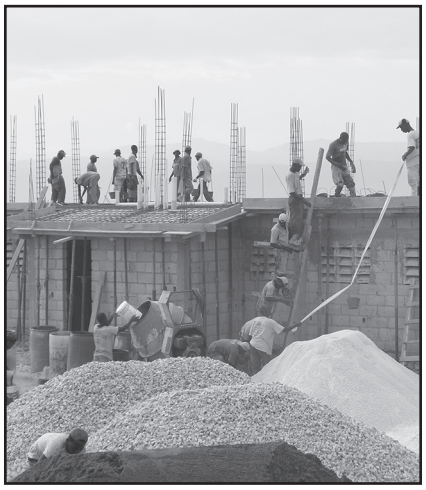
Since each client had to stand in line to register in the early morning, physical therapy time was used for wound care treatments, some for wounds unhealed since the earthquake of January 2010 (our visit was February 2011). Wound dressings and meds were sparse, and

were always on the donation list for volunteers to bring with them. The wound dressings/medication cabinet contained numerous items that were found that were expired, and as heartbreaking as it was to throw out dressing items that were one month expired, it was necessary to avoid facility closure by the Haitian Department of Health if an inspector paid a visit.

Mission of Hope Haiti (MOHH) was managed by core volunteers and local Haitians---an ER physician, a wound care nurse, a chiropractor, an RN, a facility manager, and a construction engineer, to name a few. The mission also provides staff for a K-12 school for 2500 students, an orphanage for 50 children, and the kitchen that feeds those living on site. The kitchen also hires Haitians to help produce thousands of meals for distribution to the surrounding community. Feed the Children, as well as other benevolent organizations, contribute to the food supply.

Mosquito nets over the beds and the 4 AM rooster call were daily reminders of our surroundings. We lived as locals did, with no special treatment. Merely walking to the clinic and meals was a constant climb, negotiating the rocky and treacherous terrain, constant reminders of the rearranging that the earthquake had created. In Haiti, PTs can write orders for x-rays; however, the access to care was a challenge. Extra supplies were scarce. We sifted through a mound of crutches to build a new pair out of various parts.

Provisions for health care and physical therapy for MOHH were fairly typical for the area outpatient clinics, with a copay required to register (with provisions available for those who could not pay) giving accountability for the services. The MOHH was a regional community service facility and a main trauma center and fully functioning hospital following the earthquake and cholera epidemics. A permanent hospital is currently being built with donation dollars. Ancillary services were marginal as physical therapy was only provided by volunteers. Medications were given in one to two day doses, with a prescription for more if needed. The physician gave the script with full knowledge of possible noncompliance due to inability to pay or lack of access to a pharmacy.



Mixing concrete manually to build and expand the hospital clinic.

Silo of supplies donated after the earthquake to MOHH.

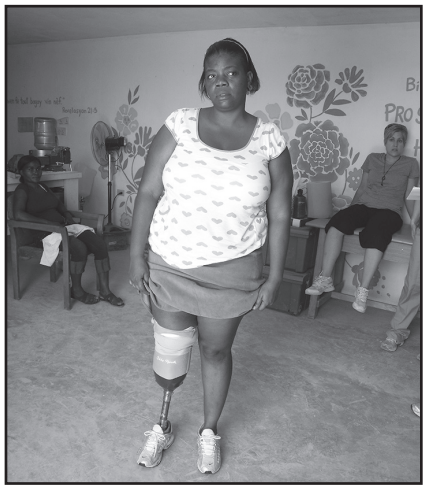
TO WALK AGAIN

The prosthetic clinic was a busy place on the days the prosthetists arrived from Puerto Rico with deliveries of prostheses ordered, repaired, and revised. Individuals were triaged to the clinic without the need for the copay. It was the first prosthesis for several of the individuals. We as PTs took patients out of the crowded clinic to train them on the rugged terrain they would have to negotiate with their new limb. We assisted with alignment evaluation, gait training, and foot and shoe management. One limb for a young woman was delivered with a white foot. After searching boxes and shelves, we finally located a brown foot in her size. The wall of shoes provided a pair to fit the prosthetic and her residual foot. Another young man had a more difficult time adjusting to his prosthetic training due to a short residual limb. Managing the knee extension moment and alignment proved a challenge. He would be returning to the clinic for additional training in the parallel bars. Two prosthetic technicians did the revisions during the time between visits. They had instruction and on the job training from the prosthetists. One of the technicians spoke excellent English due to being a translator in a previous job at the hospital. He was essential to the successful translation from Creole to English of home program instruction and patient communication.

Medical issues also presented themselves in the prosthetic/physical therapy clinic. Poorly managed high blood pressure was a factor with the high level of energy expenditure for gait for the older adults with paresis from stroke and injury. Some would return every other day for the next day's medication. In one case, we learned that the husband gave his wife his blood pressure medicine so she would be able to tolerate the increased effort required for gait training. Other issues impacted physical therapy that was to be given to individuals. Public health concerns abound in these surroundings. A lack of clean water, poor medication education (when and how to take medications), and the unavailability of needed x-rays and other special tests were constant barriers to surpass.

The x-ray machine was broken at MOHH for 6 months. The closest vendor for repair was in Puerto Rico. The prosthetic group had an orthopedic surgeon traveling with the team who offered to research the repair. This was a tremendous boost, since x-rays at the Port au Prince Hospital were 25 Haitian dollars. A 32-year-old man, Robert, had a femoral fracture after being hit by a "tapap," Haiti's overcrowded small buses. He had a surgical repair with a rod and pin in the left LE. He was excited to come to the clinic, and he literally waved the x-ray and the report at us when he arrived. He had saved for a month to afford the x-ray fee. He was healed and ready for a stretching program. He was given a home exercise program, and the technicians, who doubled as PT aides, were instructed in supervising the exercises and progression until the next PT volunteers arrived for further evaluation. Different colors of donated elastic bands were given to him to provide resistance. Robert was told to take ibuprofen one

Young man who saved enough dollars to buy an x-ray.



First day on prosthesis since her amputation post-earthquake.

hour before he came to therapy for exercise. We gave him several doses and instructed him how to take them with meals. A striking illustration of the culture was made as he replied, "I don't know when I will eat next." He returned twice more that week, in a lot of pain from the exercises, but glad he had hope of more mobility.

We weren't always able to achieve the progress we did with Robert. A young woman visited who had fractured her femur during the earthquake and received a surgical repair of rod and pin insertion. She had used old crutches for the past year to get from place to place. Scars were healed, but an x-ray was needed to indicate the extent of healing of the femur, and allow visualization of the rod and pin placement to rule out impingement. She had knee pain, reduced knee flexion, and possible screw protrusion in the lateral distal femur. We wrote the order for an x-rays of her right knee, but she needed to travel to a hospital with a functioning machine, and we did not see her in the clinic again during our stay.

THE EIGHT DAY RULE

During the initial PT assessment, we noticed a trend that most injuries or illnesses had an onset of "8 days ago." The translator, David, said that frequently individual health history was neither time sensitive nor reliable as to occurrence. He said that the Haitians were a relaxed people, with time holding a lesser importance. This made the evaluations difficult, because one never quite knew the duration or intensity of the illness. Acquiring health histories was a challenge especially with wound care. One 17- year-old had a leg wound that reportedly was over a year old, received during the earthquake. His parents had given their last dollars to a voodoo doctor to bring healing, which never materialized. He eventually came to the clinic and was able to enroll in the school. He came every morning before school to get his wound dressed. The "Eight Day Rule" was proven incorrect by the extent of the injury and poor healing, which were evidence of a chronic condition. However, sometimes the relaxed nature of the culture was advantageous, since people could wait for several hours in the open air clinic waiting room before seeing the doctor.

TRIAGE FOR HEALING

Amputee care was at times haphazard after the earthquake. Limbs were revised as needed to save infection and limb loss, resulting in limb lengths varying as the need to revise arose. At one point, surgeons in Port au Prince were doing an average of 40 amputations a day to prevent further infection. Early medical intervention was similar to that of a war zone, with crush injuries from falling debris. Everyone had their earthquake story. One PT tech at the clinic lost his daughter, another had to jump out of a second story window because the floor cracked and separated in his house, and he injured his back and fractured his arm. Another family was miraculously saved because their stove had broken, causing them to leave the house to go to the outdoor market. Everyone was affected, all were traumatized, and surviving was the task of the day.

LOOKING AHEAD, WORKING TOGETHER

This is third world medicine, with limited sterilization and best efforts to prevent cross contamination and improve the health and function of individuals. Follow up on interventions and medications can be difficult, since many patients do not return regularly to the clinic. Thus there is great need for community health initiatives. Haiti One is an effort to coordinate the non-governmental organizations to prevent and guard against task overlap and duplication in the country. The organization focused on uniting the efforts of non-profits on the ground in Haiti, working together to build a sustainable Haiti. It is a collaborative effort to disseminate information and resources for training, rebuilding, medical care, and food distribution. The country may need a generation of healing with coordination and contributions from industry, medical services, international aid groups, and above all, a unified effort on the ground in Haiti committed to providing the people with a sustainable economy. Mission of Hope Haiti has a 3- to 5-year plan of building elder housing on their southern property, the first effort of its kind in the country. It is a start. There is so much to do, but many hands make lighter work. Lives are at stake. Multiple groups are on the ground, and though the task is daunting at times, every success counts.

Lucy Jones has worked in a variety of geriatric settings from inpatient to outpatient, home health to skilled nursing facilities. She served in Titanyen, Haiti with Mission of Hope Haiti in their prosthetic and hospital-based clinic. Her practice has come full circle serving currently as the Geriatric Specialist for FIT Rehab, a Home Health and Outpatient group in southern New Jersey.

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THE ROLE OF PHYSICAL THERAPY FOR OLDER PERSONS: THE SINGAPORE PERSPECTIVE

Sin Yi Lee, PT, CEEAA

INTRODUCTION

"Age well together, live life to the fullest." This is our vision, as the first geriatric special interest group of the Singapore Physiotherapy Association (SPA) since its establishment in 1964. Our team of dedicated physical therapists with an average age of less than 30, set our heart on achieving our mission: "To be proactive in advocating for holistic care to improve the health, functioning, and well-being of older persons." Founded in November 2011, the Geriatric Chapter knows that our journey has just begun.

This discussion will provide a brief account of Singapore's demographics and health trends, followed by an outline of our health care system and some of the governmental strategies. Next, we will elaborate on how this impacts on physical therapy practice and education in geriatrics and gerontology, as well as how the Geriatric Chapter can move physical therapy for older persons forward in our country.

DEMOGRAPHICS AND TRENDS

Singapore is the second fastest aging population in the world today primarily due to our declining total fertility rate and rising life expectancy at birth.[1] In 2011, 9.3% of our population was above age 65[2] and this is estimated to reach approximately one-quarter by 2030.[3]

More worrying is the apparent rise in functional disability described in a local study that 5% of people older than 60 years of age require personal assistance in at least one out of 5 activities of daily living (ADLs) related to self-care compared to 2.9% in 1997.[4] The prevalence increases to a greater extent with the older age groups. This population-based survey conducted in 2003 to 2004 also showed that chronic medical conditions such as hip fractures, stroke, arthritis, asthma/ chronic obstructive pulmonary disease, kidney failure, urinary problems, and cognitive impairment were significantly associated with ADL disability.[4]

The national trend demonstrates the shrinking of social networks, including that of older persons above age 65, portraying a shift towards a smaller household size of predominantly two and 3 members, with about half living with their children.[3] In addition, close to one-fifth (17%) are cared for by foreign domestic workers.[3]

The proportion of older persons above age 65 who are employed has nearly doubled (from 10.4% to 20.4%) between 2004 and 2011, with a higher proportion of men compared to women.[5] The 3 primary sources of income for older men and women are from their children/ grandchildren/ relatives, work, and savings.[3]

SINGAPORE'S HEALTH CARE SYSTEM AND POLICIES

Evolving Health Care Structure and Delivery

In view of our changing demographics, the Singapore government, incorporating various other strategies in the social, housing, and infrastructure arenas, is also restructuring the health care system and its delivery of care services, moving from a "compartmentalized episodic care" towards a more integrated approach.[1]

There are 5 regional health care clusters in Singapore, each anchored by a tertiary hospital collaborating with a network of primary, intermediate, and long- term care partners.[6] The primary aim is to provide comprehensiveness, accessibility, continuity, and coordination of care from one setting to the next. Our primary health care services include close to 2000 private practitioners (80%) and 18 island-wide government polyclinics (20%), while public hospitals provide 80% of the tertiary care compared to the private hospitals (20%).[7] Our long-term care services include both residential (eg, community hospitals, sheltered homes, nursing homes, chronic sick hospitals, hospices) and community-based services (eg, day rehabilitation and day care centres, home-based medical, nursing and rehabilitation services).[7] Long term care in Singapore is mainly provided by voluntary welfare organizations, with partial governmental support (provides up to 90% capital funding and up to 50% operating expenditure).[8] Much of their funds are raised via community and charity donations.[8]

The Agency for Integrated Care was tasked in 2009 to drive and facilitate the reforms towards a seamless delivery of health care, one of which involves the implementation of a new national care assessment framework.[1] In addition, underlying the reform is the development of an electronic health record system that will be accessible by authorized health care practitioners across all care sectors.[1]

ENHANCING HEALTH CARE FINANCING

At the same time, Singapore's health care financing policies are also undergoing remodeling. The coupling of a rapidly aging population and the growth of chronic diseases is expected to raise Singapore's health care costs[9] together with other factors, such as the advancement in medical technology and interventions, as well as an increase in public expectations.[10] Annually, Singapore spends about 4% of our Gross Domestic Product on health care.[11] The first tier of protection is provided by government subsidies up to 80% of the total bill in acute public hospitals and is accessible to all Singaporeans through financial means testing.[11]

Based on the philosophy of shared responsibility and the economic principle that health care services should not be supplied freely on demand without reference to price, the "3M" system-Medisave (1984), Medishield (1990), and Medifund (1993) forms the cornerstone of Singapore's health

care financing system.[10] These, however, were not initially designed to incorporate long-term care needs. [9] Eldershield (2002), Interim Disability Assistance Program (2002), Medifund Silver (2007), and Community Health Assist Scheme (2012) were subsequently launched to ensure that health care is made affordable for all Singaporeans. The schemes are described in greater detail in table 1.

In addition to government financing schemes, health care is also disbursed for by means of private medical insurance, either on an individual basis or through organizations and employers.[8] Physical therapy services, however, are mostly paid out-of-pocket. Medisave covers up to $450 per day for hospital inpatient services including rehabilitation.[13] From June 2010 onwards, a maximum of $25 per day can be claimed for rehabilitation services at day rehabilitation centers.[13] Private insurance plans do not commonly offer protection against the costs of outpatient rehabilitation.

RECENT DEVELOPMENTS IN HEALTH CARE POLICY: PREVENTATIVE, CURATIVE, AND PALLIATIVE CARE

At the beginning of 2012, the Singapore government introduced a series of health care reforms, accompanied by various other socio-economic strategies. Some of the policies will be highlighted below. There are plans to build more facilities including community hospitals (with 2 more opening in the next 3 years), day care and senior activity centres,[14] expand the tertiary hospitals' capacity, and engage more health care professionals.[15] They have also announced an enhancement of subsidies for intermediate and long-term care services (eg, community hospitals, day rehabilitation, day care and home care services), on top of easing the qualifying criteria for subsidy.[16] The "Enhance for Active Seniors" or "EASE" program will be launched to provide approximately 90% subsidy for home modifications and safety features[13] in households with older persons.

At the same time, the Singapore government, looking into redefining aging as opportunity, set up the Council for Third Age (C3A) to change the traditional perceptions of old age and to promote active aging.[17] Since 2007, the C3A has been championing to foster a society where seniors lead 'full, active, and meaningful lives' through education, outreach, and partnership.[18] Some of their activities include organizing activities for health and wellness, encouraging life long learning, as well as conducting intergenerational programs. Its approach is in line with the World Health Organization's policy framework of active ageing that encompasses the interplay of physical, health, social, economic, personal, and behavioral factors.[19]

Besides the above, health care resources are also channeled with a greater emphasis on palliative care with the Ministry of Health announcing in 2009 the expansion of hospice care, enhancing end-of-life care in nursing homes and ramping up the number of

Table 1. Health Care Financing Schemes in Singapore

Schemes	Description
Medisave	• A compulsory individual medical savings account • Working Singaporeans and their employees contribute a part of their monthly wages into. • Can be used for hospitalization bills and certain outpatient treatment including health screening, approved vaccinations, cancer treatment and chronic diseases
Medishield	• A low cost catastrophic medical insurance scheme through features of deductibles and co-payment
Medifund	• An endowment fund set up by the Government to help needy Singaporeans who are unable to pay for their medical expenses despite MediSave and MediShield.
Medifund Silver	• Launched in 2007, to carve out a portion of MediFund specifically for the older population age 65 and above
Eldershield	• A severe disability insurance that provides a monthly cash payout for out-of-pocket expenses for a severely disabled person. • The premium, payable till age 65 is determined at the age of entry and does not increase with age. • Singapore citizens and permanent residents who have Medisave accounts are automatically covered under ElderShield at age 40.
Interim Disability Assistance Program	• Provides government assistance for needy and disabled older persons who are not qualified for ElderShield
Community Health Assist Scheme	• Started in Jan 2012 • Provides affordable healthcare for the needy older persons and disabled Singaporeans with the qualifying age of 40 years old and qualifying income criteria of less than SGD 1500 monthly. • The program also covers treatment for the chronic diseases covered under the Chronic Disease Management Program that includes diabetes mellitus, hypertension, lipid disorders, stroke, asthma, COPD, schizophrenia, major depression, dementia and bipolar disorder.

palliative-trained doctors and nurses.[20] The report on the National Strategy for Palliative Care published in January 2012 recommends to 'ensure that all health care professionals are provided with the necessary training to provide the appropriate level of palliative care for patients' and 'incorporate palliative care training in all undergraduate and diploma courses for doctors, nurses, and allied health professionals to ensure that all new health care professionals have basic knowledge in palliative care.'[21]

PHYSICAL THERAPY PRACTICE AND EDUCATION IN GERIATRICS AND GERONTOLOGY

Current Situation

At present, physical therapists are trained at a diploma level at the Nanyang Polytechnic, School of Health Sciences.[22] Since the course began in 1992, the cohort of students have grown yearly from less than 20 to approximately 100 in 2012. Yet, this is scarcely meeting the needs of our population. In year 3, the students attend a 45-hour "Physiotherapy in Gerontology" module, including lectures and practical sessions. There are currently no compulsory clinical placements for gerontology in the course.

Students are also able to pursue their degree conversion overseas or locally through a Bachelor in Science (Physiotherapy) course offered by Trinity College Dublin, in collaboration with the Singapore Institute of Technology. [23] In the latter program, education on the aspects of geriatric care is blended into the one-year course curriculum.

Locally, as of December 2010, we have about 6 physical therapists trained at a post-graduate level in gerontology compared to over 60 in the fields of musculoskeletal and sports. On top of that, more than half of the physical therapists work in the acute hospital settings with the others in the community.

THE GROWTH OF THE AGEING POPULATION: ITS SIGNIFICANCE FOR PHYSICAL THERAPISTS

The dawning of the "silver tsunami" can be either a "bloom" or "gloom," and the implications for us, as physical therapists working with older persons, is huge. Extending from preventative, curative to palliative care, we play a crucial part in all aspects of health, 'providing services to individuals and populations to develop, maintain, and restore maximum movement and functional ability throughout the lifespan.' [24] On a personal note, it is also undeniable that we all grow older together, and some of us may also end up as caregivers for our parents' generation. There is an imminent need to not only train more physical therapists in Singapore, but also to encourage positive attitudes and equip them with the appropriate knowledge and skills to work with older persons and their families across the various care spectrums.

At the undergraduate level, we need to ensure that our curriculum is well designed and updated to meet the requirements of the evolving Singapore health care system and landscape. Geriatrics and gerontology should be blended into the entire curriculum, eg, including relevant case studies on older persons in a sports clinic practical. Incorporating necessary research skills to facilitate greater evidence-based practice in the field of geriatrics and gerontology is crucial to spur our profession forward. Experience and exposure in managing older persons and their families needs to be introduced, not just within a focused attachment but also within attachments in other areas such as cardiopulmonary, neurology, and musculoskeletal. Clinical supervisors have to be aligned with the revised curriculum as well, to ensure translation of knowledge into actual practice. Ideally, training should be carried out with other members of the health care team, whether in school or in the clinical settings.

More physical therapists need to be trained at postgraduate levels with a focus in geriatrics and gerontology. We envision a Masters course in the future that allows the cultivation of a team of clinicians, educators, and researchers with advanced skills in physical therapy for older persons, and also an all-encompassing understanding of the bio-psycho-social and economic aspects of aging. In addition, more continuing professional education courses focusing on practical and active approaches with emphasis on evidence-based and knowledge translation is essential to promote the actual improvement in the management of older persons. Educational and health care institutions can provide greater education and funding for research in the discipline of physical therapy and geriatrics/gerontology.

As physical therapists working with older persons, we have to advocate for them and their families and caregivers, and collaborate with the interdisciplinary team to strive for comprehensive, coordinated person-centred care. We have to be proactive in achieving proficiency in the discipline and commit to applying the best available evidence, including our clinical expertise, as well as the older persons' and their families' experiences into our practice. In Singapore, there is a tremendous call to move beyond the scope of acute hospital care, and focus on the preventative and community aspects as well. It entails the necessity for us to empower and facilitate the older population to travel up the slippery slope of aging as far as possible. When no longer able to, we learn to be present and support the older persons adequately with comfort care.

CONCLUSION

The SPA Geriatric Chapter holds a pivotal role in leading the change. No doubt, we are a young team, but one who is devoted and steadfast in uniting physical therapists in Singapore with the upheaval task ahead. It will be a steep learning curve, but with our friends and colleagues from the local and international community, we can pool and share our knowledge, skills and resources. Together, we endeavor to achieve what we have envisaged, for a better future not only for the older persons and families we work with, but perhaps more importantly for our parents, ourselves, and the generations to come.

ACKNOWLEDGEMENTS

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Sin Yi Lee is the chairperson of the SPA Geriatric Chapter. She is currently pursuing the Masters of Applied Gerontology from Flinders University, Adelaide. After completing CEEAA in New Jersey in 2012, she hopes to further contribute to developing geriatric physical therapy practice and education in Singapore.

POLICY TALK: OUTLOOK FOR 2013 – HOW ARE THE CHANGES INFLUENCING YOUR PRACTICE?

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

The number 13 is considered by many to be an unlucky number. If the number is any indication for the kind of year rehab providers will have, it is going to be a very long year. 2013 opened in typical fashion. Congress waited until the very last minute to pass a bill that would extend the therapy caps exception process and prevent the devastating cuts to the Physician Fee Schedule, both for another calendar year. The American Taxpayer Relief Act (ATRA) of 2012 was signed on January 1, 2013, and while many providers celebrated with another glass of champagne, it wasn't all celebration.

The American Taxpayer Relief Act included provisions that 'may' significantly affect rehabilitation providers. The first is the Multiple Procedure Payment Reduction Act which will increase to 50% of the Practice Expense for all Part B providers on April 1, 2013. This reduction applies to the 2nd and subsequent codes billed on the same day for the same patient, no matter what discipline (PT, OT, ST) provides the service. It is estimated practices will see between a 6% and 10% decrease in their total revenues. Since this policy will affect all therapists who bill Part B (skilled nursing facilities, home health agencies, hospital outpatient departments, and private practitioners), the impact will be felt throughout the industry and nation.[1] A second part of ATRA was the repeal of the Community Living Assistance Services and supports program (CLASS Act). The CLASS Act was a program passed as a part of the Patient Protection and Affordable Care Act (PPACA) and was designed to expand options for people who become functionally disabled and required long-term care services and supports, up to and including cash benefits that adults could use to purchase non-medical services and supports necessary to maintain community residence. In its place, ATRA established a Commission on Long Term Care that is tasked with developing a plan for the establishment, implementation and financing of a high quality system that ensures the availability of long-term services and supports for individuals. The commission is also required to provide recommendations for "issues related to workers who provide long-term services and supports," including (1) whether the number of such workers is adequate to provide long-term services and supports to individuals with long-term care needs, (2) workforce development necessary to deliver high-quality services to such individuals, (3) development of entities that have the capacity to serve as employers and fiscal agents for workers who provide long-term services and supports in the homes of such individuals, and (4) addressing gaps in Federal and State infrastructure that prevent delivery of high-quality long term services and supports to such individuals. This will be an important Commission to watch and hopefully a productive one.

2013 should be something of a transitional year for providers, as we continue to grapple with the current payment policies focused on retrospective reviews of quantity of services while also trying to position our profession and our companies for the integrated care models of the future which are focused on patient care outcomes more than the granular aspects of billing. All rehab settings will continue to feel this push towards insuring they are providing the right amount of services at the right time and measuring the effectiveness of that care.

Why are we seeing all of this focus on therapy services in every setting? The facts illustrate why (Figures 1-4). The utilization of therapy services is increasing. Do we have the facts to explain why? The characteristics of the Medicare beneficiary have changed over the last 10 years, but CMS analysis of its beneficiaries' demographic data still does not account for the variation. How do we identify who needs therapy and how much therapy is needed? We have a lack of universal quality outcome measures to compare patients across the spectrum of care or even within our own practice settings. Each practitioner or company chooses their own method of measuring functional outcomes, and therefore, it is difficult to benchmark results or quantify best practices. How do we begin to define these metrics so we can illustrate the value we provide to the health care system?

While providers have heard this 'theme' written and spoken about over the last several years, 2013 will be a year of tangible evolution of these concepts. Many settings where physical therapists and physical therapist assistants work will be involved in some kind of quality reporting or value-based payment system this calendar year.

Therapists who work in home health agencies (HHAs) may not even realize they are currently collecting outcomes data, and many of the measures are functional areas that physical therapy can impact. With the initiation of the OASIS-C tool, home health agencies started collecting process-based measures, including: timely initiation of care; multifactor fall risk assessment and prevention in the plan of care; pain assessment and intervention in the plan of care; and pressure ulcer assessment, prevention, and treatment in the plan of care. Outcomes are also measured through the OASIS tool. There are 37 risk-adjusted outcome measures taken from the OASIS that measure the change in a patient's health status between two or more time points, including improvement in the

[1] Please get involved in advocating for the repeal of this policy. APTA and the Section on Geriatrics have information available on their Web site to make it easier for you to contact your Congressional Representatives and Senators.

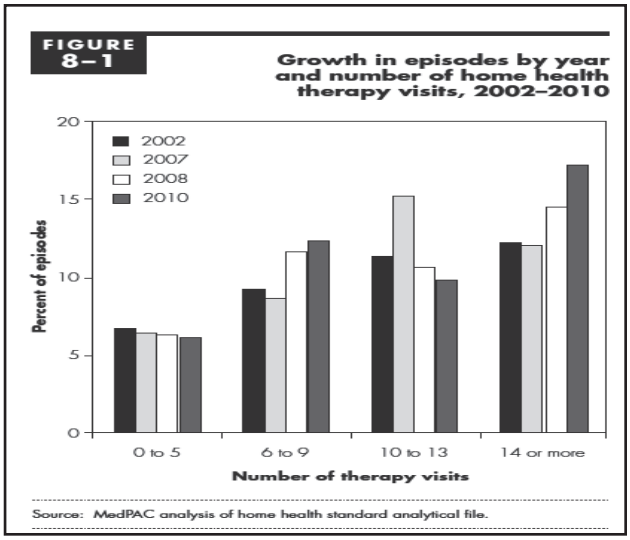


Figure 1. Source—MedPAC Report to Congress; March 2012.

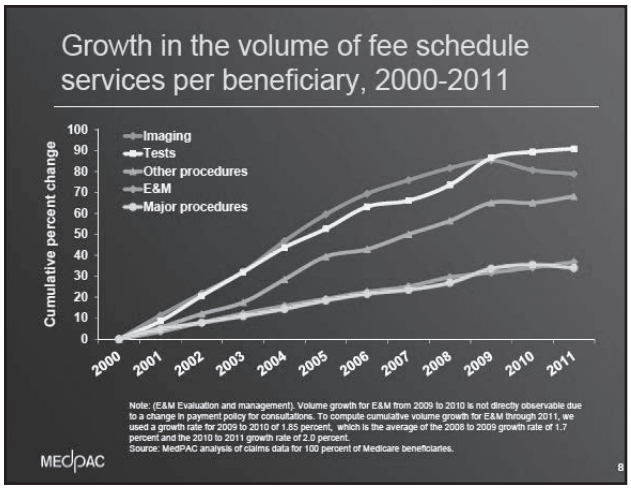


Figure 3. Source—MedPAC meeting; January 2013. *Therapy services fall into the category labeled "other procedures"*

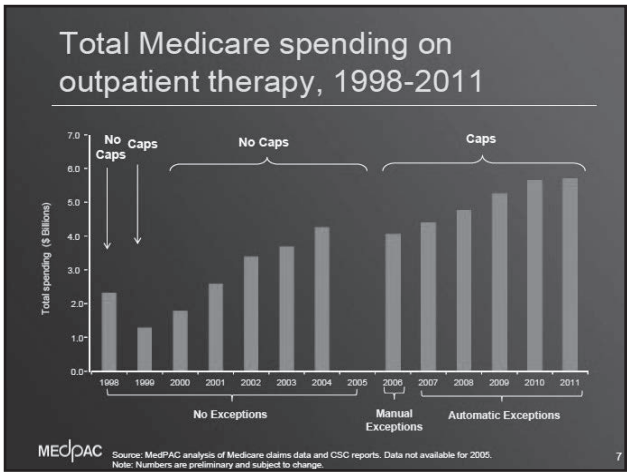


Figure 2. Source—MedPAC Meeting; October 2012.

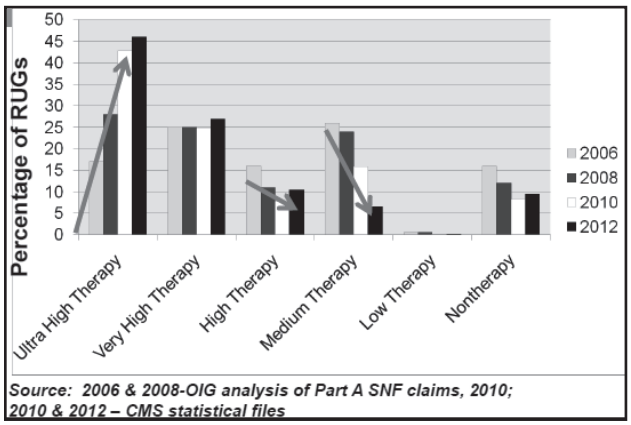


Figure 4. Changes in SNF Billing 2006 to 2012.

following areas: ambulation, dyspnea, pain interfering with activity, grooming, bathing, transferring, dyspnea, toileting, and dressing. Today those HHAs who report these measures receive a full payment update every calendar year. Those agencies who don't report, receive a payment penalty the following year. It is important for home health therapists to be involved in their agencies' practice models to insure effective clinical care is delivered that will impact these outcome measures in a positive way.

As Medicare and other payers have moved toward transparency in reporting clinical performance measures, the skilled nursing facility (SNF)/long term care rehabilitation industry has moved a little slower. The biggest challenge is often trying to consolidate the information in a manner that is useful to the provider. Nursing homes have a multitude of costs, and depending on whether the provider of the therapy is a direct employee or a contractor, it may be extremely difficult to gather the necessary information and to analyze it in a way that assists providers to change their performance and efficiency. For example, a nursing home that uses contract staff probably depends on its contractor to develop quality measures and interpret them. However, a nursing home that has its own in-house therapy staff may get more involved in the development and monitoring of quality measures. As an industry then, it is very difficult to compare one facility to another unless you know they have like characteristics and/or like measures. The same is true when trying to compare clinical performance measures. The reporting systems currently in place for nursing homes are largely focused on "medical" information, such as severity of condition. The information is collected from the Minimum Data Set (MDS) 3.0, and therefore the change in condition is due to the composite of care provided to the resident. There is no direct provider-type cause–effect relationship that can be measured, and while rehabilitation is an integral part of the "composite of care," there is no way to differentiate how much of the improvement (or decline) was a direct effect of the intensity (or lack) of rehabilitation provided.

As a result of the increase in Rehab RUG use over the last 10 years, providers are facing increased scrutiny from Medicare Administrative Contractors and Program Safeguard Contractors. CMS has begun to question the value of intense rehabilitation in the nursing home setting. The rehabilitation

industry is struggling with how to justify this increase in higher rehab RUGs to entities that are primarily interested in the burden of cost it has imposed on the health care system. While each therapy discipline uses standardized clinical performance tools specific to their own professional literature and some rehabilitation companies have their own proprietary tools, there is no one tool or measure that all providers have accepted as "the" measure of quality rehabilitative care in the skilled nursing and long term care setting. The result is an absence of industry accepted metrics, and therefore, the industry must find ways to overcome these present and future challenges.

Therapists who work in Part B outpatient settings will experience the biggest change this year with the implementation of the Claims Based Data Collection. The collection of the data will solely depend on the therapists to determine the most appropriate codes, document the codes, and report them for inclusion on the therapy claims. This provision was included in the Middle Class Tax Relief and Job Creation Act of 2012 (MCTRJC) when Congress extended the physician fee schedule freeze and therapy cap exception process through Dec 31, 2012. The law was intended to help answer the question, "Why do Medicare expenditures for therapy services continue to increase?" Between 1998 and 2008, therapy expenditures increased by 10.1%/year while the number of beneficiaries receiving therapy only increased 2.9%/year. In Medicare's mind, this leaves 7.2% unexplained. The physician fee schedule final rule for 2013, which finalized the therapy claim based data collection, actually acknowledged that *"although a significant number of Medicare*

An overview of the system includes:

The requirement will apply to ALL therapy claims ……..in ALL therapy settings	
• Claims below the therapy cap • Claims above the therapy cap • PT, OT, and SLP claims	• Hospital outpatient and observation patients • Critical access hospital patients • Skilled nursing facility Part B patients • Rehab agency and CORF patients • Patients seen under the Part B benefit by home health agencies • Part B therapy provided in private practices • Part B therapy provided in physician offices
The requirement will NOT apply to therapy claims for Medicare Managed Care insurance, private insurance, and Medicaid patients.	
Therapist will report on <u>only one</u> functional limitation at the outset of therapy. If therapy continues after this treatment goal/functional limitation goal is achieved, reporting will be required for another functional limitation	
The G-codes chosen should be: 1. The most appropriate <u>as determined by the therapist; AND</u> 2. Most closely relate to the <u>most clinically relevant functional limitation</u> at the time of the initial therapy evaluation & establishment of the therapy POC; AND/OR 3. Be one that would yield the quickest &/or greatest change; AND/OR 4. Be the one that is the greatest priority for the patient.	
For each G-code, a modifier must be used to report the severity/complexity for that functional measure.	
Two G-codes per discipline must be reported:	

At Evaluation	Every 10th visit at the time of the required Progress Report	At formal re-evaluation	At discharge from therapy
A subsequent functional limitation may be reported if care continues to address the subsequent limitation after you end reporting of the primary limitation.			
How should therapists choose the code? • Therapists will use a valid and reliable assessment tool(s) and/or objective measure(s) in determination of the severity of the functional limitation. • Although CMS recommends using one of 4 tools in the Internet Only Manual 100-2, Chapter 15, they are <u>not requiring the use of a particular tool or even the use of any tool</u> to determine the severity/complexity modifier. • They do encourage the use of a tool. • Therapist judgment may be used in combination with the data gathered. • It is acceptable for therapists to use their professional judgment in selecting the appropriate modifier. • There will be many cases for which one single functional measure tool is not available or clinically appropriate. • Therapists will need to document in the medical record how they made the modifier selection so the same process can be followed at succeeding assessment intervals.			

beneficiaries benefit from therapy services, the rapid growth in Medicare expenditures for these services has long been of concern to Congress and the Agency." While CMS has focused on several projects over the years to develop payment incentives (many of which have been highlighted in Gerinotes), CMS concluded they needed more information about the patients treated by therapists. Therefore MCTRJCA requires CMS to implement: *"..a claims based data collection strategy that is designed to assist in reforming the Medicare payment system for outpatient therapy services…Such strategy shall be designed to provide for the collection of data on patient function during the course of therapy services in order to better understand patent condition and outcomes."* While the requirement will be burdensome and challenging to implement by July 1, 2013, it will take the first step towards collecting more information about Medicare beneficiaries who receive therapy services. Furthermore, CMS encourages providers to draw no conclusions about whether it will be used in any future payment system.

We are entering a unique time as we witness our industry and our professions significantly threatened by increasing regulations and payment cuts. In an effort to remain a viable and affordable part of the health care system, rehabilitation providers are more incentivized to share information in an effort to find a valid method of measuring the value of rehabilitation services in all settings.

Watch for additional learning opportunities on the Functional Claims Reporting sponsored by the Section on Geriatrics and Health Policy Administration. Two webinars will be held in April 2013.

Ellen Strunk is President and Owner of Rehab Resources & Consulting, Inc., a company providing consulting services and training to providers in post-acute care settings with a focus on helping customers understand the CMS prospective payment systems. She also lectures nationally on the topics of pharmacology for rehabilitation professionals, exercise & wellness for older adults, and coding/billing/documentation to meet medical necessity guidelines and payer regulations.

WELCOME JGPT EDITOR,

DR RICHARD BOHANNON

The Section on Geriatrics welcomes Dr. Richard Bohannon as the new Editor of the *Journal of Geriatric Physical Therapy*. Richard Bohannon is Professor in the Physical Therapy Program of the Department of Kinesiology at the University of Connecticut (Storrs) and the Department of Medicine of the University of Connecticut Health Center (Farmington). He is also the Principal of Physical Therapy Consultants (West Hartford, CT). Dr. Bohannon is a licensed physical therapist with almost 35 years of continuous clinical experience in acute care, rehabilitation, and home-care settings. He is a board certified specialist in Neurologic Physical Therapy and a Fellow of the Stroke Council of the American Heart Association, the American Physical Therapy Association, the American Society of Neurorehabilitation, and the American Academy for Cerebral Palsy and Developmental Medicine. He is a prolific writer with over 400 publications in more than 50 different journals to his credit. In 1996, he received the American Physical Therapy Association's Helen Hislop Award for Outstanding Contributions to the Professional Literature. In 2005, he was awarded the Association's Marian Williams Award for Research in Physical Therapy and in 2008, he was honored with the Association's Jules Rothstein Golden Pen Award for Scientific Writing. Dr. Bohannon serves on numerous editorial boards; he was the Founding Editor of the *Journal of Human Muscle Performance* and was Editor-in-Chief of the *Journal of Geriatric Physical Therapy* previously. Currently, Dr. Bohannon's research and teaching is focused primarily on the measurement, implications, and treatment of impairments and activity limitations in older adult and neurologic populations. We are grateful to have Dr. Bohannon serving the Section on Geriatrics.

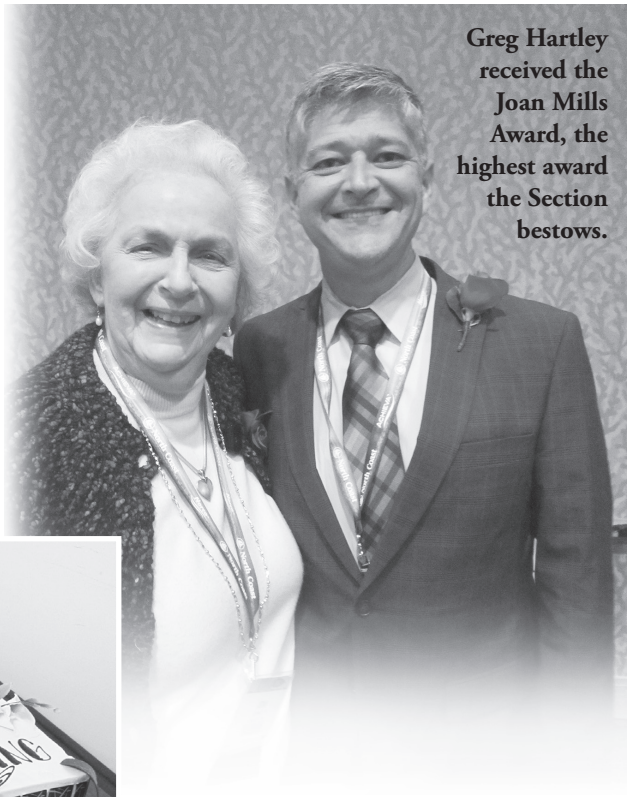
Highlights of CSM 2013

Busy Section booth at CSM in San Diego.

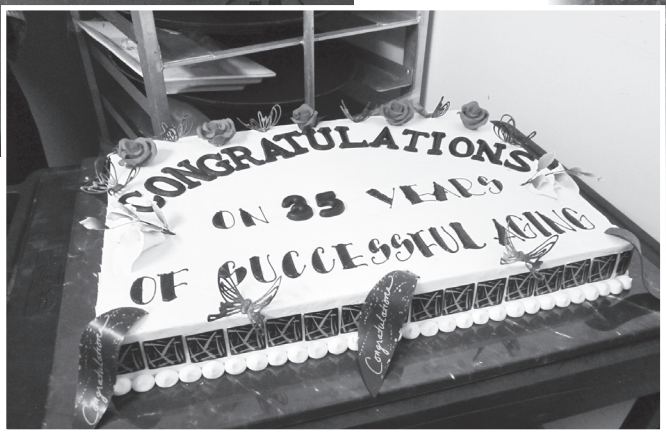
Crowd gathers for the Section on Geriatrics Business Meeting.

An impressive gathering of Joan Mills Award Winners.

Section President, Bill Staples.



Greg Hartley received the Joan Mills Award, the highest award the Section bestows.



Celebrating 35 years of the Section on Geriatrics.

2013 SECTION ON GERIATRICS AWARDS

The beautiful weather in San Diego provided the perfect back drop to celebrate the wonderful accomplishments of our Section on Geriatrics membership! This year we started the evening off with the Awards Ceremony, followed by a fantastic cake to celebrate the 35th anniversary of the Section on Geriatrics. The room was overflowing with individuals who came to cheer on this year's awards recipients! Awards were given for student merit, clinical excellence, and research.

The Joan M. Mills Award is the most significant recognition that the Section can give to one of its members. This prestigious award was initiated in 1980 to honor individuals who have generously, unselfishly, and creatively given of their time and gifts in service to the Section. These wonderful attributes are those that typify Joan M. Mills, the founder of the Section. There are a select number of Section members, who have demonstrated, over many years, a high level of competence in meeting the needs of the Section, dedication to meeting these needs and the ability to innovate when there is no worn path to follow. The Section is proud to honor Greg Hartley, PT, DPT, GCS, CEEAA, for his long-standing dedication and leadership with the 2013 Joan M. Mills Award. Greg is passionate about developing and expanding the Practice Committee as his many committee members can attest to and is active in promoting the development of residency programs in geriatrics and expanding member benefits including development and publication of evidence-based resources. Current subgroups of the Practice Committee include EBP/CPG, GCS Prep, AP for the PTA, PTNow/Move Forward, Residency/Fellowship Development, and Home Study Courses. Greg has contributed his time, energy, enthusiasm, and efforts to the Section on Geriatrics and his commitment and dedication is phenomenal.

The Section on Geriatrics President's Award recognizes an individual who has provided outstanding service to the Section while fostering the mission of the Section. The President relies on support, advice, dedication and enthusiasm from others committed to advancing the goals of the Section on Geriatrics and this year's winner of the President's Award has generously contributed her time and talent in many ways. This year's recipient is Ellen Strunk, PT, MS, GCS, CEEAA, Chair of the Section's Reimbursement/Legislative Committee. Ellen is the owner of Rehab Resources & Consulting, Inc., Birmingham, AL. Ellen's contributions are numerous including serving in many leadership roles both within the Section and APTA and her home chapter of Alabama. Ellen has been providing Section members with information regarding critical issues such as CSM policies, the Medicare cap, therapy claims, the exceptions process, PPS rules, MedPAC, Medicare coverage, and many more. Ellen also co-presented the very popular Section webinar "Be Prepared: Know Your Risk: How to set up a Comprehensive Medical Record Review Process for your Practice" last September and represents the Section at APTA's annual State Policy and Payment Forum.

This year, the Section on Geriatrics Award for Clinical Excellence in Geriatrics was awarded to NovaLeigh Dodge-Krupa PT, CEEAA. As advocates, role models innovators, and leaders in geriatric care settings, the recipients of the Clinical Excellence in Geriatrics Award demonstrate their commitment to improving the lives of older adults. NovaLeigh currently serves as the Director of Clinical Operations at Genesis Rehabilitation's New England Division and leads a team of clinical specialists, facilitating and implementing clinical initiatives servicing the older adult population. She demonstrates compassionate, unwavering adherence and leadership in directing her teams to ensure patient examinations and plans of care maintain alignment with APTA guidelines, practice expectations, and the ever changing regulatory environment. NovaLeigh continually demonstrated her passion, expertise, and commitment to her patients, co-workers, and the profession of physical therapy. Through her many roles in the profession, as a mentor, and as a leader, NovaLeigh has touched and improved countless lives, both directly and indirectly.

This year the Section has a new award. The Outstanding PT & PTA Student Award identifies student physical therapists and student physical therapist assistants with exceptional scholastic ability and potential for contribution to geriatric physical therapy. The inaugural recipient of this award is Debora A. Lasure from Somerset Community College in Kentucky. Debbie is a shining example of an outstanding student; maintaining excellent grades, successfully fundraising for several organizations, participating in numerous events for individuals with special needs, and serving in leadership roles at the college and within APTA. All of this has been accomplished while at the same time balancing the responsibilities of raising two children and caring for two older parents who are disabled. Debbie's joy in interacting, her service to others, her dedication to her scholastic program and our organization set her apart as an exemplary student physical therapist and an asset to our profession. We are excited to see all the wonderful things Debbie will do for this profession!

The Section also held its annual Consumer Brochure Contest for students. The goal of this contest is to promote learning in our physical therapy programs while helping the Section develop a library of clinical pamphlets to be published on the Section's Web site and displayed at the Section booth at CSM. This year's award recipients are as follows:

First Place:
Preparing for a Knee Replacement
Brandon Lindeman, Christopher Windy Central Michigan University

Second Place:
Osteoporosis: Awareness and Prevention
Kate MacKenzie, Erin Raquepaw
University of Michigan - Flint

Third Place:
Let's Prevent Osteoporosis!
Katherine Matlock
University of Oklahoma HSC

Fourth Place
Vision and Aging
Mallory Fetta, Danielle Ortego
Marquette University

Also of importance are the several research awards handed out by the Section this year.

The Section on Geriatrics Adopt-A-Doc program seeks to recognize outstanding doctoral students committed to geriatric physical therapy. This year's recipients of the Adopt-a-Doc Awards are as follows:

Dana Lyn Judd, PT, DPT
University. of Colorado
Novel interventions to improve mobility and function after total hip replacement

Jennifer Blackwood, PT, MPT, GCS
Western Michigan University
Relation of cognition and fall-risk in community-dwelling older adults

The Fellowship for Geriatric Research is intended to provide partial financial support to physical therapists pursuing research in geriatrics. This year's recipient is Jaclyn Megan Scions, PT, PhD, OCS, from the University of Delaware, with fellowship work at Northwestern University for her experience in advanced MRI techniques for application to trunk musculature assessment in older adults.

The Excellence in Research Award is to recognized outstanding contributions to research in the field of geriatrics. This year the award was given to Jennifer E Stevens-Lapsley for the publication: Stevens-Lapsley JE, Balter JE, Wolfe P, Eckhoff DG, Kohrt WM. Early neuromuscular electrical stimulation to improve quadriceps muscle strength after total knee arthroplasty: a randomized controlled trial. *Physical Therapy*. 2012;92(2):210-226.

The Student Award for Research is intended to facilitate interest in geriatric research among entry-level physical therapy students and recognizes outstanding research-related activity completed by entry-level physical therapy students. The recipients of this year's awards are:

Emily Bartels Young, DPT
University of Nebraska; research experiences assisting in the study of cognition and dual-task performance in community-dwelling older adults in wellness and memory assisted living centers

Kayla R Braddock, SPT
University of South Alabama; research leadership activities involved in defining practice patterns, knowledge of geriatric physical therapists related to delirium screening in older adults

Congratulations to all of our award recipients and thank you for your dedication to our profession, the Section on Geriatrics, and most importantly caring for our older adults!

NOTES FROM CSM 2013

From the windy streets of Chicago to the sunny skies of San Diego, the Combined Sections Meeting continued to be filled with jammed pack programming, meetings, and events. Those who attended the GCS breakfast and the members awards banquet and business meeting can attest they were "jammed packed," as we celebrated members' achievements. Educational sessions were well attended, with several reaching maximum capacity. The Section celebrated 35 years of "successful aging" by enjoying a delicious cake at the members reception/meeting.

Many changes occurred this year: Platforms were recognized as continuing educational sessions, and scanners were used to track participants' attendance. Sessions across all sections occurred in blocks, and extended breaks between sessions provided easier transitions. Unique programming included a complimentary Tai Chi session lead by Dr. Kristi Hallisy, held outside on the Hilton Bayfront lawn on Thursday morning.

CEEAA alums gathered at a reception and we would like to thank our equipment sponsors during the course series: Hygenic Corp, Med Patent USA, and Total Gym.

A special thank you to the following sponsors:
Aegis (Gold Sponsor)
Fox Rehab (Gold Sponsor)
Genesis Rehabilitation (Gold Sponsor)
Medi-USA (Sponsor of Bone Health SIG meeting)

Planning for CSM 2014 in Las Vegas is already in process; educational session proposals are due March 4, 2013, and platform and poster abstracts are due May 20, 2013. Look for a call for a Section Program Co-chair in the spring. This person would start the last day of CSM 2014. Thank you to the members of the Geriatric Section for making CSM 2013 a huge success!

Kind Regards,

Sue Wenker and Tiffany Hilton
Section Program Co-chairs

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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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