GeriNotes

Academy of Geriatric Physical Therapy

This Issue

May 2015 | Volume 22, No. 3

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Publication Title: *GeriNotes*

Statement of Frequency: Bi-monthly; January, March, May, July, September, and November

Authorized Organization's Name and Address: Orthopaedic Section, APTA, Inc.

For Academy of Geriatric Physical Therapy, APTA., 2920 East Avenue South, Suite 200, La Crosse, WI 54601-7202

Newsletter Deadlines: January 15, March 15, May 15, July 15, September 15, November 15

Editorial Statement: *GeriNotes* is not a peer-reviewed journal. Opinions expressed by the authors are their own and do not necessarily reflect the views of the Academy of Geriatric Physical Therapy, APTA. The Editor reserves the right to edit manuscripts as necessary for publication.

All advertisements that appear in or accompany *GeriNotes* are accepted on the basis of conformation to ethical physical therapy standards, but acceptance does not imply endorsement by the Academy of Geriatric Physical Therapy, APTA.

IN HONOR/MEMORIAM FUND

Each of us, as we pass through life, is supported, assisted and nurtured by others. There is no better way to make a lasting tribute to these individuals than by making a memorial or honorary contribution in the individual's name. The Academy of Geriatric Physical Therapy has established such a fund which supports geriatric research. Send contributions to:

The Academy of Geriatric Physical Therapy | 3510 East Washington Avenue | Madison, WI 53704

Also, when sending a contribution, please include the individual's name and any other person you would like notified about your contribution. If you are honoring someone, a letter will be sent to that person, and if you are memorializing someone, the surviving family will be notified of your contribution.

In the field of geriatric physical therapy, we receive many rewards from our patients, associates, and our mentors. A commemorative gift to the Academy of Geriatric Physical Therapy In Honor/Memoriam Fund is a wonderful expressive memorial.

PRESIDENT'S MESSAGE: MOVING FORWARD FROM CSM

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

Much of this issue of *GeriNotes* will report on the happenings at CSM in Indianapolis. For your President, it is a busy time indeed running from meeting to meeting, waving to friends, former students, and colleagues as we pass by and wishing I had more time to catch-up with everyone. As President, I attended an all-day meeting with APTA leadership and a second meeting with all the Section Presidents to discuss our common interests and to learn from each other. One item we discussed was membership and cost. For the average physical therapist, it only costs $1.20 per day to belong to the national APTA and individual state organizations, which is really a bargain considering what it does for us as practicing health professionals. This money gives us a voice on Capitol Hill and in our state governments. Without that voice, our practices would be severely limited and imposed upon by other providers. Other measures that cost money are the production, publication, and notification of evidence-based research such as PTNow. Along with this, the APTA is developing the Physical Therapy Outcomes Registry. This will be a national registry for clinical outcomes, providing a much needed database to improve clinical research and evidence-based care, and to support payment for physical therapy services. Another point of discussion was payment policies. As it appears now, Medicare will most likely be going with a value-based system where hopefully quality will be rewarded over quantity. The APTA estimates that the fee schedule may be gone by 75% by 2020.

Another meeting that occurred at CSM was our ExPAAC (Exercise, Physical Activity and Aging Conference) II planning committee meeting. The much-awaited ExPAAC II is now scheduled for the end of July 2016, at the University of Indianapolis and Dr. Ellen Miller has graciously consented to take the reins again on this venture. We look forward to building on the success of the first conference held in 2010.

A lot of Academy business gets accomplished at CSM; it is the only time that the Board and committee chairs actually get to meet face-to-face. We have two Board meetings with the Member's Meeting in between where we take care of the Academy work, including the orientation of new Board members and committee chairs. In the Board meetings we need to ratify our email votes to comply with our bylaws. We are working to have all the elections at one time, which would put the SIG elections on the same ballot as the Academy officers. We are working on a policy to enable Academy members to use our new logo on business cards and other items. We decided to sponsor two students to the "Capitol Hill Day" before the start of the NEXT conference in Washington, DC, in June this year. The Board and committee chairs have also set a goal of ensuring that all people wanting to volunteer get a chance no matter how small. So if you have been considering an opportunity to volunteer for the Academy, give us a call at the office. We will connect you to a committee.

At the Member's Meeting and "Logo Launch Party," we unveiled our new logo, and installed the new officers. We also passed our bylaw changes to fully comply with Virginia state laws regarding non-profits. A big thank you to Ann Medley, and the rest of the Bylaws Committee for a complete review of our bylaws, the first time in almost a decade that this was done. We provided a $25,000 donation to the Foundation for Physical Therapy research. Our Geriatric Research Fund, through the Foundation, will be announcing a $40,000 research grant later this year. During our Academy Awards portion of the meeting, we presented plaques and certificates of recognition to many "retiring" Board members and committee chairs. Additionally, we had the pleasure to recognize our award winners, including the latest Joan Mills awardee, Dr. Richard Bohannon. For those of you who know Richard, it is an award well deserved for all he has done for research and evidence-based geriatric practice, in addition to guiding the *Journal of Geriatric Physical Therapy.* See you in DC!

EDITOR'S MESSAGE: THANKS FOR ANOTHER GREAT CSM!

Meri Goehring, PT, PhD, GCS

Combined Sections Meeting (CSM) 2015 in Indianapolis was a great success. What makes this conference so wonderful? My first thought? The chance to network. I see a good number of people that I rarely see at any other event. The CSM provides a forum for seeing old friends, peers, former students, and co-workers. But also, the programming is fantastic. The many opportunities to learn from experts in their respective fields can be overwhelming. Luckily, APTA offers many ways to re-live and review the learning materials. I urge you to take advantage of these offers! Go to the APTA Learning Center for more information.

If you have not yet had the chance to attend, the CSM is a collaborative effort between APTA and the 18 specialty sections, bringing together 500 exhibiting companies and over 10,000 physical therapists and physical therapist assistants for 3 days of section-designed programming. Additionally, the exhibitors present many different types of products and the exhibit hall is teeming with attendees.

This year, the Academy of Geriatric Physical Therapy President, William (Bill) Staples was a wonderful asset as he lives and works in Indianapolis. What a great city in which to have a convention! The covered walkways kept attendees comfortable while it also provided many different rooms for the wide variety of programming. And, there was plenty of room for all who wanted to attend. Furthermore, the city of Indianapolis has beautifully preserved historical buildings alongside bright, fresh, contemporary architecture. And, there were plenty of places to shop, eat, and play within walking distance of the convention center.

I hope you plan to attend CSM next year in Anaheim, California. And please consider helping the Academy of Geriatric Physical Therapy to welcome new members at the booth. Or, just stop by the booth and say hello! We are happy to have members pick up a ribbon to add to their name badges. This helps to promote our group to others who may be considering joining. To those of you who attended CSM 2015, thank you for your participation. Take a look at this issue of *GeriNotes* and remember the great times or see what you missed!

IS THIS DEMENTIA, DEPRESSION, OR ALCOHOLISM?

Jill Heitzman, PT, DPT, GCS, NCS, CWS, CEEAA, FACCWS

Jill's article was printed in the March 2015 issue; however, the references were not included with the article. Please find the references below.

REFERENCES

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CSM 2015 HIGHLIGHTS
FEBRUARY 4-7, 2015, IN INDIANAPOLIS

Karen Curran, CAE

The Academy's big logo rollout and celebration of our new name took place at CSM 2015 in Indianapolis complete with our version of the "Academy" Awards, including red carpet and the paparazzi!

Members received sunglasses (because our future is so bright!), "Oscar" shaped chocolates, and a cake with our new logo on it. Awardees not only received a plaque of recognition from the Academy, they also each received their own personal "Oscar" statuette.

Installation of new officers
William Staples: President
Jill Heitzman: VP
Lucy Jones: Director
Patti Brick: Director
Laurie Page: Nominating Committee

A big Thank You to our outgoing committee chairs and BOD members

Danille Parker, PT, MPT, DPT, GCS, CEEAA, Director - 2011-2014

Ken Miller, PT, DPT, CEEAA, Nominating Chair – 2014-2015

Sue Wenker, PT, MS, GCS, CEEAA, Program Co-Chair – 2010-2015

Martha Acosta, PT, PhD, MS, GCS, Geriatric Specialty Chair – 2013-2014

2015 "ACADEMY" AWARDS PRESENTED

The Academy is pleased to announce the following award recipients for 2015. The awards were presented at the Academy's annual Member Meeting on February 5th.

PRESIDENT'S AWARD

The Academy of Geriatric Physical Therapy President's Award recognizes individuals who have provided outstanding service while fostering the mission of the Academy. The President relies on support, advice, dedication, and enthusiasm from others committed to advancing the goals of the Academy.

Our first winner of the President's Award has generously contributed her time and talent in many ways, usually behind the scenes without recognition. Please congratulate **Jessie Van Swearingen, PT, PhD, FAPTA**, our very capable Research Chair. Since 2008, Jessie has coordinated the review of both CSM and NEXT abstract submissions for platform and poster presentations and assisted with onsite details. She annually reviews the many Academy Research Awards for accurate purpose, rationale, and criteria. She selects the winners each year by thoroughly reviewing each submission's research and goes above and beyond the call of duty when asked by coaching, editing, and recommending statistical approaches to those not chosen for an award so they can improve future submissions. She selects and presents the Research Award recipients after extensive assessment and reflection at the Awards Ceremony at the Member Meeting at CSM.

President's Award-Myles Quiben

Jessie graduated from the University of Delaware with a BS in PT, Ohio State University with a Master's in PT, and a PhD in Anatomy and Cell Science from the University of Pittsburgh School of Medicine, and she is a Neurology Certified Specialist. She is currently an Associate Professor in Physical Therapy at the University of Pittsburgh. She has been the recipient of multiple awards and is the author/co-author of many publications related to research efforts and clinical work. Jessie has presented at numerous professional meetings and internationally in Canada and Norway. She truly advocates for optimal aging, contributing to uplifting the Academy to advance research for the older adult, making it reachable for us all. The Academy's mission is to further our members' ability to provide best practice physical therapy and to advocate for optimal aging. We thank Jessie for her numerous contributions to the Academy on Geriatrics.

Our second recipient was **Myles Quiben**. She serves on the Academy's Board of Directors as Director of Education and has been an integral part of improving the Academy's CEEAA certification series. She has also been involved in the transition to a new Home Study Editor, a position recently filled. As the Board Liaison for the Regional Course Committee, the CSM and NEXT Program Chairs, and the Home Study Course Series, Myles works tirelessly to ensure that these programs serve our members well. She also serves our Academy on the ABPTS for specialty certification and on the FSBPT entry level exam as a geriatric expert. She mentors others on how to do presentations and at CSM last year, she presented how newly certified GCSs can get more involved in APTA and its components. Myles is a great mentor for emerging leaders by being a role model of professionalism and involvement. It is not hard to see how she works tirelessly to move the Academy forward with her knowledge and insight.

Dr. Quiben earned her PhD in Physical Therapy with an emphasis on motion analysis, her post-professional DPT from the University of Central Arkansas, and a BS in Physical Therapy from the University of the Philippines. She is a board certified Neurologic and Geriatric Clinical Specialist by the American Board of Physical Therapy Specialties. And so publicly we recognize your many good works Myles. We are grateful for your energy and celebrate your many contributions to the Academy.

JOAN M. MILLS AWARD

The Academy of Geriatric Physical Therapy has developed a number of awards to recognize the diverse accomplishments of its members in service to patients, the physical therapy community, and research. Among the earliest awards established was the Joan M. Mills Award. The Joan M. Mills Award is the most significant recognition that the Academy 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 Academy. These wonderful attributes are those that typify Joan M. Mills, the founder of the Academy. Through her innumerable contributions to the Academy, she helped shape us into the dynamic organization we continuously work toward becoming. There are a select number of Academy members, who have demonstrated over many years, a high level of competence in meeting the needs of the Academy. The Academy is proud to honor **Richard Bohannon's** long-standing dedication and leadership with the 2015 Joan M. Mills Award.

Richard has served the Academy as the Editor of the *Journal of Geriatric Physical Therapy* since 2013. It is also a position he held from 2002 to 2007. The *Journal of Geriatric Physical Therapy* is the leading source of clinically applicable evidence for achieving optimal health, wellness, mobility, and physical

Joan M. Mills Award-Richard Bohannon

Very proud of all of our Joan M. Mills winners throughout the years!

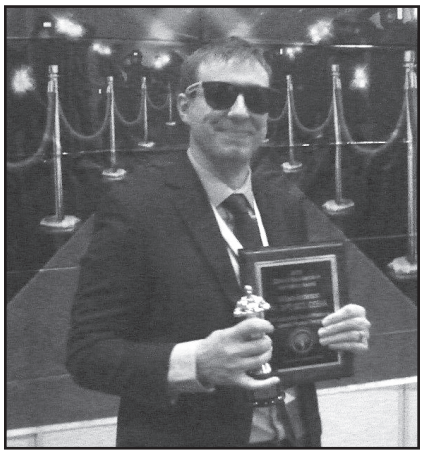
function across the continuum of health status for the aging adult. Additionally, Richard has been the issue Editor for *Topics in Geriatric Rehabilitation* and an item writer for the Geriatric Physical Therapy Certification Examination as well as an expert neuromuscular member assisting with the development of *A Guide to Physical Therapy Practice, Volume II: Preferred Practice Patterns.* He is currently an instructor and contributor for the Academy's very successful CEEAA course series. Richard attended the University of North Carolina, Chapel Hill where he received his BS in Physical Therapy and his Master of Science in Physical Therapy. He received a Doctor of Education in Adult and Community College Education from North Carolina State University in Raleigh, NC, and his Doctor of Physical Therapy from Boston University in 2007. He has been a professor at the University of Connecticut in Storrs in the Department of Kinesiology since 1993 and at the University of Connecticut Department of Medicine in Farmington, CT, since 2008.

Richard is recognized both nationally and internationally as a manuscript reviewer for over 80 journals, editorial board member or associate editor for more than 10 journals, consultant, author, visiting professor, lecturer, and research poster presenter. He has been recognized for many other awards including the APTA Neurology Section Research Award, the Connecticut Chapter Research Award, the APTA Jules M Rothstein Golden Pen Award for Scientific Writing, and was named an APTA Catherine Worthingham Fellow in 2006. His contribution of time and energy on behalf of the Academy has been more than generous, and those who have sat on the *JGPT* Editorial Board find him gracious and a wonderful resource for submitting authors. He epitomizes our mission of advocating for our older adults with his research efforts. Just Google "grip strength" to see what I mean!

Dr Bohannon has been very generous with his time and energy on behalf of the Academy and the APTA. It is with great honor and respect that I present this most prestigious award on behalf of the membership of the Academy of Geriatric Physical Therapy to Richard Bohannon. This celebrated award is given to a most deserving individual. A heartfelt congratulations to you and thank you for all you do.

CLINICAL EXCELLENCE AWARD

The Clinical Excellence Award recognizes a physical therapist for outstanding clinical practice in the geriatric health care setting. This year's award winner was Bill Anderson. Bill was nominated and supported by his colleagues at VNA Home Health Hospice because of his innovation and evidence-based vision to improve the quality of health care for older adults. Included on his long list of achievements has been implementing agency wide promotion of physical therapists obtaining their GCS, as well as other educational opportunities to promote evidence-based quality care for the aging adult population. To accomplish this goal, he has written



Clinical Excellence Award - *This award for outstanding clinical practice in a geriatric health care setting was presented to Bill Anderson, PT, DPT, GCS, CEEAA.*

grants for funding, used technology to promote learning, and mentored many fellow physical therapists who wished to practice in similar fashion to him. Outside of the workplace, Bill is the Maine advocate for the older adult. He has developed an outreach program that screens older adults for balance to raise awareness of the problems that occur with balance loss. He helped organize a Geriatric Symposium that highlighted topics concerning older adults. As a result, many participants sought his knowledge on obtaining GSC certification for themselves. He has also played an active role as advocate for removing the 13th and 19th visit reassessment Medicare guideline. A colleague had this to say about Bill, "I personally feel blessed to work with such a model of excellence."

DISTINGUISHED EDUCATOR AWARD

This year's Distinguished Educator Award winner is Dr Jennifer Blackwood from the physical therapy program at the University of Michigan-Flint. Her nominator and research assistant said, "Physical therapy schools need more professors like Jennifer Blackwood to inspire students to be active in their learning." Indeed, she does inspire students in her entry level, tDPT, and residency courses where she uses a variety of teaching methods to engage students that include use of technology and arranging various hands on clinical experiences that enhance learning in the class she is teaching. Her enthusiasm and successful teaching strategies have been recognized by several teaching awards from her university and the students she teaches. Outside of the classroom, she continues to engage students in community outreach events that range from fall prevention clinics to beta testing and App to help with use of outcome measures to various research opportunities. She has published multiple articles and has presented locally and nationally on topics that focus on issues that affect the geriatric population.

Jason Falvey, PT, DPT, GCS, CEEAA, University of Colorado-Denver, received a **Fellowship for Geriatric Research** for his research on higher intensity therapies post-hospitalization in older adults.

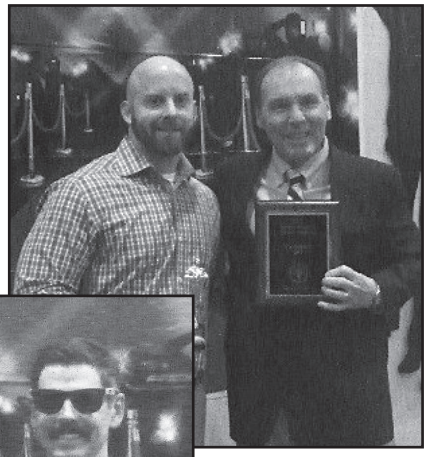
Adopt-a-Doc Awards were awarded to the each of the following physical therapists to support their doctoral studies: **Jennifer L Vincenzo**, PT, MPH, University of Arkansas, evaluation of smart-device assisted, balance assessment in older adults and **Andrew Kittleson**, DPT, University of Colorado-Anschutz Medical Campus, studying the pain experience among older adults with knee osteoarthritis.

The **Excellence in Research Award** was awarded to Dawn Venema, PT, PhD, for the article, Task matters: a cross-sectional relationship of cognition and dual-task performance in older adults. *J Geriatr Phys Ther.* 2013;36:115-122.

Student Research Awards were awarded to Katie Fandrey, SPT, University of Minnesota and Troy Goetsch, SPT, University of Nebraska

Excellence in Research Award-Dawn Venema

Student Research Award-Katie Fandrey



Student Research Award-Troy Goetsch

Distinguished Educator Award – *Jennifer Blackwood, PT, PhD, GCS, has been awarded the Distinguished Educator Award for excellence in teaching.*

Award winners-Jason Falvey, Jennifer Vincenzo, Andrew Kittleson

OUTSTANDING PTA STUDENT

This year's Outstanding PTA Student award was presented to Brittany McKee from Somerset Community College. Brittany has demonstrated excellence in academics by acquiring a 3.639 cumulative GPA while being involved in a considerable amount of professional and community activities. She has been active in fundraising for the Miami Marquette challenge, where Somerset Community College was recognized last year as the Most Successful PTA School, and ran for the Student Assembly Board of Director's PTA position. As a student member of the Academy of Geriatric Physical Therapy, she has co-authored 2 submissions for the student brochure contest. She has a passion for APTA membership, successfully helping to recruit student members to join the association. As indicated by her support letters, she is respected by her faculty and peers.

STUDENT BROCHURE WINNERS:

1st Place - Osteoarthritis: Know the Facts and Move Beyond the Pain by Joni Johnson, SPT, Idaho State University

2nd Place - Foot Care 101 by Emily Dudzik, SPT, and Tracy Lytle, SPT, University of Michigan-Flint

3rd Place - Managing Multiple Medications by Rilee Glenn, SPT, Idaho State University

Honorable Mention - Staying Strong by Daniel O'Keef, SPT, Idaho State University

Membership Committee Chair, Tamara Gravano recognized Outstanding PTA Student Brittany McKee, SPTA! She is shown here with President, Bill Staples.

Please be sure to sign up to volunteer at the AGPT booth at Annual Conference, now known as NEXT, in National Harbor in June for another chance to win.

We also thank our CSM Gold Sponsor Aegis Therapies!!

aegis therapies

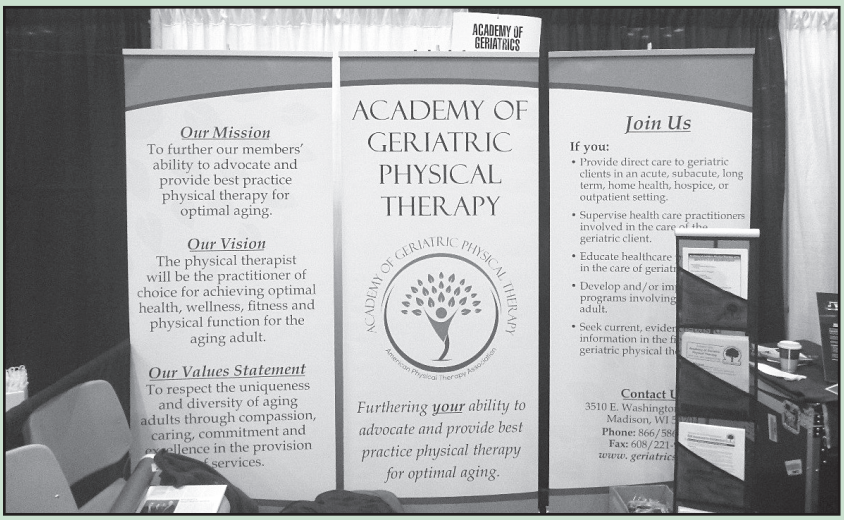
THANK YOU BOOTH VOLUNTEERS!

Visitors to our booth saw our new booth set up with the new name and logo and were treated to lots of new logo giveaways including mouse pads, book marks, magnets, and coolie cups.

Many thanks to the many dedicated Section members who volunteered at the booth at CSM 2015 in Indianapolis. This year was a great success as every volunteer slot was filled! For each hour volunteered at the booth, members were eligible to be placed in a drawing for one free year of geriatrics membership. **This year, the winner was Charles Starr!**

VOLUNTEERS

Mona Fazzina	**Lisa Grabbe**	**Karleen Cordeau**
Bonnie Rogulj	**Susan Serbinski**	**Aileen Ledingham**
Bonnie Lucio	**Joy Kuebler**	**Carleen Lindsey**
Stefany Shaibi	**Melissa Ortiz**	**Missy Criss**
Veronica Southard	**Lora Andrews**	**Teresa Wurster**
Olumide Aderoba	**Anne Knox**	**Lisa Dehner**
Judy Daniel	**Ellen Erdman**	**Charles Starr**
Debbie Hanka	**Jane Killough**	**Christy Ross**
Reenie Euhardy	**Beth Black**	**Paula Graul**
Patty Brick	**Peter Coyle**	**Julie Bibo**



CSM 2015, INDIANAPOLIS: PERILS, PITFALLS, AND GREAT TIMES

Chris Childers, PT, MS, GCS

As the cold blast of air struck me as I exited the Indianapolis airport, my immediate thought was, "Have I made the right decision?" The warmth of the taxi ride was much appreciated, especially considering I had left behind the balmy 80° climate of California. Yet, for those of us attending CSM 2015 in Indianapolis, the cold welcome was most certainly worth the trip.

The walkways between the Indianapolis conference center, the JW Marriot, and the Westin proved to be both a blessing and a burden. We avoided walking in the snow, which fell on the Tuesday night, and avoided being blasted by frigid cold air. However, traversing the walkways from the JW Marriott to the Westin and back via the conference center totaled over 2000 steps round trip, nearly a mile, and this was performed 5 or more times for assorted educational sessions, meetings, receptions, and gatherings. So, most of us exceeded our 10,000 steps a day before even hitting the gym. But of course, access to a piece of equipment in a hotel gym during a PT conference is about as elusive as the perfectly compliant patient.

Interestingly, that round trip from the JW Marriot to the conference center and the Westin to get access to the various conference center rooms involved several large flights of stairs, flanked by escalators. Sadly, despite being at a PT conference the escalators saw way more traffic than the stairs!

For the Academy of Geriatric physical therapist, the preconference work involved a wonderful 2-day course on Tai Chi, while others of us were mentoring new SACE item writers and helped in the celebration of our newly qualified Geriatric Clinical Specialists. In the opening ceremony, it was an honor to greet so many of our new specialists at they "walked" the stage and then to see them again just a few precious hours, and close to 4000 steps later, at the celebratory breakfast!

Thursday many of us spent the day immersed in sexual activity; no not what you may be thinking, but in the conference rooms. Sex is an ADL and was an extremely popular presentation first thing Thursday morning. Rumors were flying around about using the concept of sex as an activity of DAILY living, sparking many an interesting conversations. While the afternoon session about sexual health after 50, chose to call it an ANL—activity of nightly living. The overall message was clear, ask your patients about how their condition has impacted their bowel, bladder, and sexual activity and then treat them accordingly.

Thursday evening we all struggled to be in multiple places at the same time as we juggled the Academy meeting and unveiling of the new logo, the specialist recertification workshop, alumni and friend meetings, and receptions. Somehow we made an appearance at all of them while gaining 6000 steps in the process.

Friday was the longest line of the day, not at the prime time lectures, but at the JW Marriot Starbucks both pre and post opening sessions. Meanwhile, the exhibit hall was transformed from free pens and sticky note pads, popular 5 years ago, to car chargers, smartphone pockets, and of course, the smiley faced stress balls. Technology is rampant with split belt treadmills, body support concepts, robotics, and dance revolution in among the classic textbooks, Thera-Band, and how to pass the NPTE.

Sadly, Friday was not a full sea of red to celebrate National Wear Red Day, although there was a lot of red being worn. Thanks to all those who remembered. Let us do better as a profession next year!

Evidently, our President (President Obama, not the President of APTA) decided to be in Indianapolis on Friday. This resulted in road closures and the airport being less accessible. Hopefully, anyone trying to leave on Friday made the flights on time. Saturday many members had to catch flights, but the programming continued. Kudos to those who stayed the course.

Was it worth it? 10,000 steps a day, freezing cold weather, crowded hallways, and long lines for coffee, BUT excellent lectures, great networking, amazing organization, and incredibly friendly hospitality? Will we be back in Anaheim next year? Of course! After all, it is CSM!

Chris Childers is currently serving as a Board member for the Geriatric Specialty Council for the American Board of Physical Therapy Specialists. She is a full time faculty member at the University of St. Augustine, San Marcos, CA campus where she teaches the gerontology program and part of the neurology triad. She submits the following casual analysis of the excellent programming experienced at the 2015 CSM in Indianapolis.

BONE HEALTH SPECIAL INTEREST GROUP 2015 REPORT

Sherri Betz, PT, GCS, CEEAA, PMA®-CPT

It was an exciting year for the Bone Health Special Interest Group at CSM in Indianapolis this year! There were 3 presentations related to bone health:

1. *Age-Related Hyperkyphosis: Are We Destined to Stoop?* by Wendy Katzman, PT, DPTSc, OCS, researcher at UCSF, creator of the Stand Tall Program and recipient of two NIH grants for her research on kyphosis and physical function in older adults. Dr. Katzman's presentation provided a great summary of the exercise interventions that have been found to be effective in reducing hyperkyphosis. Dr. Katzman also published the following 4 studies in 2014:

   Bansal S, **Katzman WB**, Giangregorio LM. Exercise for improving age-related hyperkyphotic posture: a systematic review. *Arch Phys Med Rehabil*. 2014;95(1):129-140.

   Kado DM, Miller-Martinez D, Lui LY, Cawthon P, **Katzman WB,** Hillier TA, Fink HA, Ensrud KE. Hyperkyphosis, kyphosis progression, and risk of non-spine fractures in older community dwelling women: the Study of Osteoporotic Fractures (SOF). *J Bone Miner Res.* 2014; 29(10):2210-2216.

   Nardo L, Lane NE, Parimi N, Cawthon,P, Fan B, Shepherd J, Cauley J, Zucker-Levine A, Murphy R, **Katzman WB.** Diffuse idiopathic skeletal hyperostosis association with thoracic spine kyphosis: a cross-sectional study for the Health Aging and Body Composition Study. *Spine (Phila Pa 1976).* 2014;39(24):E1418-1424.

   Katzman WB, Miller-Martinez D, Marshall LM, Lane NE, Kado DM. Kyphosis and paraspinal muscle composition in older men: a cross-sectional study for the Osteoporotic Fractures in Men (MrOS) research group. *BMC Musculoskelet Disord*. 2014;15:19. doi: 10.1186/1471-2474-15-19.

2. *Optimizing Bone Health Across the Lifespan* was presented by the physical therapy program faculty of the University of the Incarnate Word. Mona Bains, PhD, provided a refreshing review of the science of bone building through the lifespan, while Susan N. Smith, PT, PhD, PCS, presented the newest information on pediatric bone health. Jennifer Kish, PT, DPT, SCS, gave dynamic recommendations for physical activities to promote bone building during the very important adolescent years. Amy Wagner, PT, DPT, GCS, presented bone building during the female reproductive years, ironically while 7 months pregnant! Amy Crocker, PT, DPT, OCS, related important information about risk factors for skeletal fragility and beneficial exercise choices for our older adults.
3. *Osteoporosis: Drug Therapy, Nutrition, Exercise* by Suzanne Tinsley, PT, PhD, NCS, and Marie Vazquez Morgan, PT, PhD, professors of the physical therapy program at LSUMC, Shreveport, LA, and Sherri Betz, PT, GCS, CEEAA, PMA®-CPT, graduate of LSUMC and director of TheraPilates® Physical Therapy in Santa Cruz, CA. Dr Tinsley explained the pharmacology of common medications, such as Fosamax® and Forteo® that are used to treat osteoporosis. She also unveiled one of the new drugs containing anti-sclerostin antibodies that is currently being studied and may just be the miracle cure for osteoporosis. Dr Morgan made recommendations for the best foods and supplements to promote osteoblastic activity at all ages. Finally, Sherri Betz got the group moving and they experienced the best exercises to prevent fracture and preserve bone in older adults!

At our Bone Health SIG Meeting, we had a lot of interest in using evidence-based programs to start an exercise program targeting older adults with osteoporosis. The members also had interest in updating the consumer educational PowerPoint presentation, as well as an updated bone health related reference list. We will be collaborating with the Balance and Falls SIG, Health and Wellness SIG, and Cognitive Mental Health SIG to create a *Healthy Tips for Older Adults 2016 Calendar*! If you would like to be involved, please contact us. We are collecting photos and tips through June 2015. The Bone Health SIG is also looking for volunteers to hold the positions of Vice Chair and Secretary to fill our slate by June 2015. Our BHSIG elections will be held with the general Academy of Geriatric Physical Therapy elections in October 2015. The Bone Health SIG is very active in promoting consumer and practitioner awareness about bone health. We would love for you to join our group! We meet every year at CSM. Please view our activities at https://www.geriatricspt.org website. If you are interested in joining or would like more information, visit: https://www.geriatricspt.org/members/special-interest-groups or contact the Bone Health SIG Chair, Sherri Betz at sherri@therapilates.com.

See you in 2016!

Sherri Betz serves as the Chair of the Bone Health Special Interest Group, and Chair of the PMA Research Commission and Certification Board. She also serves on the Exercise and Rehabilitation Advisory Council of the National Osteoporosis Foundation and on the American Bone Health Board of Directors. She is the owner of TheraPilates® Physical Therapy Clinic in Santa Cruz, CA, where she is passionately devoted to treating patients with spine pathologies and implementing low-cost, Pilates-based group exercise programs for seniors and older adults with osteoporosis.

LOOKING BACK PAST THE CHECKERED FLAGS

Sarah Ross, PT, DPT, GCS, CEEAA

The Academy of Geriatric Physical Therapy hit top speeds at CSM in Indianapolis! Preconference sessions addressing Tai Chi Fundamentals and Interventions for Bladder Control got things off to a fast start. One hundred and fifty nine new Geriatric Clinical Specialists were recognized by the ABPTS at the Opening Ceremony. The Academy sponsored 19 and co-sponsored several other educational sessions that were appreciated by a multitude of attendees. The new AGPT logo was unveiled at the Members Meeting. We are very grateful to Aegis Therapies, our Gold-level sponsor for their support of the AGPT and our Members Meeting.

We are off and racing, preparing for CSM 2016. Please plan to join us in Anaheim, CA, February 17-20, 2016. Educational session proposals are currently being reviewed. Poster and platform abstracts are due by June 23, 2015. We look forward to seeing you there.

Kind regards,
Tiffany Hilton, Sue Wenker,
and Sarah Ross
Programming Co-Chairs

Sarah Ross is the incoming Programming Co-Chair for the Academy. She graduated with her MPT from Marquette University in 2000, and with her DPT from the College of St. Scholastica in 2014. She works for Functional Pathways at Plymouth Harbor on Sarasota Bay in Sarasota, FL. She has recently joined the faculty at the State College of Florida and will begin her adjunct work in their PTA program in the fall.

A THOUSAND THANKS FOR HELPING WITH THE SUCCESSFUL BIRTH OF OUR BRAND-NEW COGNITIVE AND MENTAL HEALTH SIG

Lise McCarthy, PT, DPT, GCS

Although not a big fan of air transportation, I ventured back to my Midwestern roots for CSM 2015 to fulfill a mission—to help make official, the Cognitive and Mental Health Special Interest Group of the Academy of Geriatric Physical Therapy of the American Physical Therapy Association. It is quite a mouthful to repeat to family and friends, not to mention strangers – even people in our profession. Those of us founding organizers, who have been working together to organize and promote our fledging SIG, have reduced its lofty title to the CMH SIG.

Now that our first official mission is accomplished and the CMH SIG is legit, I would like to send a BIG "***THANK YOU!!!***" shout-out to all of you who supported the idea for our CMH SIG with your encouraging emails over this past year. We now have a web page on the AGPT website, which you can view by going to www.geriatricspt.org. Perhaps while you are looking at some of our resources about issues related to cognitive and mental health, you might consider taking a few more minutes to make an active statement of support of our efforts so far by officially signing up to be an interested member of our list-serve group. Maybe you also might consider looking at the web pages of our other 4 geriatric SIGs to see what they are doing and what might be a good fit for you to become more involved in your/our profession. There are many reasons to engage/re-engage with the APTA and some of them are listed below.

I also think it is important to publically acknowledge some of the wonderful people who are volunteering 1 to 2 hours a month (or more when they can) to develop and actively promote the mission of the CMH SIG (stated on our web page). The least we can all do is pay them with our sincere compliments for generously sharing with us their time, interests, and talents. I hope you will find a way to let our liaisons and officers know how much you appreciate their leadership and volunteer time. Again, one way you can do this is to officially sign up as a member of our CMH SIG, and if you happen to work with these fabulous people, I hope you tell them that you appreciate them in person.

One way I can show my appreciation for their efforts is to help put a spotlight on them. So I posed 3 questions to our liaisons and officers, and I am posting their responses here in my first *GeriNotes* article as the CMH SIG Chair. Not all of us are represented in this article because of our other time commitments in February when this article was conceived, but there will be other articles and opportunities to continue to offer thanks to all our CMH SIG leaders. We are lucky to have so many people who can periodically step up to collaborate in valuable and creative ways.

MIKE STUDER

Mike Studer, PT, MHS, NCS, CEEAA, CWT, CSST, is our CMH SIG Vice-Chair. He is also President of Northwest Rehabilitation Associates Inc., located in Salem, Oregon.

Why are you a member of AGPT?

Because I have consistently found that (1) volunteerism pays back—always look to pay it forward with your time and you will be rewarded back with energy and optimism if nothing else; and (2) we are stronger as an individual when we make those around us stronger.

What was the catalyst that prompted you to take on your current volunteer CMH SIG leadership role?

Lise's introduction was a match with my past experience and career-long dedication to integrating cognition into PT.

What environment do you work in and can you name one cognitive and one mental health patient issue that you/your staff/students are interested in learning more about?

Outpatient. Our clinic is studying new methodologies for dual tasking AND I am continuing to investigate self-efficacy in rehab.

GRACE KNOTT

Grace Knott, PT, GCS, is our CMH SIG Secretary. She works as the Rehab Services Administrator at Hillcrest Health Services in Bellevue, Nebraska.

Why are you a member of AGPT?

The Academy of Geriatric PT provides the most resources for my career and I always know that there will be interesting articles in *GeriNotes* that I can use right away, thought provoking research articles that I can ponder about. The geriatric list-serve alone is worth the cost of Section membership. I also believe the therapists that make up the membership of the AGPT are making a difference in our profession and driving clinical excellence.

What was the catalyst that prompted you to take on your current volunteer CMH SIG leadership role?

I just completed 6 years of being on the Program Committee for the HPA The Catalyst section and loved it. I felt if I could do the program chair for a Section, I could do anything and geriatrics is my love. I have a personal interest in this SIG having a mother who is suffering with Alzheimer's disease and having a very strong family history for this dreadful disease.

What environment do you work in and can you name one cognitive and one mental health patient issue that you/your staff/students are interested in learning more about?

I currently work as an administrator in the areas of post-acute skilled nursing, outpatient therapy, and long term care. The one cognitive issue that I would like to learn more about is the dementia associated with Parkinson's disease. For mental health, my whole team would benefit from learning about chronic mental illness and its impact on function in later life and how to work effectively with someone with mental illness.

ROBERT CLARK

Robert Clark, PT, DPT, GCS, is our CMH SIG Treasurer. He is the Director of Education and Development at Ascend Rehab, LLC and CareOne Management, LLC in Connecticut.

Why are you a member of AGPT?

I became a member of AGPT because my passion is not only treating older adults but also includes educating and training other PTs in how to enhance the quality of life of older adults. My role as an educator focuses on ensuring that therapists feel confident in their ability to treat older adults based on a strong degree of self-competence. In my efforts to be an effective educator, the AGPT provides me a wealth of knowledge, both through its publications (*JGPT*, *GeriNotes*) as well as through the ability to network and share ideas with like-minded physical therapists who are advocates dedicated to improving the lives of aging adults.

What was the catalyst that prompted you to take on your current volunteer CMH SIG leadership role?

As a profession, I believe that the creation of a special interest group focused on cognition and mental health related to the older adult was long overdue. With the ever-increasing prevalence of cognitive impairment and dementia in the United States, I believe this SIG, through information sharing and networking, has the ability to advance the knowledge and skill sets of physical therapists. Having a background in non-profit organizations, with a focus on finance, I felt I could best serve this group in the role of Treasurer and was excited to take on that responsibility.

What environment do you work in and can you name one cognitive and one mental health patient issue that you/your staff/students are interested in learning more about?

I am a Director of Education and Development for a large health care provider that focuses on caring for older adults in a variety of settings, with a focus on sub-acute and long-term care. One of my desires is for therapists, working with older adults, to have a fundamental knowledge base regarding cognitive impairment and dementia. I hear too often that clients are not appropriate for physical therapy because they have dementia. There is tremendous opportunity for our profession to more robustly engage and train therapists in the ability to treat those with cognitive and mental health issues. Physical therapists that lack confidence in their ability to treat cognitively impaired patients will avoid treating patients with cognitive issues until they gain the competence necessary to boldly move forward and effect a positive outcome. Therefore, I am excited to see how this SIG shares CMH information and resources that ultimately results in more competent, and more importantly, confident physical therapists.

MICHELE STANLEY

Michele Stanley, PT, DPT, GCS, CEEAA, is our CMH SIG Nominating Committee Chair. She works at St. Mary's Hospital, SSM Health in Madison, Wisconsin.

Why are you a member of AGPT?

I am a member of the AGPT because no matter what your practice setting (except exclusive pediatrics), a large segment of your practice will be with those who are age 60 or older.

What was the catalyst that prompted you to take on your current volunteer CMH SIG leadership role?

Persons with anxiety and mental health issues, including dementia, are prevalent in practice settings. Resources and training for physical therapists to maximally adapt and modify practice to optimize experiences for these clients is limited. It is my passion to change this. Volunteering with this SIG seems like a good way to get started on the process.

What environment do you work in and can you name one cognitive and one mental health patient issue that you/your staff/students are interested in learning more about?

I practice in acute and subacute settings. My perception is that clients and client families as well as therapists want more information about function, possible programs, and goals for those with CMH issues.

DANILLE PARKER

Danille Parker, PT, MPT, DPT, GCS, CEEAA, and our other CMH SIG Nominating Committee Member. She is also a Clinical Associate Professor and Director of Clinical Education at Marquette University Physical Therapy in Milwaukee, Wisconsin.

Why are you a member of AGPT?

I am a member because adults are living longer lives and as therapists, we have an opportunity to improve and impact the quality of life and activity levels for such a large majority of the population.

What was the catalyst that prompted you to take on your current volunteer CMH SIG leadership role?

I believe in improving the quality of care that is being provided by PTs and PTAs to those individuals with cognitive impairments. This group is the perfect avenue to provide the education and resources for therapists to improve those services.

What environment do you work in and can you name one cognitive and one mental health patient issue that you/your staff/students are interested in learning more about?

I am currently in the academic realm, focusing my teaching on the older adult rehabilitation principles. I do practice in the clinic and work with many individuals with varied types of dementia and cognitive deficits. The biggest issue I have encountered in practice when working with older adults with cognitive deficits is the limited quality of care that is being provided. I have found that individuals are not being pushed to their full potential and therapists are too easily "giving up" on patients because they believe an individual with cognitive deficits cannot learn. I believe that

individuals are interested in learning how to assess these individuals and how to teach someone skills in an appropriate manner.

LAURA WHITE

Laura White, PT, DScPT, GCS, is one of our CMH SIG Academic Liaisons. She is the Director of Clinical Education in the Physical Therapy Department at the University of South Alabama in Mobile.

Why are you a member of AGPT?

I became a member of the AGPT 20 years ago as a PT student to gain access to resources that would maximize my ability to improve the lives of older adults. My professional roles have changed throughout the years, from clinician to manager to educator, but my goal of improving the lives of older adults has remained the same. In all of my professional roles, the AGPT has been a valuable source of relevant information.

What was the catalyst that prompted you to take on your current volunteer CMH SIG leadership role?

As an educator, clinician, and researcher, I have a strong interest in the relationship between mobility and cognitive function in older adults. I volunteered for the role of academic liaison to gain and share information with current and future PT professionals who have a similar interest in optimizing mobility and cognitive health in older adults.

What environment do you work in and can you name one cognitive and one mental health patient issue that you/your staff/students are interested in learning more about?

Academia (entry-level DPT program), a community-based health promotion clinic, and sub-acute rehabilitation. I am interested in learning more about the effectiveness of screening for dementia, delirium, and depression by physical therapists.

JEN NASH

Jen Nash, PT, DPT, NCS, is one of our CMH SIG Clinical Liaisons. She works as the Outpatient Neurologic Clinical Rehab Manager at Cleveland Clinic Lou Ruvo Center for Brain Health in Las Vegas, Nevada.

Why are you a member of AGPT?

I am a member of the AGPT to learn and network with my colleagues to maximize my ability to help my older adult patients. I enjoy working with this population and feel they teach me as much as I teach them. They motivate me every day to work harder towards improving our profession's ability to maximize their mobility and quality of life while reducing their fall risk. I feel membership in the AGPT connects me with like-minded PT who are all striving toward the same goal with passion matched to mine.

What was the catalyst that prompted you to take on your current volunteer CMH SIG leadership role?

Brain disorders are growing at an astonishing rate. One in 8 adults develops Alzheimer's disease by age 65, and one in two by 85. That puts over 4 million Americans at risk of developing this insidious, mind-robbing disease every year. Physical activity has been shown in research to reduce of dementia and improve cognitive performance as well as physical performance, mood, and behavior. As the exercise experts, physical therapists are perfectly skilled to design and instruct individualized home exercise programs for people with MCI.

I volunteered for CMH SIG leadership because I work daily with people who have neurodegenerative diseases. More than 80% of my caseload has cognitive impairment. I am well-supported by neurologists who specialize in brain health and can help to bridge a gap that exists in the knowledge base of both neurologists and physical therapists regarding physical activity and cognitive impairments. I work at the site of the largest Alzheimer's disease clinical trials program in the country with 30 active trials and feel I want to share our discoveries with our profession.

Though it is difficult to get a person with a neurologic disorder to change their behavior in regards to exercise, physical therapists that address the barriers of exercise including self-efficacy, outcome expectations, and goals and incorporate facilitators may have the ability to improve cognition, mobility, and reduce fall risk. Physical therapists need to provide education and tools to promote brain health. Neurologists also need to better understand how we can help their patients, and as clinical liaison, I hope to help PTs and PTAs reach out to their referral sources and their communities to educate them on how our skill set can improve their patient's and caregiver's quality of lives.

What environment do you work in and can you name one cognitive and one mental health patient issue that you/your staff/students are interested in learning more about?

I work at Cleveland Clinic Lou Ruvo Center for Brain Health as the clinical rehab manager of our outpatient neurologic rehabilitation clinic in Las Vegas, Nevada. I am interested in learning more about communication and motivational strategies with a variety of people with cognitive and mental health issues. Also I am interested in learning about the community resources that others utilize to engage this population in physical activity and how we can all improve our community's ability to serve this population.

CHRISTY ROSS

Christy Ross, PT, DPT, GCS, is one of our CMH SIG Inter-Section Liaisons. She works with Jen Nash at the Cleveland Clinic Lou Ruvo Center for Brain Health in Nevada.

Why are you a member of AGPT?

I love working with older adults, pure and simple. It is what I am supposed to do with my career, a calling. Being able to develop relationships and learn from other physical therapists, to grow as a geriatric physical therapist and develop expertise, and be surrounded by others that are passionate about working with older adults so joining this group just made sense to me. I value the efforts of the Academy serving to provide important resources for all clinicians, researchers, professors, and students. I believe so strongly in the mission and vision of this organization, and as a member, I get to do my part in paying that forward.

What was the catalyst that prompted you to take on your current volunteer CMH SIG leadership role?

I have had the opportunity to grow as a geriatric physical therapist while working at the Cleveland Clinic Lou Ruvo Center for Brain Health. I have

met individuals with neurodegenerative diseases and their caregivers and assist them improving their quality of life. Along the way, I have developed a special interest in serving those with cognitive impairment, seeing how preconceived notions or stigmas, a lack of knowledge, and minimal resources affect the quality of life of these individuals. I believe so strongly that we have a duty to serve, to improve functional activity performance, and to provide caregiver education as physical therapists. I have always appreciated the knowledge gained and relationships developed when participating in the APTA groups, and I am convinced that this newly developed group could grow to help so many PTs/PTAs serving these individuals with cognitive impairment and their caregivers.

What environment do you work in and can you name one cognitive and one mental health patient issue that you/your staff/students are interested in learning more about?

I work in an outpatient physical therapy setting with individuals with neurodegenerative diseases and their caregivers. Some patient/caregiver concerns and interests that are present often at our clinic are how to best address behavioral concerns, especially when in an environment that is full of distractions making it difficult to provide quality care; how to assist caregivers with home exercise program integration and recommending respite care and support group services to assist with maintaining a strong quality of life for both the individual with cognitive impairment and the caregiver; use of implicit learning and appropriate PT cuing/instructions to assist with functional performance for successful examination, especially for those with later stages of dementia; and identifying the best outcome measures to use for those with cognitive impairment throughout the spectrum of this disease – even if that means development of outcome measures and researching for validity and feasibility.

SUSAN WENKER

Susan Wenker, PT, MS, GCS, CEEAA, is our CMH SIG Research Liaison. She is also the Director of Clinical Education for the Doctor of Physical Therapy Program at the University of Wisconsin in Madison.

Why are you a member of AGPT?

To become a better clinician/educator for the older adult in order to promote improved care for older adults.

What was the catalyst that prompted you to take on your current volunteer CMH SIG leadership role?

I continually seek ways to become a part of the AGPT and stepping down from the Programming Co-chair gave me a void to fill. Additionally, the need to have increased knowledge to evaluate and treat patents/clients with CMH disorders is only going to increase. I want to be a clinician with the knowledge and know how to do so!

What environment do you work in and can you name one cognitive and one mental health patient issue that you/your staff/students are interested in learning more about?

Education- 1. Multi-cultural impact of caregiving to people with CMH disorders and 2. Providing evidenced-based care throughout the continuum of progressive CMH disorders.

LISE MCCARTHY

Lise McCarthy, PT, DPT, GCS, is Chair of the CMH SIG. She has an incorporated gerogeriatric physical therapy house-calls practice in San Francisco, California.

Why are you a member of AGPT?

My patient population is almost exclusively over the age of 80 which means they have multiple impairments (often including cognitive deficits and mental health issues) and functional limitations with complex underlying medical conditions. For me, AGPT is a great resource for learning, networking, mentoring, and fellowship.

What was the catalyst that prompted you to take on your current volunteer CMH SIG leadership role?

In 2012, I started to get really distressed by a number the Medicare changes taking place that were negatively impacting my patients and affecting my ability to practice. The changes kept coming fast over the next two years and it became clear I needed to redirect my anger and frustration toward projects that were meaningful and productive. So I re-engaged with my profession and deepened my commitment to advance physical therapy practice as a doctoring profession. In doing so, I have found a way to de-stress and remain confident in my abilities to continue to practice during this difficult transitional period called health care reform.

What environment do you work in and can you name one cognitive and one mental health patient issue that you/your staff/students are interested in learning more about?

I started a home health /outpatient geriatric physical therapy practice nearly 15 years ago. MIPT recently incorporated and now has 3 employees. Our small size and dedicated focus to an age-specific patient population allows us to quickly adapt to changes while remaining experts in our areas of interest. We provide high quality physical therapy care management services in the home setting (eg, long-term care, assisted living communities, board and care homes, and individual residences) and accept only Medicare or private payment. We are always interested in learning more about chronic progressive cognitive impairments in older adults. Recently, we have become interested in underlying conditions, such as high-functioning Asperger's syndrome.

Last, but not least by any means, I would like to mention two other remarkable individuals who were also instrumental in the development of our CMH SIG. **Ellen Strunk, PT, MS, GCS, CEEAA, (and AGPT Federal Affairs Liaison, and with Rehab Resources and Consulting, Inc.**) who twice urged me to post an inquiry to our geriatric chat group to see if there was any interest in forming a SIG about dementia, as she knew a little about my niche practice and interest in forming such SIG. **Mindy Renfro, PT, PhD, DPT**, (**and Chair of AGPT's Balance & Falls Special Interest Group, and Professor at the University of Montana in Missoula, Montana**) who had the brilliant idea of changing the name of our proposed Dementia SIG to the Cognitive and Mental Health SIG to make it more all-encompassing. I had the great pleasure of finally meeting them at CSM 2015 and giving them my thanks and a hug. So there you go—proof that we are better and feel better when we work collaboratively together. More next time….

GCS AS A CONSULTANT

Amie Marie Flores, PT, DPT, GCS, NCS, PhD Candidate

It is truly rewarding to help older adults succeed wherever they may be across the continuum of care. Specialization in geriatrics is enhanced by the amount of time a clinician promotes successful and optimal aging. Taking and passing the geriatric certification examination affirms that the level of expertise achieved by the geriatric clinician is at par with the standards set by the American Board of Physical Therapy Specialties (ABPTS). However, being certified is just the beginning. The passion to make a difference in the lives of the older adults has propelled many geriatric certified specialists (GCS) to newly found niches and territories by joining universities to teach, participating in research studies, and mentoring in residency programs. Ongoing investments to improve confidence and competence in the delivery of geriatric physical therapy has led to transformation of GCS into resource persons for solutions and has opened floodgates for greater and challenging roles. This article aims to explore another career path for the GCS, the role of a consultant.

Mindy Renfro, PhD, DPT, GCS, CPH, had been a consultant prior to attaining her GCS. The certification made her more marketable, which led to expanded programs and more consulting roles. After many years of watching people end their lives in the nursing home, she became passionate in helping older people to successfully age-in-place. Preventing the first fall that spelled out "the end" for so many became her driving ambition.

Establishing a fall prevention program is an example of a consultation service, which Dr. Renfro offers. Consultants capitalize on their problem solving skills. Knowledge and skills in diagnosis and treatment, which are central to the physical therapy profession, ease the transition of a therapist to a consultant role. While clinicians provide individualistic and patient-centered interventions, the consultant's trade, on the other hand, are solutions and recommendations that bring about changes to an organization. Hence, the consultant has the capacity to influence on a larger scale and to reach out farther.

With the expected steady growth in the geriatric population in the years to come, the prospect of seeking the services of consultants who understand the needs and concerns of older adults should not be underestimated. Expert opinions on improving cost-effectiveness, outcome measures, and collaborative efforts are valuable. According to Dr. Renfro, "consultants will always be needed and someone will always be willing to pay for their services, opinions, education, and presentation. Those who treat the masses with a public health approach will find greater opportunities than those focused on treating one person at a time."

The success of a consultant depends on the ability to deliver results. Building a good reputation is crucial to the growth of a consulting practice. In return, one can enjoy higher income, flexibility, and control over the business, which are some of the benefits of working as a consultant. Dr. Renfro advised those who are considering this as a career advancement, be well networked locally, statewide, and nationally both within their profession and interdisciplinary, in order to rise to the top. Other helpful tips that Dr. Renfro gave are to find a consultant that is willing be a mentor, to keep an edge by staying up-to-date and evidence-based, and to surround yourself with people you aspire to be. Dr. Renfro noted how her colleagues amaze her.

In this era of health care reforms comprised of restructuring of organizations and reinventing of the delivery of care, it is a privilege to have more career roles to choose from. Having the GCS certification increases the options. Being a consultant is only one among the many opportunities to consider in the journey of a GCS.

Amie Marie Flores is the lead of the Subcommittee on Geriatric Specialization and Advanced Proficiency for PTA. She is a physical therapist at Halifax Health/Brook Rehab Center for Inpatient Rehabilitation and an adjunct instructor teaching Geriatric Physical Therapy for the transitional DPT program at A.T. Still University.

REHABILITATIVE MANAGEMENT OF A 66-YEAR-OLD FEMALE WITH CHRONIC LOWER BACK PAIN: A CASE REPORT

Rachael Matthews, SPT, Dr Russell Carter, Dr Dale Schiut, Dr Roberta O'Shea

INTRODUCTION

Chronic low back pain is the second most common cause of disability in adults living in the United States.[1] The lifetime prevalence rate of low back pain ranges from 75% to 85%.[2] Leg pain is often associated with low back pain. It is present in up to 57% of the patients diagnosed with low back pain caused from either neural or non-neural structures.[3]

Low back pain has many causes, one being lumbar spinal stenosis. Lumbar spinal stenosis is a degenerative condition defined as the narrowing of the spinal canal or associated regions, including central, lateral recesses, foraminal and extraforaminal regions.[4] The narrowing is due to mechanical compression caused by bone and/or soft tissue of the spinal nerve roots.[4] The compression can result in weakness, reflex alterations, gait disturbances, bowel and/or bladder dysfunction, motor and sensory changes, radicular pain or atypical leg pain, and neurogenic claudication.[4] The prevalence of lumbar spinal stenosis is about 50% in those over the age of 60 and 80% in those over the age of 70 as well as being a source of decreased quality of life in those over the age of 50.[5,6]

Physical therapy can help improve or restore mobility and reduce the symptoms of low back pain leading to the restoration of normal function. Research has suggested that patients receiving physical therapy for low back pain reduced their likelihood of receiving surgery within one year of treatment.[5] When it comes to treatment interventions for lumbar spinal stenosis, the research states that initially treatment includes medication for pain control, exercise, steroid injections, and physical therapy, but suggested interventions lack specific protocols or standardization of physical therapy treatment.[4,8]

The purpose of this case report was to examine the effectiveness of a physical therapy rehabilitation program for a 66-year-old female referred for lumbar radiculopathy and lumbar spinal stenosis. The treatment interventions used in this report focused on lumbar extension exercises, upper and lower extremity strengthening exercises, postural control exercises, aerobic training, and modalities, including interferential current, moist heat, and/or cold pack, in order to achieve the patient's short- and long-term goals and to improve quality of life.

CASE DESCRIPTION

The patient was a 66-year-old Caucasian female referred to physical therapy with a medical diagnosis of lumbar spinal stenosis and lumbar radiculopathy. She had a history of chronic low back pain that had an insidious onset years prior. Her significant past medical history included osteoporosis, arthritis, and numbness and tingling into her right upper extremity. Before being referred to physical therapy she was prescribed medications to help control her pain. The medications included hydrocodone, cyclobenzaprine, lidocaine patches, and meloxicam. She stated that she had an MRI done of her lumbar spine 3 weeks prior to the initial evaluation. She presented to physical therapy with an exacerbation of her low back pain symptoms that began one month prior to the initial evaluation. The pain locations included her low back with the left side being greater than the right side, left posterior thigh, left lateral leg, and left lateral foot. The patient described the pain at the time of initial evaluation as intermittent and rated it an 8 out of 10 on the Numerical Pain Rating Scale (NPRS). The patient's prior level of function before the exacerbation was limited due to her chronic low back pain. Aggravating factors at the time of initial evaluation included rolling from side to side, transferring from sit to stand, and prolonged sitting, while walking provided pain relief. The patient stated that her goal was to return to her prior level of function, allowing her to participate in activities she enjoyed that included volunteering as receptionist at a cancer center, walking 30 minutes daily, and attending services at her synagogue.

SYSTEMS REVIEW

Before the physical examination began, the patient's blood pressure, as a part of the cardiopulmonary portion of the systems review, was taken by a physical therapy aide and found to be 116/70 mmHg. The patient had a comorbidity of aortic valve regurgitation for which she was taking baby aspirin, possibly causing her blood pressure to be lower. The musculoskeletal portion of the systems review found impairments that included decreased lumbar range of motion (ROM) and decreased lower extremity strength found from the screening of myotomes/postural strength.

Myotomes of Lower Extremity

This screen was done to test the patient's muscle power for possible neurological weakness.[9] The myotomes were measured seated for bilateral nerve roots L1-S2. These included hip flexion (L1-2), knee extension (L3), ankle dorsiflexion (L4), great toe extension (L5), ankle plantar flexion (S1), and knee flexion (S2). The movements were performed as explained by Magee in 2008.[9]

CLINICAL IMPRESSION #1

After obtaining the patient's history and performing a systems review, the primary impairments were identified. They included increased lower back and left lower extremity pain, decreased bilateral lumbar ROM, and overall decreased lower extremity strength. In order to provide a more accurate description of the patient's condition, more specific tests and measures were performed. By

using the NPRS and obtaining a subjective pain description, an accurate pain account could be gathered, suggesting a possible source of the pain. Manual muscle testing was performed due to the weaknesses found during the myotomal testing of the lower extremities. Lumbar ROM was measured to assess the possible causes of the limitation. Neurodynamic testing was performed due to complaints of radiculopathy and the pain pattern in the lower extremities on the left side from the lower back to the foot, suggesting possible neural tissue involvement. The Modified Oswestry Disability Scale was used to assess any functional limitations or disability caused by her condition due to her goal to return to her prior level of function. The results of her MRI were also obtained after the initial evaluation to provide more insight on what was occurring in her lumbar spine and are described in the clinical impression #2 of this case report.

TESTS AND MEASURES

Numerical Pain Rating Scale

This test was used to measure the patient's pain intensity. She was asked to rate her pain at that moment on a scale of 0 to 10, where 0 indicated no pain and 10 indicated the most intense pain imaginable causing the patient to seek care at an emergency room. This test was chosen in order to provide data regarding the patient's current pain level. It also requires no equipment and can be done in less than 3 minutes. Childs et al in 2005 reported that the NRPS was found to have a standard error of measurement of 1.02, a minimal detectable change (MDC) of 2 points, a minimal clinically important difference (MCID) of 1.5 points during the first week of physical therapy treatment and 2.2 points after 4 weeks of physical therapy treatment, and a large effect size (ES) at 1 week and 4 weeks (ES= 0.95-1.2) in patients receiving physical therapy for low back pain.[10] In 2001, Farrer et al reported that the NRPS was found to have a MCID of 1.7 points or a 27.9% reduction.[11] Herr et al in 2004 reported that the NRPS was found to have an excellent internal consistency in those aged 65-94 with a Cronbach's alpha of 0.87.[12] During initial evaluation, the patient reported her NPRS score to be 8 out of 10.

Lumbar Range of Motion

Lumbar ROM was measured grossly for lumbar flexion, extension, right rotation and sidebending, and left rotation and sidebending. The movements were performed as explained by Reese and Bandy in 2010, but not recorded using an instrument, such as a goniometer or tape measure.[13] It was scored instead using subjective observation and given a rating. The rating could be one of the following: within normal limits (WNL), meaning no significant limitation, minimally limited (75% of range present), moderately limited (50% of range present), and severely limited (25% or less of range present). During initial evaluation, the patient demonstrated a rating of moderately limited for lumbar flexion that elicited pain. Bilateral lumbar rotation was WNL, but elicited pain. Also to note, the patient experienced a centralization of symptoms when performing lumbar extension.

Manual Muscle Testing

Lower extremity manual muscle testing was performed bilaterally for hip flexion, knee extension, ankle dorsiflexion, great toe extension, ankle plantar flexion, and knee flexion. The movements were performed as explained by Hislop and Montgomery in 2007.[14] Plantar flexion and knee flexion were performed in a short seated position in order to allow for patient comfort. Scoring ranged from 0 to 5 including pluses and minuses, with 5 meaning normal, 4 meaning good, 3 meaning fair, 2 meaning poor, 1 meaning trace activity, and 0 meaning no activity.[14] During the initial evaluation, weaknesses were found bilaterally in all muscles tested; complete results are found in Table 1.

Neurodynamic Tests

Straight Leg Raise (SLR): This test is used to determine lumbosacral neural tissue mechanosensitivity by putting a mechanical and possibly physiological strain on the sciatic nerve and the nerve roots.[3] In order to perform the test, the patient is lying in the supine position with head and pelvis flat.[2] The examiner slowly lifts one of the patient's feet off the table into hip flexion while maintaining knee extension.[2] The leg is progressively elevated until maximum hip flexion is reached or the patient experiences a reproduction of their symptoms.[2] The test is positive if there is a reproduction of the symptoms or if the examiner finds significant resistance.[3] Majlesi et al in 2008 reported that the test was found to have a sensitivity of 0.52 and a specificity of 0.89, suggesting that when looking at the results there were fewer false positive scores, allowing for confidence when ruling in the condition when finding a positive result.[2] Walsh and Hall in 2009 reported that the test was found to have good reliability of 0.80 and a good interrater reliability interclass correlation co-

Table 1. Lower Extremity Manual Muscle Testing

	Initial Evaluation	3 Weeks	Discharge (8 weeks)
Hip flexion	Right 4-/5; Left 3+/5	Bilateral 4/5	Bilateral 5-/5
Knee extension	Bilateral 4-/5	Right 4/5; Left 4-/5	Bilateral 5/5
Ankle dorsiflexion	Bilateral 4/5	Bilateral 4+/5	Bilateral 5/5
Great toe extension	Bilateral 4/5	Bilateral 4+/5	Bilateral 5/5
Ankle plantar flexion	Bilateral 4/5	Bilateral 4+/5	Bilateral 5/5
Knee flexion	Bilateral 4-/5	Bilateral 4/5	Bilateral 5-/5

efficient (ICC) of 0.82 and 0.77.[3] Gabbe et al in 2004 reported that the test was found to have an excellent inter-rater reliability with an ICC of 0.95, a SEM of 4, and good test-retest reliability with an ICC of 0.91 and 0.91 and a SEM of 2 and 4.[15] During initial evaluation, the patient demonstrated a positive finding on the left side and a negative finding on the right side.

Slump Test: This test is designed to put the sciatic nerve roots under increasing tension. The test is performed by the patient sitting on the side of the examination table with the back straight, looking straight ahead.[2] The patient is then instructed to "slump" over putting the thoracic and lumbar spines into flexion while continuing to look straight ahead.[2] The next portion of the test is to put the cervical spine into full flexion, then to extend the knee of one of the lower extremities, and ending with the examiner placing the patient's foot of the extremity with the extended knee into ankle dorsiflexion.[2] Throughout the test, the patient reports to the examiner what they are experiencing and if their radicular symptoms have been reproduced.[2] The test is considered positive if there is a reproduction of symptoms suggesting sciatic nerve root tension.[2] Majlesi et al reported that the test was found to have a sensitivity of 0.84 and a specificity of 0.83, suggesting good false negative and false positive rates.[2] Walsh and Hall reported that the test was found to have a fair reliability of 0.71 and a good inter-rater reliability with an ICC of 0.89 and 0.70.[3] Gabbe et al reported that the test was found to have an excellent inter-rater reliability with an ICC of 0.92 and SEM of 3 and excellent test-retest reliability with an ICC of 0.95 and 0.80 and SEM of 3 and 5.[15] During initial evaluation, the patient demonstrated a positive finding in the left lower extremity and a negative finding in the right lower extremity.

Picture 1. Total Back Table

Saunders Total Back. ScripHessco. http://www.scriphessco.com/products/saunders-totalback/. Published 2014. Accessed November 17, 2014.

Modified Oswestry Disability Index

This outcome tool measures activity limitation in people with low back pain. It consists of 10 questions that address different aspects of function and can be completed on paper or on a computer.[7,16] Each question is scored from 0 to 5.[7] The total score is expressed as a percentage with 0 meaning no disability, 0-20 minimal disability, 20-40 moderate disability, 40-60 severe disability, 60-80 housebound, and 80-100 bedbound/maximum disability.[16,17] Cleland et al in 2012 reported that the test was found to have a good to excellent reliability with an ICC of 0.863, a MDC of 13.1, MCID of 5.0, and a SEM of 5.65.[17] Davidson and Keating in 2002 reported that the measure was found to have good test-retest reliability with an ICC of 0.92, an SEM of 4.5, and a MDC of 10.5 in those who self-reported being "about the same" post treatment.[7] During initial evaluation, the patient scored a 42%, suggesting severe disability.

CLINICAL IMPRESSION #2

The initial evaluation was performed one month after an exacerbation of the patient's chronic low back pain symptoms. The patient was treated with prescription medications to control the pain before being referred to physical therapy. During the examination, there were key impairments found. The first impairment found was an increased pain level. According to the patient's NPRS score of 8 out of 10 at the time of initial evaluation, she had a high pain intensity level. The patient subjectively described her pain as intermittent starting in her bilateral lower back with the left side being more painful than the right side following a path down her left lower extremity into her foot. Myotome screening of the lower extremities found generalized bilateral lower extremity muscle weakness, suggesting a possible neurological cause, but also could have suggested general muscle weakness. Manual muscle testing was then completed and generalized bilateral weakness was found in all muscles tested, which included hip flexion, knee extension, ankle dorsiflexion, great toe extension, ankle plantar flexion, and knee flexion. Lumbar ROM testing revealed a moderate limitation, meaning 50% of the range was present, with lumbar flexion as well as pain with

Table 2. Lumbar Range of Motion

	Initial Evaluation	3 Weeks	Discharge (8 weeks)
Flexion	Moderately Limited*	Minimally Limited*	WNL*
Extension	WNL	WNL	WNL
Sidebend Right	WNL	WNL	WNL
Sidebend Left	WNL	WNL	WNL
Rotation Right	WNL*	WNL	WNL
Rotation Left	WNL*	WNL	WNL

* Elicited Pain; Abbreviation: WNL, within normal limits

lumbar flexion and bilateral rotation. Neurodynamic testing found positive results in the left lower extremity for the SLR and the Slump tests, suggesting possible neural tissue involvement and/or sciatic nerve or nerve root tension. The Modified Oswestry Disability Index reported a score of 42%, suggesting severe disability, which was not allowing the patient to perform actions, tasks, or activities required of her to fulfill her roles.[18] These roles included self-care, household management/chores, and volunteer work. The posture exam revealed that the patient had decreased lordosis of her lumbar spine (flat back), which could be a possible compensation for spinal stenosis allowing for an increase in the foraminal space. Results of the patient's MRI completed 3 weeks prior to the initial evaluation were obtained. They stated that there was severe bilateral foraminal stenosis at L5/S1, due to loss of disc height and hypertrophy of the facet joints and mild central canal and foraminal stenosis at L4/L5, due to grade 1 anterior subluxation of L4 and L5 and disc bulge.

DIAGNOSIS AND PROGNOSIS

The patient was referred to physical therapy with a medical diagnosis of lumbar radiculopathy and lumbar spinal stenosis. The key impairments discovered during the initial evaluation included abnormal posture, decreased strength, pain affecting function, decreased mobility, and decreased functional mobility, falling into the preferred practice pattern 4F (Impaired Joint Mobility, Muscle Performance, ROM, and Reflex Integrity Associated with Spinal Disorders). Due to the patient's condition, age, level of impairment, motivation to improve and prior level of function, the patient was given a prognosis of excellent. This prognosis is supported by research. Kou et al in 2005 reported that that those with radicular type of low back pain associated with lumbar spinal stenosis were good candidates for conservative treatment, such as physical therapy, due to a positive outcome.[18] Verkerk et al in 2013 reported that there was a 30% improvement rate for those with the following characteristics, married or living with one other adult, younger age, higher disability at baseline, and no previous rehabilitation.[20] The patient did not fall in line with all of those factors, but she was of a younger age, had a higher disability at baseline, and had no previous rehabilitation. There is also contradicting evidence that suggests there is little evidence as to which prognostic factors are of value in the recovery of chronic nonspecific low back pain.[21] The subject of this case study was chosen based on her condition and symptoms. She was referred with a medical diagnosis of lumbar radiculopathy and lumbar spinal stenosis, but according to the MRI she received she also had a herniated disc and grade 1 spondylolisthesis. The symptoms she presented with did not fully agree with lumbar spinal stenosis. Lumbar spinal stenosis is characterized by back pain, burning pain in the buttock or legs, weakness in the legs, increased pain with walking, and decreased pain with leaning forward or sitting.[6] The subject of this case report did not describe her pain as burning, had increased pain with lumbar flexion and prolonged sitting, and decreased pain with walking. The patient also reported a centralization of her pain and symptoms with lumbar extension, suggesting the pain being partially due to the herniated disc.

PLAN OF CARE

It was decided after the initial evaluation that the patient would be seen for physical therapy 2 to 3 times per week for 4 weeks. The treatments would include modalities as indicated, pain management, patient education, postural education, and therapeutic exercise, including ROM, stretching, and strengthening, all in order to achieve short- and long-term goals listed in Table 3. These goals addressed the key impairments found including increased pain, decreased lumbar flexion ROM, and decreased general lower extremity strength.

INTERVENTIONS

The patient attended 20 physical therapy treatment sessions. Each session lasted between 45 to 55 minutes. Interventions focused on lumbar extension exercises, upper and lower extremity strengthening exercises, postural control exercises, aerobic training,

Table 3. Goals

Short Term Goals	Re-Assessment	Discharge
Patient will report pain at a 25-50% reduction with tolerating prolonged sitting.	In progress	Met
Patient will demonstrate increased lumbar flexion mobility by 25-50% improved ability to perform activities such as dressing/washing, sitting, transfers, lifting and occupational/recreational activities.	Met	Met
Patient will demonstrate increased lumbar myotome/postural strength to 5-/5 for performing transfers such as getting in/out of car/tub and/or rising from chair/toilet.	In progress	Met
Patient will demonstrate independence with current home exercise program.	Met	Met
Long Term Goals		
Patient will report pain at a 50-75% reduction with sleeping/turning in bed.	In progress	Met
Patient will demonstrate increase lumbar flexion mobility by 50-75% to improve ability to perform activities such as dressing/washing, sitting, transfers, and lifting.	In progress	Met
Patient will demonstrate increased lumbar myotome/postural strength to 5/5 for performing household ADLs such as vacuuming, making the bed, and cooking.	In progress	Partially met

and modalities, including interferential current, moist heat, and/or cold pack. Interventions were selected based on the patient's level of function and support in the research. Specific exercises and progressions are listed in the Appendix. The patient was also provided with a home exercise program (HEP) in addition to the treatment sessions to maintain gains achieved and to promote a return to prior level of function as quickly and effectively as possible. During the last treatment session, the patient was provided with a new HEP, which included strengthening exercises from the original HEP with added progression of increased repetitions as well as new exercises, in order to maintain the improvements made in therapy. She was able to verbalize and demonstrate her understanding of before discharge.

OUTCOMES

The patient's goals were developed based on the impairments found during the initial evaluation as well as what the patient wanted to achieve by the end of the therapy. The patient met 6 out of the 7 goals and partially met 1 out of the 7 goals; the data is represented in Table 3. The one goal was only partially met because not all strength gains were 5 out of 5, some were 5- out of 5. Also to note was the goal involving pain. It stated that the patient would report pain at a 50% to 75% reduction with sleeping/turning in bed, this was not true at discharge do to her pain level being reported as a 6 out of 10. The therapist who conducted the discharge took into consideration that at the session prior to discharge she rated her pain as a 3 out of 10, as well as the patient subjectively reporting that she was experiencing less pain with sleeping and turning in bed resulting in a decision to document that the patient met that goal.

Modified Oswestry Disability Index

The patient's score at initial evaluation was 42%, suggesting severe disability. After 3 weeks, the patient reported a score of 48%. The score at discharge, after 8 weeks, was 42%. The patient overall did not demonstrate an improvement, still suggesting that she had a severe disability (Table 4).

Table 4. Modified Oswestry Disability Index

Date	Score
Initial Evaluation	42%
3 Weeks	48%
Discharge (8 weeks)	42%

Lumbar Range of Motion

The patient demonstrated decreased lumbar flexion ROM, as well as an increase in pain with lumbar flexion and bilateral lumbar rotation. The lumbar flexion was measured as moderately limited suggesting that the patient had 50% of the range present. During the reassessment at 3 weeks, the patient demonstrated an increase in lumbar flexion from moderately impaired to minimally impaired, suggesting the patient had 75% of the range present. No pain was experienced with bilateral lumbar rotation. After 8 weeks, the patient increased her lumbar flexion from minimally impaired to WNL, showing an overall improvement that may be the result of a decrease in pain level The decrease in pain level could be the result of the improvement of the herniated disc present at L4-5. The patient continued to experience no pain with bilateral lumbar rotation. Specific data is represented in Table 2.

Lower Extremity Manual Muscle Testing

During initial evaluation, the patient had decreased bilateral lower extremity strength. After 3 weeks at reassessment, the patient demonstrated an improvement at all levels of at least a half grade. The reason for this quick increase in strength is possibly due to a decrease in pain level. Again with the decrease in pain possibly being the result of an improvement of the herniated disc. The patient continued to show improvement at discharge after 8 weeks by improving by at least a half grade from reassessment; specific data represented in Table 1.

Numerical Pain Rating Scale

The patient was asked to rate her pain using the NPRS at every treatment session. Figure 1 shows the pain level progression from initial evaluation through discharge. After 3 weeks, the patient had a two point decrease in pain level from 8 out of 10 to 6 out of 10. According to the research, the MDC was found to be 2 points, suggesting that the patient had a significant decrease in pain level after 3 weeks of treatment.[10] After 8 weeks, the patient reported her pain level a 6 out of 10. Because the level stayed at 6 out of 10, there was no significant change from reassessment at 3 weeks to discharge at 8 weeks. During weeks 2 through 5, there was a fluctuation of pain scores. There was no adverse event reported by the patient. The only change that occurred was the patient had received an epidural steroid injection into her lumbar spine between weeks 2 and 3. Prior to the injection, the patient was showing a decrease in pain, but post injection she experienced an increase. According to a retrospective study by Mashari et al in 2012, it was found that 15% of patients who received an epidural steroid injection for either lumbar spinal stenosis or lumbar disc herniation, reported worsening or no change in pain level, suggesting that the increase and fluctuation in pain possibly could have been due to the epidural steroid injection.[22] During treatment session two, the patient received intermittent pelvic traction, which increased the patient's NPRS score reflected in Figure 1.

DISCUSSION

The purpose of the study was to examine the effectiveness of a physical therapy rehabilitation program for a 66-year-old female referred for lumbar spinal stenosis and lumbar radiculopathy. The treatment interventions focused on lumbar extension exercises, upper and lower extremity strengthening exercises, postural control exercises, aerobic training, and modalities, including interferential current, moist heat, and/or cold pack, in order to achieve the patient's short- and long-term goals and to improve quality of life. By the end of the treatment, the patient met 6 out of the 7 goals set at the initial evaluation, as well as partially meeting 1 out of the 7 goals. The one goal was only partially met because not all strength gains were 5 out of 5, some were 5- out of 5. Also to note was the goal involving pain. It stated that the patient would report pain at a 50% to 75% reduction with sleeping/turning in bed; this was not true at discharge due to her pain level being reported as a 6 out of 10. The therapist who conducted the discharge took into consideration that at the session prior to discharge she rated her pain as a 3 out of 10, as

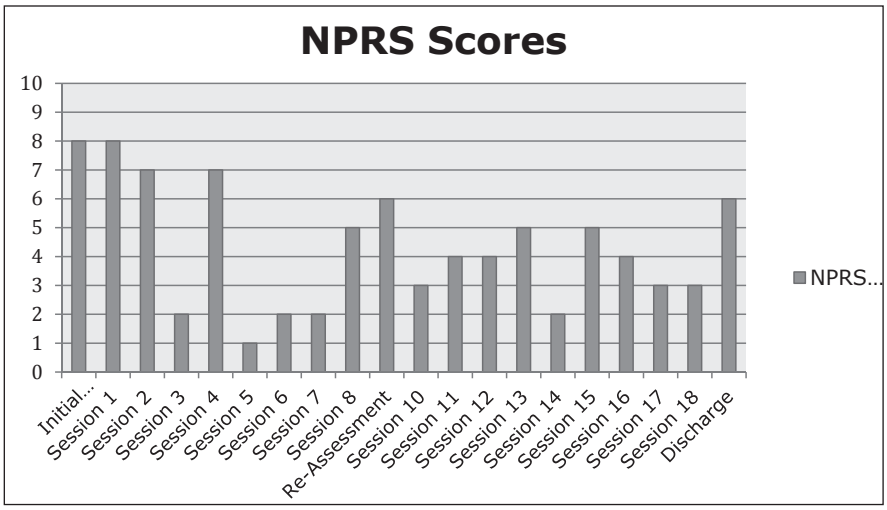


Figure 1. Numeric Pain Rating Scale

well as the patient subjectively reporting that she was experiencing less pain with sleeping and turning in bed resulting in a decision to document that the patient met that goal. Although the patient met the majority of her goals, her score on the Modified Oswestry Disability Index stayed the same as it was at the initial evaluation. This case report is significant because of the prevalence of chronic low back pain in adults in the United States. The research suggests that 60% to 90% of individuals will report low back pain during their lifetime.[6] Lumbar spinal stenosis is one many possible causes identified as a cause of low back pain. It is reported to have a high prevalence in the aging population at approximately 10% to 25% of the US population, and is diagnosed in 22% of patients with chronic low back pain.[6] Conservative treatments are recommended before surgery in the majority of cases.[6] The standard practice includes joint mobilizations, lumbosacral corset, flexibility, stabilization, aerobic conditioning, and strengthening exercises in order to decrease pain and increase function.[6] Fritz et al in 2014 suggested that physical therapy could reduce the likelihood of patients receiving surgery within one year.[5] Although there is evidence supporting physical therapy as being an appropriate conservative treatment choice for patients with low back pain and lumbar spinal stenosis, there is a lack of standardization of the treatment protocol being used. Tomkins et al in 2010 concluded that after looking at the physical therapy treatment options for lumbar spinal stenosis, more research needs to be performed in order to develop a standardization of care for patient with low back pain and lumbar spinal stenosis.[23] The results of this case report can add to the gap of literature on the specific treatment interventions used to treat patients with low back pain and lumbar spinal stenosis. The interventions used were supported by research in order to treat chronic low back pain. Interferential current (IFC) was used to address the high level of pain she was experiencing. Fuentes et al in 2014 suggested that those with chronic low back pain who received IFC combined with therapeutic alliance, defined as working rapport/positive social connection, demonstrated a decrease in pain intensity by 77.4% and a decrease in muscle pain sensitivity by 51.5%.[24] Extension exercises were chosen due to the patient's centralization of symptoms with lumbar extension. These exercises are supported by clinical practice guidelines set by the Orthopaedic Section of the American Physical Therapy Association (APTA) in 2012.[25] The guidelines state that centralization and directional preference have a grade A for patients with low back pain, suggesting strong evidence support by research at levels I-II, which are considered high quality diagnostic studies, prospective studies, or randomized control trails.[24] Lower extremity and upper extremity exercises were also chosen as an intervention in order to address the strength deficit. Traction was initially chosen due to the patient's radicular symptoms, but was discontinued after the patient reported an increase in pain. Traction was given a grade D by the Orthopaedic Section, APTA, suggesting that there is conflicting research on its outcomes.[25] Postural control exercises were added to the intervention plan in order to increase the dynamic strength of the scapular muscles. It has also been found that postural control is impaired in individuals with chronic low back pain relative to control.[26] The exercises chosen were performed as explained by Kisner and Colby in 2012.[27] Treadmill walking was also added to the intervention plan to increase the patient's overall fitness as a form of pain management. The Orthopaedic Section, APTA rates fitness and endurance activities as a grade A for pain management.[25] There is also some conflicting evidence found by Hendrick et al in 2010. The results of that article state that walking has only moderate level evidence supporting positive outcomes and treadmill walking has poor evidence.[28] Even though there is some conflicting evidence, the patient found pain relief from walking, so it was included in the intervention plan. During treatment session 9, the patient reported an increase in pain level. Due to this increase in pain, positional distraction was performed using a bolster applying overpressure to the spinous processes of L1-5 as explained by Kisner and Colby in 2012, which is generally chosen to relieve pain in patients with lateral stenosis.[29]

Factors other than physical therapy interventions may have influenced this patient's outcome. Treatment began one month post exacerbation of her chronic low back pain symptoms, which may have factored into the outcomes. The patient had a decrease in activity due to increase of pain in her lower back, possibly causing a decrease in strength and ROM. The patient also received a lumbar epidural injection between weeks 2 and 3 of treatment. Prior to the epidural, the patient was making significant gains when it came to decreasing pain level, but after the injection, she experienced an increase in pain symptoms, possibly causing the fluctuation of scores on the NPRS during weeks 2 through 5; represented in Figure 1. The increase in pain included a peripheralization into her left lower extremity similar to the symptoms found at the initial evaluation. The cause of this increase in pain could have been due to the herniated disc. There was a

change in interventions post injection. The focused returned to decreasing pain, as opposed to increasing strength and ROM, which included an increase in modalities used.

There were limitations presented in this case report. This is a single case report, so no generalizations or conclusions can be reported about the results found. The patient also received other treatments outside of physical therapy, including an epidural steroid injection into her lumbar spine and pain medications, which could have affected the outcomes.

Suggestions for future research may include studies comparing different modes of treatment such as muscular strengthening exercises and aerobic exercises and comparing them to each other to see which produces superior outcomes.

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Appendix

Session	Modalities	Lumbar Extension Exercises[24]	Lower Extremity Strengthening[24]	Upper Extremity Strengthening[24]	Postural Control Exercises[26]	Aerobic Training[24,26]	Traction/ Positional Distraction
1	IFC with moist heat x 15 minutes[23]						
2	Moist heat x 10 minutes	Prone on elbows x 2 minutes Prone press ups x 20 reps Prone alternating hip extensions x 20 reps	Calf stretching x 2 minutes Long arc quads 10# x 20 reps Hip abduction 40# x 20 reps Seated leg curls 10# x 20 reps	Overhead pull down 10# x 20 reps Rows 10# x 20 reps			Intermittent pelvic traction 60#/40# with moist heat 60 sec/20 sec x 15 minutes[24]
3	Moist heat x 10 minutes IFC with moist heat x 15 minutes	Prone on elbows x 2 minutes Prone press ups x 20 reps Prone alternating hip extensions x 20 reps	Calf stretching x 2 minutes Long arc quads 10# x 20 reps Hip abduction 40# x 20 reps Seated leg curls 10# x 20 reps	Overhead pull down 10# x 20 reps Rows 10# x 20 reps Lat pull downs 20# x 20 reps			
4	Moist heat x 10 minutes IFC with moist heat x 15 minutes	Prone on elbows x 2 minutes Prone press ups x 20 reps Prone alternating hip extensions x 20 reps	Calf stretching x 2 minutes Long arc quads 10# x 20 reps Hip abduction 45# x 20 reps Seated leg curls 15# x 20 reps	Overhead pull down 10# x 20 reps Rows 10# x 20 reps Lat pull downs 20# x 20 reps			
5	Moist heat x 10 minutes IFC with moist heat x 15 minutes	Prone on elbows x 2 minutes Prone press ups x 20 reps Prone alternating hip extensions x 20 reps	Calf stretching x 2 minutes Long arc quads 10# x 20 reps Hip abduction 45# x 20 reps Seated leg curls 15# x 20 reps	Overhead pull down 10# x 20 reps Rows 10# x 20 reps Lat pull downs 20# x 20 reps			
6	Moist heat x 10 minutes IFC with moist heat x 15 minutes	Prone on elbows x 2 minutes Prone press ups x 20 reps Prone alternating hip extensions x 20 reps	Calf stretching x 2 minutes Long arc quads 10# x 20 reps Hip abduction 55# x 20 reps Seated leg curls 15# x 20 reps	Overhead pull down 10# x 20 reps Rows 10# x 20 reps Lat pull downs 25# x 20 reps	Total Back Table (Picture 1) 0# x 20 reps each in prone position Shoulder Extensions Scapular Retractions Horizontal abduction Flexion at 110° abduction		

7	Moist heat x 10 minutes IFC with moist heat x 15 minutes	Prone on elbows x 2 minutes Prone press ups x 20 reps Prone alternating hip extensions x 20 reps	Calf stretching x 2 minutes Long arc quads 10# x 20 reps Hip abduction 55# x 20 reps Seated leg curls 15# x 20 reps	Overhead pull down 10# x 20 reps Rows 10# x 20 reps Lat pull downs 25# x 20 reps	Total Back Table 0# x 20 reps each in prone position Shoulder Extensions Scapular Retractions Horizontal abduction Flexion at 110° abductio-n		
8	IFC with cold pack x 15 minutes	Prone on elbows x 2 minutes Prone press ups x 20 reps Prone alternating hip extensions x 20 reps	Calf stretching x 2 minutes Long arc quads 15# x 20 reps Hip abduction 55# x 20 reps Seat leg curls 20# x 20 reps	Overhead pull down 12.5# x 20 reps Rows 12.5# x 20 reps Lat pull downs 25# x 20 reps	Total Back Table 1# x 20 reps each in prone Shoulder Extensions Scapular Retractions Horizontal abduction Flexion at 110° abduction	Treadmill walking speed 2.0 x 5 minutes	
9	IFC with moist heat x 15 minutes		Calf stretching x 2 minutes Long arc quads 15# x 20 reps Hip abduction 55# x 20 reps Seated leg curls 10# x 20 reps			Treadmill walking speed 2.5 x 5 minutes	Right sidelying positional distraction using bolster applying over-pressure to spinous processes L1-L5[27]
10	Moist heat x 10 minutes IFC with moist heat x 15 minutes	Prone on elbows x 2 minutes Prone press ups x 20 reps	Long arc quads 15# x 20 reps Hip abduction 55# x 20 reps	Overhead pull down 12.5# x 20 reps Rows 12.5# x 20 reps Lat pull downs 25# x 20 reps			
11	Moist heat x 10 minutes IFC with moist heat x 15 minutes	Prone on elbows x 2 minutes Prone press ups x 20 reps	Calf stretching x 2 minutes Long arc quads 15# x 20 reps Hip abduction 55# x 20 reps Seated leg curls 10# x 20 reps	Overhead pull down 12.5# x 20 reps Rows 12.5# x 20 reps Lat pull downs 25# x 20 reps	Total Back Table 0# x 20 reps each in prone Shoulder Extensions Scapular Retractions Horizontal abduction Flexion at 110° abduction Pushups		

12	Moist heat x 10 minutes IFC with moist heat x 15 minutes	Prone on elbows x 2 minutes Prone press ups x 20 reps	Calf stretching x 2 minutes Long arc quads 15# x 20 reps Hip abduction 55# x 20 reps Seated leg curls 10# x 20 reps	Overhead pull down 12.5# x 20 reps Rows 12.5# x 20 reps Lat pull downs 25# x 20 reps	Total Back Table 0# x 20 reps each in prone Shoulder Extensions Scapular Retractions Horizontal abduction Flexion at 110° abduction Pushups		
13	Moist heat x 10 minutes IFC with moist heat x 15 minutes	Prone on elbows x 2 minutes Prone press ups x 20 reps	Calf stretching x 2 minutes Long arc quads 20# x 20 reps Hip abduction 55# x 20 reps Seated leg curls 10# x 20 reps	Overhead pull down 12.5# x 20 reps Rows 12.5# x 20 reps Lat pull downs 25# x 20 reps	Total Back Table 1# x 20 reps each in prone Shoulder Extensions Scapular Retractions Horizontal abduction Flexion at 110° abduction Pushups		
14	Moist heat x 10 minutes IFC with moist heat x 15 minutes	Prone on elbows x 2 minutes Prone press ups x 20 reps	Calf stretching x 2 minutes Long arc quads 20# x 20 reps Hip abduction 55# x 20 reps	Overhead pull down 12.5# x 20 reps Rows 12.5# x 20 reps Lat pull downs 25# x 20 reps	Total Back Table 1# x 20 reps each in prone Shoulder Extensions Scapular Retractions Horizontal abduction Flexion at 110° abduction Pushups		
15	Moist heat x 10 minutes	Prone on elbows x 2 minutes Prone press ups x 20 reps	Calf stretching x 3 minutes Long arc quads 30# x 20 reps Hip abduction 55# x 20 reps Seated leg curls 15# x 20 reps	Overhead pull down 12.5# x 20 reps Rows 12.5# x 20 reps Lat pull downs 30# x 20 reps	Total Back Table 2# x 20 reps each in prone Shoulder Extensions Scapular Re-tractions Horizontal abduction Flexion at 110° abduction Pushups	Treadmill walking speed 1.0 x 8 minutes	

16	IFC with moist heat x 15 minutes		Calf stretching x 3 minutes Long arc quads 30# x 20 reps Hip abduction 55# x 20 reps	Overhead pull down 12.5# x 20 reps Rows 12.5# x 20 reps Lat pull downs 30# x 20 reps	Total Back Table 3# x 20 reps each in prone Shoulder Extensions Scapular Retractions Horizontal abduction Flexion at 110° abduction Pushups	Treadmill walking speed 1.0 x 8 minutes	
17	Moist heat x 10 minutes	Prone on elbows x 2 minutes Prone press ups x 20 reps	Calf stretching x 3 minutes Long arc quads 30# x 20 reps Hip abduction 60# x 20 reps	Overhead pull down 15# x 20 reps Rows 15# x 20 reps Lat pull downs 30# x 20 reps	Total Back Table 3# x 20 reps each in prone Shoulder Extensions Scapular Retractions Horizontal abduction Flexion at 110° abduction Pushups	Treadmill walking speed 1.0 x 8 minutes	
18	Moist heat x 10 minutes	Prone on elbows x 2 minutes Prone press ups x 20 reps	Calf stretching x 3 minutes Long arc quads 30# x 20 reps Hip abduction 60# x 20 reps	Overhead pull down 15# x 20 reps Rows 15# x 20 reps Lat pull downs 30# x 20 reps	Total Back Table 3# x 20 reps each in prone Shoulder Extensions Scapular Retractions Horizontal abduction Flexion at 110° abduction Pushups	Treadmill walking speed 2.0 x 9 minutes	
19	Moist heat x 10 minutes	Prone on elbows x 2 minutes Prone press ups x 20 reps Prone alternating leg extensions x 20 reps	Calf stretching x 3 minutes Long arc quads 30# x 20 reps Hip abduction 60# x 20 reps	Overhead pull down 17.5# x 20 reps Rows 17.5# x 20 reps Lat pull downs 30# x 20 reps	Total Back Table 3# x 20 reps each in prone Shoulder Extensions Horizontal abduction Flexion at 110° abduction Pushups	Treadmill walking speed 2.0 x 9 minutes	

20	Moist heat x 10 minutes	Prone on elbows x 2 minutes Prone press ups x 20 reps Prone alternat-ing leg exten-sions x 20 reps	Calf stretching x 3 minutes Long arc quads 30# x 20 reps Hip abduction 60# x 20 reps	Overhead pull down 17.5# x 20 reps Rows 17.5# x 20 reps Lat pull downs 30# x 20 reps	Total Back Table 3# x 20 reps each in prone Shoulder Extensio-ns Scapular Retracti-ons Horizont-al abductio-n Flexion at 110° abductio-n Pushups	Treadmill walking speed 2.0 x 9 min-utes	

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American Physical Therapy Association

Congratulations to Our 2015 Honors and Awards Recipients!

Each year APTA honors outstanding achievements on the part of its members in the areas of overall accomplishment, education, practice and service, publications, research, and academic excellence. The Academy is proud to recognize the following members.

Name	Award
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Recognition for these recipients will take place during the Honors and Awards Ceremony and Reception on Thursday, June 4, during the ***NEXT Conference and Exposition*** in National Harbor, Maryland.