

GERI NOTES

Academy of Geriatric Physical Therapy

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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/Memorial Fund is a wonderful expressive memorial.

PRESIDENT'S MESSAGE: BE HAPPY

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



Before I get started with this issue's message I wanted to give my due respects to Joan Mills, who recently passed away. She had the initial vision and insight to guide us in the beginning as a new Section that has led us to where we are today as an Academy. Her memorial will be found within this issue. She will be missed.

A great honor has been bestowed upon one of our former Section presidents, Carole B. Lewis, PT, DPT, PhD, GCS, GTC, MSG, FAPTA, who has been named the 47th McMillan lecturer. This popular, high-profile lecture will be delivered as part of the 2016 APTA, NEXT Conference and Exposition in Nashville, Tennessee.

Lastly, by popular demand the ExPAAC (Exercise Physical Activity and Aging Conference) II will be returning July 27-30 to the University of Indianapolis in 2016. Plans are well underway with a preconference FOCUS course on Wednesday, followed by 3 days of programming regarding aging adults. Ask anyone who attended in 2009—it was a great course and 2016 will be all new and improved.

I recently attended a community presentation called "Ten Scientifically Supported Suggestions for Greater Happiness," presented by a self-proclaimed "Happiness Counselor." With all the stresses of the everyday world, who couldn't use a little extra happiness, and besides, the session was free. The speaker quoted several scientific studies and I am not sure who the original author of this information is, but I did find a collaborating website (not the same person as the speaker) which is: <http://www.inc.com/jeff-haden/10-scientifically-proven-ways-to-be-incredibly-happy-wed.html>. I hope that many of you will take the opportunity to be happier!

1. Exercise more, apparently even 7 minutes a day might be enough. Research with 3 groups of patients with a diagnosis of depression indicated that of the 3, the group that exercised, without taking any anti-depressants, were much less likely to relapse after 6 months. But you don't have to be depressed to benefit from exercise. Exercise can help you relax, increase your brain power, and make you fit to take on the daily routines. We're not talking about cardiovascular fitness here, just being happier.
2. Sleep more. Having enough sleep makes us less susceptible to feeling emotions such as anger or fear. We feel happier, are better able to focus, and will be more productive.
3. Shorten your commute. Nothing like a long, frustrating commute to drag you down during your work week and a terrible way to start the day. But many of us can't move due to a spouse's job, child care, housing, etc. But perhaps you can find a way to make the commute more tolerable, such as a book on tape or avoiding rush hour traffic by getting in earlier.
4. Spend time with friends and family. The most important key to happiness in life, according to various research studies, is having good relationships with family and friends. Our older adults who are successfully aging show us this all the time.
5. Go outdoors. Happiness is maximized at 13.9° C. That's 57° F. This study was done in England, so perhaps it might a bit higher in Arizona or for those of you who love the beach. This is pretty good news for those of us who are worried about fitting new habits into our already-busy schedules. Twenty minutes is enough time to spend outside that you could fit it into your early commute or even your lunch break. I personally may take this to the extreme with my 120-mile, week-long backpacking trips.
6. Help others, volunteer at a food kitchen or a favorite charity, or help an older neighbor. One hundred hours a year appears to be the magic number.
7. Practice smiling. A fake smile doesn't do it. Try to find something to smile about. A fake smile can lead to a real one, however, so don't despair. I love to laugh and I make regular stops at comedy clubs. Laughter is the best medicine. Also, sometimes just sit back and contemplate the lighter side of life. On Facebook, I saw a toddler who had completely painted herself and parts of her home with white paint. Did her mom get upset and angry? No, she saw the lighter side, smiled, laughed, and posted it.
8. Plan a trip. You don't necessarily have to take it. The best part of a vacation seems to be during the planning of it. Where would you go if you could go anywhere? Actually, taking a trip can be stressful for some people, but the planning will ease the tension.
9. Meditate. Meditation increases calmness, contentment, and empathy for others. This may help you with the stresses of patient care.
10. Practice gratitude. Say thank you whenever you can. Share your good times with friends or family. I see this on Facebook all the time. Another way to practice gratitude would be before you go to sleep every night think of at least one thing (maybe more) that you are grateful for.

Finally, just getting older tends to make people feel happier. One hypothesis is that older people have learned how to regulate their moods better than younger individuals. People learn what things make them happy and they do them. We also become less suppressed by peer pressure when compared to younger persons. So take a break, follow some of the suggestions, and be happy!

EDITOR'S MESSAGE: WORDS MATTER

Meri Goehring, PT, PhD, GCS



I was recently contacted by a reader who thought that some information in the July issue of *GeriNotes* could be construed as ageism. Ageism is stereotyping and discriminating against individuals or groups on the basis of their age. I quickly realized that I should have identified the wording and recommended changes. This led me to thinking about the importance of words. Jeff Goins is a writer who echoes my thinking in this area. His website is available at www.goinswriter.com/words-matter. He lists several principles about words that I would like to share.

1. Context is important.
2. There are correct and incorrect ways to use words.

3. Habits matter.
4. Laziness with words is an epidemic.

Let me explain what these principles mean. First of all, context is important. When writing or talking about an older adult, we should always remember that not all older adults are alike. Yet, when writing about older adults with dementia, authors may report various components of dementia that are common. Taken out of context, this may be misconstrued as *ageism* when this is not the intent of the author. Furthermore, there are correct and incorrect ways to use words. An older adult should not be labeled as *frail* just because they are old. A *frail* older adult would have certain medical and/or physical problems that have contributed to his or her frailty. Also, habit matters. As I use words and read articles, I need to work harder to look for and eliminate aspects of writings that could be considered ageist. Developing the habit of looking for ageism should

be part of our work. I will certainly try harder to find and correct any such language. But, as Mr. Goins also notes, laziness with words is an epidemic. Writers may not realize their words to express ageism because ageism is all around us. We must, then, as members of the Academy of Geriatric Physical Therapy, find ways to identify language in articles, texts, and advertisements that is discriminating against older adults and try to initiate change in any such language by focusing our descriptions to accurately describe aging. Luckily, with *GeriNotes*, finding and mentoring writers is a pleasurable task and the writers are never lazy. I am honored to have such wonderful contributors and to have the opportunity to learn so much from their writings. I welcome you to consider writing for *GeriNotes* in the future and share your passion regarding our profession about working with older adults. Make your words matter.

CORRECTION TO TRIFOLD REFLECTION PAPER

It has been brought to my attention that the following sentence in the reflection paper could be misconstrued and considered ageist. "Placing an elderly person through an educational program can be difficult due to decreasing cognition, visual acuity, memory and energy." It was not the intent of the author or mentors to imply that all elderly persons will have some or all of these deficits and the sentence should have read "placing an elderly person through an educational program can have added difficulties when there are cognitive or visual deficits or potential memory and energy declines." The author and mentor share a passion for working with the geriatric population and do not condone ageism in any form.

Meri Goehring, PT, PhD, GCS, CWS

Editor, GeriNotes

IT'S ACTIVE AGING TIME

Lori Schrodt, PT, MS, PhD

The fall brings great opportunities to join the International Council on Active Aging (ICAA, an Academy of Geriatric Physical Therapy promotional partner) in celebrating and promoting active aging.

ACTIVE AGING WEEK 2015: LIVE YOUR ADVENTURE

September 27 - October 3, 2015

Active Aging Week (AAW) is an international celebration of positive, active aging. This year's AAW *Live Your Adventure* theme challenges adults 50 years and older to try something new and challenges institutions and agencies to join AAW. Each day of AAW also has a specific theme highlighting aspects of foot health, walking, and aquatics. During AAW, individuals have the opportunity to experience exercise and other healthy aging activities throughout their communities. Senior centers, retirement communities, area agencies on aging, health care, and other aging and wellness partners celebrate AAW by offering a variety of free (and fun!) programs. Programs often include group exercise classes, health fairs, educational events, group walks, dances, and arts and craft classes. Last year over 3000 organizations across Australia, Canada, and the United States participated in AAW. If you've missed planning to join in AAW this year, be sure to visit the website to plan for next year. And be sure to check with your partners and agencies to find out about AAW programs in your area.

The ICAA offers support to organizations and participants through a dedicated AAW website (www.activeagingweek.com). Organizations can join in special theme days, register their AAW events, and download AAW promotion materials. Individual participants can also access a variety of health and activity tips and videos.

Visit www.activeagingweek.com to learn more and register your event(s). You can also follow AAW on Facebook (<https://www.facebook.com/ActiveAgingWeek>) and Twitter (@AAW_ICAA).

ICAA CONFERENCE 2015: EMBRACE THE POSSIBILITIES

November 19-21, 2015

New Orleans, LA

The annual ICAA conference is coming soon. Held in conjunction with the Athletic Business Conference and Expo, Medical Fitness Association, and the National Alliance for Youth Sports Congress, the conference offers plenty of sessions to choose from. Come join the many professionals working with older adults to promote more active aging.

The conference is a great place to meet health and wellness professionals from various disciplines, other physical therapy professionals working in clinical and wellness programs, and attend interactive and engaging sessions. Diverse educational sessions focused on wellness program design, physical activity, brain fitness, wellness management and leadership, and outdoor programs are sure to fill the 3-day schedule. Physical therapists may be particularly interested in this year's sessions on balance training, walking programs, core stability, dementia care, and reducing hospital readmissions. But the sessions on other aspects of wellness are not to be missed either. The optional preconferences offer opportunities to expand your aquatic exercise skills and learn how to better train peer leaders in a multi-factorial fall-risk reduction program. In addition, poster presentations, a networking reception, and the new ICAA Idea Exchange roundtables offer networking opportunities in a supportive, collaborative atmosphere with a strong focus on application.

Consider joining your active aging colleagues in learning how to better promote health and wellness. Visit the ICAA Conference website at <http://icaa.cc/conferenceandevents/overview.htm> to learn more about the exciting programming and registration information.

Lori Schrodt currently serves as Chair of the Health Promotion and Wellness SIG and as the AGPT Liaison to the International Council on Active Aging. She specializes in community-based healthy aging and fall prevention programs. She is a professor in the Department of Physical Therapy at Western Carolina University, where she teaches geriatric and neuromuscular rehabilitation courses and treats clients in a balance and fall prevention specialty clinic. She can be contacted at lschrodt@email.wcu.edu.

THE DEMENTIA MEASURE UPDATE WORK GROUP REPORT

Lise McCarthy, PT, DPT, GCS

The American Psychiatric Association and the American Academy of Neurology invited the American Physical Therapy Association (APTA) to attend the Dementia Measure Update Work Group meeting in Chicago on June 15, 2015. As the current Cognitive and Mental Health Chair of the Academy of Geriatric Physical Therapy, I was nominated to represent the Academy.

The purpose of this meeting was to review, identify, and develop quality measures that specifically target underemphasized or gaps in the evaluation and management of care provided to people with dementia. The members of this collaborative group represented many well-respected organizations:

- American Academy of Family Physicians
- American Academy of Hospice and Palliative Medicine
- American Academy of Neurology
- American Academy of Physical Medicine and Rehabilitation
- American Association of Critical-Care Nurses
- American Association of Neuroscience Nurses

- American College of Physicians
- American Geriatrics Society
- American Healthcare Association
- American Medical Directors Association
- American Medical Association
- American Occupational Therapy Association
- American Physical Therapy Association
- American Psychiatric Association
- Gerontology Society of American
- Humana
- Lewy Body Dementia Association
- National Academy of Neuropsychology
- Veterans Administration

I am pleased to report that 3 topics I brought to this group for consideration were accepted:

- add a new measure: Pain Assessment and Follow-up,
- update the Safety Assessment Measure to include risks of sexual activity, and
- modify the language in all measures to more clearly promote inclusion of the assessment of caregiver reports and patient observation, when applicable.

There will be opportunity for the public to comment on these measure sets in late August/early September. Thereafter, the leadership team will respond to these comments and, if indicated, edit the measure sets prior to voting to approve them for publication and implementation. I hope you will take a little time to look at these measures as there are many great opportunities for physical therapists and physical therapist assistants to contribute in making dementia care more affordable, effective, and safer.

Lise McCarthy is the President of McCarthy's Interactive Physical Therapy. She is an Assistant Clinical Professor Volunteer with the Department of Physical Therapy and Rehabilitation Science at the University of California, San Francisco. Lise is also the Founding Chair of the Cognitive and Mental Health SIG of the Academy of Geriatric Physical Therapy, APTA.

THANK YOU

*Tamara Gravano, PT, DPT, GCS, CEEAA
Membership Committee Chair*

Many thanks to the many dedicated AGPT members who volunteered at the **Academy of Geriatric Physical Therapy booth at APTA NEXT2015 in National Harbor June 3-5.**

For each hour volunteered at the booth, volunteer names were placed in a drawing for one free year of Section membership. **This year, the winner is Nannette Farley.**

Please be sure to sign up again to volunteer at booth at CSM 2016 in Anaheim, CA, February 17-19, for another chance to win free membership. Watch for the volunteer call later this year. Thanks again to all of our volunteers; we couldn't do it without you all!

A MESSAGE FROM YOUR PTA ADVOCATE: 2015 PTA CAUCUS UPDATE

Ann Lowrey, PTA

PTA Caucus Representatives, PTA Caucus Alternate Representatives, and PTA Caucus Delegates gathered in National Harbor, MD, on May 30 and 31, for the PTA Caucus Annual Meeting. Amy Smith, Chief Delegate, presided over the meeting.

The PTA Caucus Nominating Committee conducted candidate interviews and elections. Those elected to serve included: Amy Smith (AL), Chief Delegate, Chris Garland (KY), Alternate Delegate and Christina Wilson (AL), Nominating Committee. The Chief Delegate, acknowledged outgoing officers Debbie Simmons (OK), Nominating Committee, and Jane Jackson (AZ), Alternate Delegate, as well as those who had attained PTA Recognition. Brad Thuringer (SD) was recognized for receiving PTA of the Year Award.

Discussion was dominated by 3 bylaw amendments coming before the 2015 House of Delegates. These motions were the result of actions taken by the PTA work group that was appointed by the Board of Directors in 2014. They

each addressed the status of PTAs in the organization.

The first bylaw amendment before the house was RC3, which was created to allow components the option to amend their bylaws, allowing Physical Therapist Assistants a full vote. The house passed this initiative. Each chapter now has the option to bring before their membership the option to alter their chapter bylaws, awarding PTA members a full vote, as opposed to the previous one-half vote mandated by APTA bylaws.

RC4, which would have allowed components the option to allow physical therapist assistants to run as a chapter delegate, was discussed and ultimately did not pass the House.

Finally, RC7, which was designed to permit physical therapist assistants the option to run for a position on APTA Board of Directors in a non-officer position, also did not pass.

Carolyn Oddo, member of the Board of Directors and PTA liaison, provided an APTA update regarding the new APTA Vision. All future initiative are being grouped into 3 “buckets”

that reflect the vision. These “buckets” are titled Transforming the Profession, Transforming the Association, and Transforming Society. Michael Bowers, CEO, reinforced the idea that all APTA initiatives, moving forward, will be examined as pertaining to one or more of these 3 categories. He also emphasized how PTAs will be integrated into the association as a whole. Bonnie Polvinale, APTA staff, provided an update on the Advanced Proficiency Pathways (APP) for the PTA. The APPs are educational routes to help PTAs move from career-entry knowledge and skill levels to advanced proficiency in several areas of emphasis. Current content areas being offered are Acute Care, Cardiopulmonary, Geriatric, Oncology, Pediatrics, and Wound Management. You can find more information at <http://www.apta.org/PTA/Careers/>.

To find out who your representative is or to see the list of PTA Caucus representatives, please visit http://www.apta.org/uploadedFiles/APTAorg/PTAs/APTA_Representation/PTACaucus-Representitives.pdf.

The next House of Delegates meeting is scheduled for June 6-8, 2016, in Nashville, TN, just prior to APTA's NEXT Conference.



Academy of Geriatric Physical Therapy Booth

Ann Lowrey is the AGPT PTA Advocate



and the PTA Caucus Representative for Pennsylvania. She currently works full time at West Park Rehab in Franklin, PA, and per diem for Aegis Therapies.

She can be contacted via email at annlowreypa@gmail.com.

FALLS PREVENTION AWARENESS DAY SEPTEMBER 23, 2015

Balance and Falls Special Interest Group

Mindy Renfro, PT, DPT, PhD, GCS
Mariana Wingood, PT, DPT, CEEAA
Emma Philips, PT, DPT, GCS, CEEAA
Ann Lowrey, PTA
Cielita Lopez-Lennon PT, DPT, NCA

Chair
Vice Chair
Vice Chair
Secretary/Treasurer
Nominating Committee

The Academy of Geriatrics Physical Therapy, the American Physical Therapy Association, and the American Occupational Therapy Association are joining forces with the NCOA's Falls Free initiative to promote Falls Prevention Awareness Day 2015 (FPAD). The FPAD is always held the first day of fall and this year it is September 23, 2015. The following joint letter has been sent to all state presidents of both professional associations to help raise awareness, promote interdisciplinary collaboration and provide links to valuable resources.

The Balance and Falls Special Interest Group of the AGPT would like to thank all those involved in the joint effort to raise awareness in falls prevention. Please visit our page at www.geriatricspt.org for more information from our SIG and join us in addressing falls in older adults.



ACADEMY OF GERIATRIC
PHYSICAL THERAPY



July 2015

Dear PT Program Chairs and Directors:

The American Occupational Therapy Association (AOTA), the American Physical Therapy Association (APTA), and APTA's Academy of Geriatric Physical Therapy are members of [The Falls Free® Initiative](#) facilitated by the National Council on Aging's (NCOA's) Center for Healthy Aging, and we support the goals of that Initiative, including [Falls Prevention Awareness Day](#). Falls Prevention Awareness Day (FPAD) occurs on **September 23rd**, marking the beginning of Fall and has grown in its impact each year.

This year's theme, **Take a Stand to Prevent Falls®** seeks to raise awareness and prevent falls. Falls among ALL older adults are a significant public health concern and one that we can help address.

As presidents of AOTA, APTA and APTA's AGPT, we bring to your attention the opportunity for meaningful inter-professional collaboration in a national fall prevention initiative. This year we ask you to collaborate with other key health care disciplines involved in fall prevention! Please be sure to engage your state coalition (www.ncoa.org/fallsmap) and community colleagues in the work.

We invite you to review some of the stories of successful collaboration from last year's [Compendium of State and National Activities](#) report, as well as the AGPT Balance & Falls special interest group website.

Helpful resources can be found on the following sites:

- NCOA Falls Free® [Falls Prevention Awareness Day](#) page
- CDC's [STEADI](#) (Stopping Elderly Accidents, Deaths & Injuries) Toolkit for Health Care Providers
- Fall Prevention Center of Excellence <http://stopfalls.org/>
- AOTA Falls Prevention [webpage](#)
- APTA Balance and Falls [webpage](#)

Be on the lookout (on our Fall Prevention webpages) in August for a new PowerPoint community presentation on falls prevention designed for interprofessional collaboration.

In addition, NCOA has created an online Resource Center to help you plan and execute a successful Falls Prevention Awareness Day event in your community, including a media kit, handouts, logos, sample press releases, and promotional materials, as well as examples of past events [Find ideas for your FPAD](#). Create your own activities or offer to assist with existing efforts.

We encourage you and your students to participate in Falls Prevention Awareness Day by showcasing occupational therapy's and physical therapy's vital roles in helping to prevent falls.

Ginny Stoffel, PhD, OT,
BCMh, FAOTA
President
American Occupational
Therapy Association

Sharon Dunn, PT, PhD, OCS
President
American Physical Therapy
Association

William Staples, PT, DHSc, DPT,
GCS, CEEAA
President
Academy of Geriatric Physical
Therapy, APTA



2015 HOUSE OF DELEGATES UPDATE

Steven Chesbro, PT, DPT, EdD, GCS

The 2015 session of the House of Delegates was held June 1-3, 2015, in National Harbor, MD. Twenty-three main motions were considered during the session, a number of which were proposed bylaw changes (bylaw changes are generally considered every 5 years in years ending in 0 or 5). One delegate responsibility is to report actions taken in the House of Delegates to the membership of the Academy. I have submitted this update to *GeriNotes*, as I did last year, to fulfill that obligation to the membership.

Governance is a year-round business for the delegates elected to serve in the House of Delegates. As the Academy's delegate, I participated in virtual town

halls, phone meetings of the Southern Caucus, collaborated with other Section delegates, and engaged in a variety of discussions with other members prior to the beginning of this year's House. It was my pleasure to serve as the Academy's Delegate to the House, and appreciate the opinions and support of Beth Black, who served as our Alternate Delegate; Karen Curran, AGPT Executive Director; Cathy Ciolek, former AGPT Delegate and Chief Delegate for the Delaware Chapter; Amy Smith, Chief Delegate for the PTA Caucus; and other AGPT members for their comments, insight, and questions related to this year's business.

I am providing you with the "unofficial" results of this year's business in order to meet the July publication deadline for *GeriNotes*. However, the final minutes of the 2015 House of Delegates are expected to be posted in August on the APTA's website. I encourage you to review the approved minutes of the House when they are made available to the membership.

The Academy of Geriatric Physical Therapy co-sponsored motions 3, 5, 6, 13, 14, and 23 in this year's House of Delegates. Motions co-sponsored by the Academy are highlighted with an asterisk (*) below.

Motion:	Title/Topic and Intent:	Result:
RC 1-15	Amend: Bylaws of the APTA and Standing Rules of the APTA to change the length and number of terms for members of the APTA Board of Directors Intent: To change the length and number of terms from two 3-year terms to one 4-year term.	Failed
RC 2-15	Amend: Bylaws of the APTA to change the qualifications for President, Vice President, Secretary, and Treasurer	Withdrawn
RC 3-15*	Amend: Bylaws of the APTA to grant Components the option of amending their bylaws to provide a full vote for PTA members Intent: To allow chapter and section members to determine if PTAs can be provided with a full vote for chapter and section business.	Passed
RC 4-15	Amend: Bylaws of the APTA to provide Chapters the option of amending their bylaws to enable PTA members to serve as chapter delegates Intent: As stated in the title.	Failed
RC 5-15*	Amend: Bylaws of the APTA to allow Sections to vote in the House of Delegates Intent: As stated in the title.	Failed
RC 6-15*	Amend: Bylaws of the APTA to grant Life Members the privilege of serving as delegates to the House of Delegates Intent: To allow those members who renew in the Life Membership category to serve in the House of Delegates.	Failed
RC 7-15	Amend: Bylaws of the APTA to grant PTA members the privilege to serve on the APTA Board of Directors Intent: As stated in the title.	Failed

RC 8-15	<p>Delivery of Value-Based PT Services</p> <p>Intent: That it is the position of the APTA that physical therapists embrace and are accountable for best practice standards to provide high quality services that promote value, and that all individuals have access to physical therapist services.</p>	Passed
RC 9-15	Adopt: Medically Necessary PT Services	Withdrawn
RC 10-15	<p>Rescind: Health care coverage for all Americans</p> <p>Intent: To rescind <i>Health Care Coverage for All Americans</i> (HOD P06-05-18-27), as this position has been incorporated into <i>Principles and Objectives for the United States Health Care System</i> (HOD P06-13-20-18).</p>	Passed
RC 11-15	<p>Adopt: Health priorities for populations and individuals</p> <p>Intent: That the population health priorities of active living, injury prevention, and secondary prevention in chronic disease and disability management guide the APTA work in the areas of prevention, wellness, fitness, health promotion, and management of disease and disability. Additionally, where opportunity exists, PTs provide education, behavioral strategies, patient advocacy, referral opportunities, and identification of supportive resources after screening for: stress management, smoking cessation, sleep health, nutrition optimization, weight management, alcohol moderation and substance-free living, violence-free living, and adherence to health care recommendations.</p>	Passed
RC 12-15	<p>Adopt: The role of the PT in diet and nutrition</p> <p>Intent: It is the role of the PT to screen for and provide information on diet and nutritional issues to patients, clients, and the community within the scope of PT practice.</p>	Passed
RC 13-15*	<p>Adopt: The Association's role in advocacy for prevention, wellness, fitness, and health promotion, and for management of disease and disability</p> <p>Intent: As stated in the title.</p>	Passed
RC 14-15*	<p>Adopt: Physical Therapists' role in prevention, wellness, fitness, health promotion, and management of disease and disability</p> <p>Intent: As stated in the title.</p>	Passed
RC 15-15	<p>Rescind: Positions related to prevention, wellness, fitness, health promotion, and management of disease and disability</p> <p>Intent: As RCs were adopted in this House session to broadly identify PTs role in prevention, wellness, fitness, health promotion, and management of disease and disability, the following previously adopted positions were rescinded: <i>Endorsement of the Falls Free: Promoting a National Falls Prevention Action Plan</i> (HOD P06-05-19-10) [NOTE: APTA is still an active member of Falls Free], <i>Health Promotion and Wellness by PTs and PTAs</i> (HOD P06-93-25-50), <i>Physical Activity Advocacy</i> (HOD P06-05-19-09), <i>Physical Education, Physical Conditioning, and Wellness Advocacy</i> (HOD P06-04-22-18), <i>PTs and PTAs as Promoters and Advocates for Physical Activity/Exercise</i> (HOD P06-08-07-08), and <i>Physical Therapists as Expert Providers of Exercise and Physical Activity Prescription</i> (HOD P06-12-20-07).</p>	Passed
RC 16-15	<p>Adopt: Management of the movement system</p> <p>Intent: A position statement specific to the PT profession's role in optimizing movement to improve the human experience, stating that APTA endorses the development of diagnostic labels that reflect and contribute to the PT's ability to manage disorders of the movement system.</p>	Passed
RC 17-15	<p>Adopt: Identification of PTs by professional title</p> <p>Intent: PTs should be identified by their professional title (ie, physical therapist or doctor of physical therapy) and not by generic terms such as allied health, non-physician provider, or physician extender.</p>	Passed

RC 18-15	Adopt: Position statement on bullying	Postpone Indefinitely
RC 19-15	Explore the roles of PTs in primary care teams Intent: The APTA will investigate and identify the roles of the PT in primary care teams, services of PT which may qualify as components of primary care delivery, and current and future practice opportunities for PTs to integrate these roles and services into practice, education, and research. A preliminary report will be provided to the 2016 House of Delegates, with a final report to be provided in 2017.	Passed
RC 20-15	Collaborations to address childhood and adult obesity Intent: The APTA shall pursue opportunities to participate as a partner in and/or endorse national campaigns against childhood and adult obesity.	Passed
RC 21-15	Incorporation of standardized PT Patient/Client Management elements in electronic health records Intent: The APTA will develop and implement a plan to promote to external stakeholders the value of appropriately incorporating standardized elements of PT patient/client management into electronic health records.	Passed
RC 22-15	Standards and interoperability for health information technology and electronic health records Intent: That the APTA develop a comprehensive health information technology and electronic health record plan.	Failed
RC 23-15*	Adopt: Designation of individuals with intellectual and developmental disabilities as a medically underserved population Intent: The APTA supports the designation of individuals who are intellectually disabled, developmentally disabled, or both as a special medically underserved population by appropriate government agencies.	Passed Unanimously

Election results from the House for 2015 can be found on the APTA website. The results of the national election were:

- President - Sharon L. Dunn
- Vice President - Lisa K. Saladin
- Director (3 elected) – Jeanine M. Gunn, Susan A. Appling, and Robert H. Rowe
- Nominating Committee – Scott Euype

Again, it was my pleasure to serve as the AGPT's Delegate at the 2015 House of Delegates. Concepts for new motions to come before the House in 2016 are being developed now. As state chapters and other Sections begin discussions about developing or supporting those motions, please feel free to let me know your thoughts and questions. My role as Delegate is to represent the Academy, so hearing from you helps me

tremendously. You can contact me at schesbro@alasu.edu.



Steven Chesbro is a Professor of Physical Therapy and Dean of the College of Health Sciences at Alabama State University in Montgomery, AL. He serves as Delegate for the AGPT.

ESSENTIAL COMPETENCIES IN THE CARE OF OLDER ADULTS – APPLICATION IN EDUCATION AND PRACTICE

Kathryn Brewer PT, DPT, MEd, GCS, CEEAA

BACKGROUND

The Essential Competencies in the Care of Older Adults at the Completion of the Entry-level Physical Therapist Professional Program of Study document was made available to Academy of Geriatric Physical Therapy membership and the academic community in May 2011. It was prepared by a Task Force of experienced educators with extensive expertise in geriatric physical therapy in response to a specific action taken as a result of the *Retooling for an Aging America* report (2008) formatting a Partnership for Health in Aging (PHA) by the American Geriatrics Society. This partnership was comprised of 10 health care disciplines, including physical therapy and called for development of overarching multidisciplinary competencies in the care of older adults to enhance preparedness of the workforce to meet the needs of an aging society. The Academy of Geriatric Physical Therapy strongly encourages accredited physical therapist educational programs to reference this document in order to provide students with critical didactic content in order to demonstrate competence in each of the domains described in the document.

The document defines competencies in 6 domains with details for more specific “subcompetencies” in each and clear descriptions and applications to clinical practice. These domains are:

1. health promotion and safety,
2. evaluation and assessment,
3. care planning and coordination across the care spectrum (including end-of-life care),
4. interdisciplinary and team care,
5. caregiver support, and
6. health care systems and benefits.

The document can be reviewed in its entirety at the following link: <http://www.geriaticsppt.org/about-academy-geriatrics-physical-therapy/essential-competencies.cfm>

CURRICULUM DEVELOPMENT

The most direct application of the essential competencies is to aid in the development of content for the entry-level didactic classroom. It is tempting for instructors to bias course development with topics of interest or personal expertise. The essential competencies document provides a framework for instructors to address specific topics identified in the core learning curriculum. The new clinician is best prepared to address the needs of an older adult client if familiar with this comprehensive list of competencies addressing a broad scope of physiological, psychosocial, clinical, and care management concepts. The document addresses comprehensive patient assessment, delivery of therapy services and transitions across care settings from prevention to palliative care, from acute to chronic conditions and from specific diagnoses to complex medical cases. Utilization of evidence to validate clinical decisions is an essential component cited throughout the competencies. Educators involved in teaching aging and geriatrics-related topics are encouraged to reference this guide for content when developing curriculum and learning experiences for entry-level professional physical therapy education programs.

STUDENT PERFORMANCE

Older adult patients are present across the majority of clinical practice settings, representing greater than 40% of patient care activity. Clinical instructors (CIs) are responsible for providing hands on learning encounters, supervision of student activities to ensure patient safety, and instruction in clinical skills and assessment of student performance. All of these CI activities are enhanced by referencing the essential competencies document. Establishing clear expectations and holding students accountable for core skills in management of the older adult client contributes to consistency of care and best practice.

Identifying gaps in learning early during internship experiences provide an opportunity to address these clinical decision making, communication, clinical skills, or knowledge-based elements of practice. Clinical instructors may be better prepared to address student performance with a definitive tool to guide them as presented in this document.

STAFF COMPETENCIES

Accreditation and certification organizations provide objective assessment of clinical practice in health care institutions to assure commitment to the safest, highest quality, best-value health care across all settings. The review process typically requires documentation of staff performance in baseline clinical skills specific to the level of care provided. Therapy services management is challenged to identify critical safety and patient management skills consistent with their practice environment for outside reviewers. The essential competencies document, again, provides a roadmap to guide fundamental skill sets necessary for serving the needs of the older adult client. In practice settings where there is a geriatric client base, it would be appropriate to measure staff performance against these same entry-level competencies.

The Essential Competencies in the Care of Older Adults at the Completion of the Entry-level Physical Therapist Professional Program of Study is appropriate for reference and application in academia and in practice. Educators, CIs, and clinical managers can benefit from the guidance outlined in this document to promote optimal care to older adults from all physical therapy providers.

The Task Force members responsible for the completion of this document are:

- Rita Wong, PT, EdD, FAPTA (Task-force Chair) Marymount University, VA;
- Dale Avers, PT, DPT, PhD, SUNY Upstate Medical University, NY;
- John O. Barr, PT, PhD, FAPTA,

- St Ambrose University, IA;
- Cathy Ciolek, PT, DPT, GCS, University of Delaware, DE;
 - Dennis Klima, PT, PhD, GCS, NCS, University of Maryland Eastern Shore, MD;
 - Mary Thompson, PT, PhD, GCS, Texas Woman's University, TX

Thanks to these colleagues for providing guidance in defining fundamental components of physical therapy care for older adults across our practice.



Kathy currently practices at Mayo Clinic, Arizona as the Director for the Geriatric Residency program and Therapy Clinical Education Specialist.

She provides care in outpatient services. Kathy has experience in development of entry-level curriculum and provides guidance for postprofessional education programs in geriatrics across health care settings. She can be contacted at brewer.kathryn@mayo.edu.

AGPT AT CSM 2016!!

CSM 2016 is already well into the planning stage. Mark your calendars and make your plans to join us in Anaheim, CA—the home of the Mouse! 2016 will bring another conference full of research presentations, practice innovations, and exposition mayhem!

Just a peak into what is to come: Sponsored by our new Cognition and Mental Health SIG: Mission Cognition: Advancing the Role of the Physical Therapist with Chronic Progressive Cognitive Impairment presented by Mike Studer, Lise McCarthy, Jennifer Nash and Christine Ross; TechnoToys: Successful Aging-in-Place Enhanced by Technology presented by Mindy Renfro; Frailty: What is it really? What does it mean for PTs? presented by Myla Quiben, Sara Espinoza, and Helen Hazuda; Caregivers in Crisis: Strategies to Address Caregiver Health and Wellness presented by Margaret Danilovich and Rodney Weir; and back due to popular demand Applying exercise prescription principles across the health care continuum for the older adult with multiple chronic conditions presented by Cathy Ciolek, Greg Hartley, Jill Heitzman and William Staples.

In addition, there are many more great education sessions and pre-conferences, platform presentations, SIG and members' meetings and receptions filling the schedule. Plan ahead so you don't miss out on any of the excitement!



Academy of Geriatric Physical Therapy Certified Exercise Experts for Aging Adults 3 COURSE SERIES

As part of our commitment to empowering PTs and to advance physical therapy for the aging adult, the Academy is proud to offer a full range of outstanding continuing education, created by leaders in the field, including the CEEAA course series.

Dates & Locations

2016

Fort Worth, TX

Course 1: April 23-24, 2016 • Course 2: September 24-25, 2016 • Course 3: Nov. 12-13, 2016

Fort Myers, FL

Course 1: June 18-19, 2016 • Course 2: July 23-24, 2016 • Course 3: October 8-9, 2016

Redwood City, CA (San Francisco Area)

Course 1: March 5-6, 2016 • Course 2: April 2-3, 2016 • Course 3: May 14-15, 2016

For more information and to register visit
www.geriaticsppt.org

Email: geriatrics@geriaticsppt.org
Phone: 866/586-8247 • Fax: 608/221-9697



CELEBRATING THE LIFE OF JOAN MILLS

A Profile of Commitment to Family, Friendship, & Profession



Joan M. Mills, of Kansas City, MO, passed away on June 12, 2015. She graduated with a B.S. in Physical Therapy from the University of Kansas in 1950. Joan worked at the Truman Medical Center East for 21 years. She was a member of the Community Christian Church and sang in the choir since 1954. Joan was a member of APTA, League of Women Voters, the Raytown Garden Club, Sho-Me African Violet Club, SPARK, National Alliance for the Mentally Ill, KU Alumni, Tune Timer's, & APTA Prime Timers. APTA. She received the Lucy Blair (APTA) and Missouri (MPTA) Service Awards, Who's Who in America, Joan M. Mills Award (APTA), Eagle Award TMC-E, & Outstanding Clinical Award (KU). Joan was preceded in death by husband, Dave, and son, Don. She is survived by daughter Dee Mills and Jeanette Higgins, son-in-law Jim Higgins, and four grandsons: Jared, Jeffrey, Joshua, and Jordan Higgins.

Joan Mills was a significant pioneer in the field of geriatrics for the profession of physical therapy. She was active at both the state and national level. Joan

worked 21 years at the Truman Medical Center. She was a member of the Community Christian Church and sang in the choir since 1954. Joan received the Lucy Blair (APTA Award, Missouri Service Award (MPTA), Who's Who in America, Joan M. Mills Award (APTA), Eagle Award TMC-E, & Outstanding Clinical Award (KU).

Joan, the first Section on Geriatrics Chairperson, had noted a dearth of material on physical therapy and long term care when she began work at Truman Medical Center East in Kansas City, MO in 1969. In 1975, she asked the Missouri State Board of the APTA if it favored a section for long term care. The response was overwhelmingly positive. Immediately, Joan contacted Kansas City area therapists to assess needs, establish goals, and form bylaws and functions for the proposed Section. Contact and inquiry on a national basis—with physical therapy education directors, major health centers, and relevant outside agencies—came in 1976. It became apparent that interest in geriatrics and long-term care was not limited to the Kansas City area. Thus, a petition to form a Long-Term Care Section was presented to the APTA Board of Directors in late 1976.

In December 1976, Joan Mills, organizer for the Long-Term Care Section, communicated progress thus far to all interested therapists. Further communication served to identify problem areas and needs. At that time, LTC curricula, information, resources, and research were scarce and/or ambiguous. Additionally, LTC interests tended to overlap with pediatric, community health, and other Sections' interests.

Joan Mills was the first heroine of the Geriatric Section, having the vision and initiative to create the Section in 1978. Her vision was to bring together physical therapists and physical therapist assistants who worked with geriatric

patients for the purpose of education, collaboration, research, and mutual support.

Joan's vision is still fundamental to the operations of the Section, recently renamed the Academy of Geriatric Physical Therapy.

(Appreciation to Paula J. Burnett, PT, of Jefferson City, MO. The above article includes partial reprint of her message to the profession.)

An Additional Tribute to Joan Mills

Forty years ago Joan Mills needed a full time PT aide for one month in the summer. She hired me—an inexperienced, shy, perplexed PT student. I remember how patient and kind she was helping me learn and perform my job duties. I followed her career through the decades and was lucky to actually see her the last week of her life. I thanked her for what she did for the profession and for me personally. She said she didn't know why people made a big deal about her activities. I said we appreciated all she has done for physical therapy and our patients/clients.

So, once again: Thank you, Joan Mills.

Bonnie Bauer Swafford, PT, DPT, received her Bachelor of Science in Physical from the University of Kansas in 1976. She received her DPT from the University of Kansas in 2010. She is a member of the Academy of Geriatric Physical Therapy as well as the Acute Care Section of APTA and has work experience in acute care, inpatient rehabilitation, outpatient, and geriatric settings.

AGPT STUDENT REPORTS

K. Luke Snelling, SPT; Dominique Forte, SPT

Thank you Academy of Geriatric Physical Therapy (AGPT) for giving me the opportunity to attend PT Day on Capitol Hill. I appreciated the experience to represent the student section of the AGPT on Capitol Hill.

As the outgoing Core Ambassador for the State of Oregon and a 3rd year Doctor of Physical Therapy Student at George Fox University, I encouraged students to send an email and call legislators about bills pertaining to the Medicare Cap/Sustainable Growth Rate (SGR). This trip gave me the experience to visit Congress and speak on the Medicare Cap/SGR and other important bills pertaining to the geriatric population and my profession. As I was speaking with Congress, many said how important it is to communicate with them about important issues in regards to our profession and patients. They have many bills that they deal with and they are not experts about making decisions that pertain to physical therapy. They encouraged us in the American Physical Therapy Association to continue our efforts to communicate with Congress about the important issues regarding our profession.

For those who were not able to attend, we had the opportunity to discuss two important issues concerning our geriatric patients, Medicare Cap/SGR and the Locum Tenens, as well as issues on concussion management and adding physical therapy to the National Health Services Corporation. While I was in National Harbor, the setting for the conference, I also had the opportunity to attend a portion of the House of Delegates, a conference where delegates from each state discuss important issues that would shape the future of our profession. This, as well as attending PT Day on Capitol Hill, was a great opportunity as a student to hear how important issues are being discussed and how we need to support our state delegates

and congressional members in shaping our profession. Thank you again to the AGPT for giving me this experience to travel to Capitol Hill and advocate for my profession.

K. Luke Snelling, SPT

I am so grateful for the Academy of Geriatric Physical Therapy and the opportunity to attend my first PT Day on Capitol Hill! It was such a great opportunity to see our profession through a different lens, beyond Physical Therapy treatments, and into the legislative process. The energy of the 1000+ advocates was so contagious; it was such an incredible atmosphere to be a part of! I especially enjoyed sharing the importance of what we do for our patients and how our legislators could assist our efforts by co-sponsoring 4 key acts. This experience has had a great impact on my clinical experience and future career. It has helped me to realize the tremendous need for advocacy for our patients as well as for our profession.

Three weeks have passed since PT Day on Capitol Hill and I am still very excited about our efforts. In fact, I have been more active in initiating discussions on advocacy with clinicians as well as fellow students. I have also discussed the importance of APTA membership and how beneficial it is to our profession and especially our patients. I believe an increase in involvement in both areas would advance our profession and make a remarkable difference in the lives of our patients.

I have also continued to follow the progression of the 4 acts. The Locum Tenens bill has been approved by the US Senate Finance Committee, and could be up for vote on the Senate floor soon. This bill would allow patients in underserved areas to receive uninterrupted therapy in the event of their primary

therapist's absence. Such progress proves our participation is very valuable and our patients are the primary beneficiaries of our advocacy.

Overall, PT Day on Capitol Hill was a very enlightening experience. It has encouraged me to be more active in advocacy as a student and future clinician. I cannot wait for the next opportunity to serve our patients and our profession. Thank you again to the Academy of Geriatric Physical Therapy for this amazing opportunity!

Dominique Forte, SPT



Student Award Winners on Capital Hill Day with Ellen Strunk

Dominique Forte, SPT, Alabama; Luke Snelling, SPT, Oregon; Ellen R. Strunk, PT, MS, GCS, CEEAA, CHC

2015 ACADEMY OF GERIATRIC PHYSICAL THERAPY ELECTION

Those elected will take office at the AGPT Member Meeting in February of 2016 at CSM in Nashville, TN. Online voting will begin on October 1, 2015. Please watch your email and www.geriaticspt.org for more details. Contact karen.curran@geriaticspt.org to request a paper ballot. Per bylaws, only PTs and PTAs are eligible to vote.

TREASURER

**Treasurer:**

Kate Brewer, PT, MBA, RAC-CT

Education:

Masters Degree in Business Administration in Health Care, Cardinal

Stritch University, 2002; Masters Degree in Physical Therapy, Marquette University, 1998; Bachelor's Degree in Communications, Marquette University, 1996

Employer/Position:

President, Greenfield Rehabilitation Agency

1. *What skills and experience do you bring to this position to assure maintenance of complete and accurate financial records for the Academy of Geriatric Physical Therapy?*

I am honored to be considered for the position of Treasurer for the Academy of Geriatric Physical Therapy. In order for our component to be effective for the membership we serve, we must be thoughtful and detailed when keeping financial records and managing the financial resources of the organization to allow us to meet our goals and plan for continued growth. As an owner and President of Greenfield Rehabilitation Agency, I am responsible for the financial operations and management for forty clinic locations that serve the geriatric population. I have many years of experience on ensuing accuracy and appropriate planning to allow an organization to address current needs and plan for future growth and expansion. I have served as Treasurer for my State Chapter previously which has provided me with the tools necessary to operate within APTA's overarching goals while still planning for the unique needs of

our component. In addition I have also served on the Finance Committee for this component in previous years. Serving under the leadership of previous Treasurers has allowed me to be familiar with the component's processes. I would bring value to the AGPT and their leadership team through my experience to help us continue to promote this valuable and vital part of the practice of physical therapy.

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

A common challenge for many organizations is how to synchronize vision and goals with operations. The role of the treasurer is vital to ensure that the resources of the component match to the strategic plan. To ensure success, my goal would be to reach out to the board member associated with an area that requires financial allocation and help them work backwards to craft the ideal budget. Often this requires the board member to create a definitive plan and identify events and costs to form the initial draft of the budget. From the initial draft, the Board of Directors should review it as a whole and look to ensure the key strategic goals for the next year area not only addressed, but funded appropriately to ensure success. Seeing the big picture can allow the group to go back and shift priorities until we agree on the plan for the next year. As Treasurer, this means keeping people accountable, engaged and often working closer with those who may struggle more or have difficulty creating a budget for their areas of responsibility. I am confident that my experience would allow me to be effective in this role and have a positive impact upon the component and their activities.

**Treasurer:**

William "Scott" Doerhoff, MPT, GCS

Education:

Masters of Science Physical Therapy, University of Central Arkansas; BS

Health Sciences, University of Central Arkansas

Employer/Position:

Senior Clinician at the Central Arkansas Veterans HealthCare System in Little Rock, Arkansas serving Veterans of the United States Military.

1. *What skills and experience do you bring to this position to assure maintenance of complete and accurate financial records for the Academy of Geriatric Physical Therapy?*

I have been a member of the Academy of Geriatric Physical Therapy for eleven years now. While never holding a formal executive office for the AGPT, my experience for complete and accurate records keeping is abundant. In my professional career as an elected government official, I was subject to both state and federal oversight for compliance of laws including but not limited to balanced budget development, audits, ethics compliance, and financial disclosure. As part of my fiduciary responsibility I regularly participated in budgeting processes to ensure accurate funding of strategic plans as well as special projects and general expenditures without shifting revenue from other areas of the overall budget.

As President of my own business for over thirteen years, I developed a skill set for financial records keeping that allowed my company to stay in good standing with the Office of Secretary of State for Arkansas as well as the United States Internal Revenue Service. I was directly responsible for maintaining detailed financial records of revenue, itemized expenditures, accounts payable,

payroll and annual tax reports. My company was always in good standing for tax collection purposes and compliance.

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

My experience in working with and reporting to a “Board of Directors” again comes from my private endeavors. Where matters of concern are financial, it is imperative for the Treasurer to communicate regularly with the BOD so they have an idea of the organizations master plan and financial goals at all times. I think this process is completed best by assigned responsibilities of each committee chair for projects and strategic planning. As well, during the budgeting process, understanding the general funding of projects, and knowing the timeliness of accounts receivable and payables is imperative for the Treasurer and must be communicated to the Board of Directors. Proposed variances in any budgeting process takes time and consideration therefore the BOD must be kept generally current with the organization’s bottom line at all times.

DIRECTOR



Director:
Sara Knox, PT,
DPT, GCS, CEEAA

Education:
PhD in Health Sciences, Nova Southeastern University, Currently enrolled;
Doctor of Physical

Therapy, Shenandoah University, 2004; Masters of Physical Therapy, Shenandoah University, 2003; Bachelors of Science, Psychology, The Ohio State University, 2000

Employer/Position:

Physical Therapist , Caretenders Home Care, Newton, Massachusetts

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

It is an honor to be slated for the position of Director for the Academy of Geriatric Physical Therapy and it would be a privilege to continue serving the AGPT in this capacity. Over the past

three years as a Director for the AGPT and during my previous role as Awards Chair for AGPT, I have seen the AGPT make great strides in moving the field of geriatric physical therapy forward. I believe my skill set and past experiences ideally position me to assist the AGPT in continuing this forward momentum.

In addition to serving the AGPT, I have also held several other leadership roles at both the Chapter and National levels. I have served as the practice chair for both the Ohio and Virginia chapters, as a delegate for both the Ohio and Virginia Chapters, as a director for the Ohio Chapter, the Policies, Procedures, & Bylaws Chair for the Ohio Chapter, as a committee member on the Physical Therapy and Society Summit Steering Committee, and on the APTA Advisory Panel on Education. I believe these positions have helped me to develop leadership skills and insight into the Association as a whole that would serve the AGPT well.

Clinically, my love and passion is home health physical therapy. Working in this setting, I have seen first hand the importance of advocacy and collaboration both within and across disciplines. As both a clinician and an educator, I value the concepts of communication and collaboration. I believe that these are strengths that I would bring with me if given the opportunity to continue serving the AGPT.

Organization, attention to detail, and process are strong assets in my skill set. In both clinical and academic settings, I am often tasked with positions or assignments related to policies and procedures. I have been intimately involved both initial accreditation and reaccreditation processes for Doctor of Physical Therapy Programs, in the paperwork process for establishing a new home health company, and the initial accreditation process for a geriatric residency. I believe that as the AGPT and the Practice Committee of the AGPT move forward with tasks such as developing competencies for the geriatric specialist, that this skill will be perfectly suited for the role of Director of Practice. I would love the opportunity to continue to serve the AGPT in this capacity and kindly ask for your vote.

2. What is the greatest challenge facing the geriatric practitioner and how can the Academy of Geriatric Physical Therapy help?

The greatest challenge facing the

geriatric practitioner is also the greatest opportunity for the geriatric practitioner, the everevolving health care arena. The AGPT can help to overcome the challenge and maximize the opportunity by providing a strong unified voice, advocating for the unique role physical therapists have in managing the health and wellness of older adults. In order to do this, the AGPT needs to continue to be proactive and advocate to have representatives present and participating in all key conversations regarding the health care of older adults. This means not only maintaining current partnerships but also seeking out new innovative partnerships, thinking outside the box, and becoming involved in conversations that we may not have previously been included in.

Additionally, it is vital to involve more of the membership into the AGPT efforts. Integrating new professionals into the AGPT early on and re-engaging long time members are strategies vital to moving the AGPT forward. A broad array of opinions and ideas will broaden the possibilities available to the AGPT and strengthen the voice of the AGPT. With more membership involvement, the AGPT will have a better sense of the desires of the membership and will be able to better serve the membership.

Finally, as health care practice continues to evolve, so must the practice of the geriatric physical therapist. The AGPT has an opportunity to assist the practitioner in advancing geriatric physical therapy through strategies such as the development of clinical practice guidelines, competencies for the geriatric specialist, promotion of residencies, development of geriatric fellowships, and promotion and support of research within the realm of geriatric physical therapy.

Continuing to explore all of these ideas is an exciting time for the AGPT and something that I am passionate about and dedicated to. It would be a privilege and honor to be able to continue to serve the AGPT and its members as a Director. Thank you for your consideration.



Director:
Myles Quiben, PT,
PhD, DPT, GCS,
NCS, CEEAA

Education:
Master of Science in
Clinical Investiga-
tion; University of
Texas Health Sci-

ence Center at San Antonio, 2014;
PhD in Physical Therapy, University
of Central Arkansas, 2009; Doctor of
Physical Therapy, University of Central
Arkansas, 2003; Bachelor of Science
in Physical Therapy, University of the
Philippines, 1995; Fellow, Education
Leadership Institute (ELI) Program,
APTA, 2015; Fellow of the Castella
Faculty Geriatric Research Fellowship,
University of Texas Health Science
Center at San Antonio, TX, 2011-
2014; Mentee, Tom Waugh Leadership
Program, Texas Physical Therapy Asso-
ciation, 2014-current

Employer/Position:

Associate Professor, University of North
Texas Health Science Center
Department of Physical Therapy

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

With a breadth of clinical back-
grounds, academic experiences, and
prior service at different levels of the
APTA and the Academy, I bring to
the Board a broad knowledge of ge-
riatric physical therapy practice issues
and leadership skills critical to advanc-
ing geriatric physical therapy practice.
I engage closely with a dynamic group
of professionals within and external to
our profession who support the PT ge-
riatric practitioner, students, and older
adults; these interactions provide me
with rich insights I bring to the posi-
tion. More importantly, I have a pas-
sion for geriatric care, for optimiz-
ing the function and quality of life of
older adults, and for promoting phys-
ical therapists as the geriatric practi-
tioner of choice.

In my diverse roles, I have seen
the importance of lifelong learning
and strongly support the initiatives to
address the unique education needs
of the PT geriatric practitioner. It
has been a privilege to serve the Acad-
emy during which I sought to actively
engage and work collaboratively with
talented members to address educa-
tional efforts, including the contin-
uity of the home study course pro-
gram and continuing education ven-
tures. Those with whom I've worked

would describe me as enthusiastic,
collaborative, and quality-driven. I
bring a strong desire to contribute
and nurture these efforts as we move
into the future.

I bring a fresh perspective with
administrative skills honed by a his-
tory of service to the profession, serv-
ing in the American Board of Physical
Therapy Specialties, Geriatric Special-
ty Council, Credentialed Clinical In-
structor Program, Federation of State
Board of Physical Therapy Specialties,
and in my local community. These ex-
periences allow me to have a holistic
insight from varying points of view.
This viewpoint coupled with my com-
mitment to excellence, work ethics,
and enthusiasm to move the Academy
forward, make me a strong candidate
for the position.

I would be honored to have your sup-
port and have the opportunity to con-
tinue serving the profession and the
Academy.

2. What is the greatest challenge facing the geriatric practitioner and how can the Academy of Geriatric Physical Therapy help?

I believe the greatest challenge fac-
ing the geriatric practitioner continues
to be the lack of recognition for the
identity of PT as the geriatric practi-
tioner of choice. We are in a unique
position to be the points of entry for
older adults into the health care sys-
tem and be the primary health care
provider in the prevention of age-
related multisystem decline, yet we
have not fully promoted or estab-
lished ourselves in the public and
in the medical profession to fulfill
these roles.

The promotion as geriatric practi-
tioners cannot be done without ack-
nowledging the need for vigorous
education at the entry- and at the
post-professional levels. The Acad-
emy has started on this path with
post professional education that
call attention to the appropriateness
of the interventions provided to
older clients and patients, with
clinical practice guidelines, recurrent
efforts towards reimbursement
issues, with essential competencies
for inclusion of geriatric content
into the PT and PTA curricula, and
with increasing presence in outside
entities involved in geriatric issues.

But there is much more to be done.
The Academy needs to develop
advanced courses to continue the
growth of PTs who have a passion
for caring for older adults. We
need to continue to have a strong
voice in external entities that
shape public policy shaping. We
need to contribute to the critical
dialogues at

the national level about issues that
are important to our older patients.

The Academy is in a distinct posi-
tion to promote the PT as the geriatric
practitioner of choice by acknowl-
edging practice issues, educating
geriatric PTs on the use of evidence
to advocate for patients, increas-
ing efforts to promote clinical
specialization (GCS) and certifi-
cation as exercise experts for the
aging adult (CEEAA), advancing
the knowledge of current geriatric
practitioners, and continuing to
have conversations about aging
and our key role in an aging
society.

It would be an honor to bring these
efforts into fruition and to continue
building a strong infrastructure for
future PT geriatric practitioners,
and put our stamp as the experts
in the care, management, and
health promotion of older adults.



Director:
Mindy Oxman
Renfro, PT,
DPT, PhD

Education:
PhD Individualized
Interdisciplinary
Program - Public
Health Policy /Ge-

riatrics /Physical Therapy, University
of Montana 2011; DPT, University
of Montana, 2011; Certificate in
Public Health, School of Public &
Community Health Sciences,
University of Montana, 2010; MS,
Allied Health Education/ Neuro-
sciences, University of Connecticut,
1984; BS Physical Therapy,
University of Vermont, 1977

Employer/Position:

Clinical Coordinator, Montana
Adaptive Equipment Program
MonTECH Programs of the Rural
Institute, University of Montana

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

There are many distinct advantages
to aging – first of all, you are alive
and second you have acquired
volumes of experience! Although
I have acquired experience in
clinical care, education, adminis-
tration and research - I consider
my greatest years in physical
therapy to be my clinical years
and, of those, my favorite were
in geriatrics. As a GCS from
2005-2015, and for many years pre-
ced-

ing my GCS, I loved working with a diverse group of elders. In acute care, acute rehab, long term care and skilled care I became very aware of the impact of federal policy upon the health care “in the trenches” and vowed to become part of the solution through education, lobbying and national engagement. As a private practicing physical therapist providing home care through Medicare Part B for elders who were not home-bound, I became very involved with the issues allowing one to age-in-place successfully – including fall prevention – my current passion and focus. When I had clinical questions for which I could find no evidence – I performed small research projects to answer the questions. As a faculty member, I have lobbied to increase the DPT curriculum to include broad, evidence-based geriatric care to prepare our graduates for the huge surge in older adults they will be serving. Through all of this and including a few years of administration – I have learned an appreciation for what these folks do and have gladly allowed them to continue.

Mixed in along the way, I have always valued and performed service to the profession both at a state and national level and to the community through interdisciplinary professional organizations such as the Montana Gerontology Society (current Past President) and the MT chapter of the NCOA’s Falls Free initiative (current facilitator). If you are a young PT, I would tell you that networking through community and professional service will be the key to the richness of your career.

Working with the AGPT in capacity of Director will allow me to work with the group that bridges the gap between elder, physical therapist, administrator and legislator. Advocating for the best care possible for our older adults through education, supporting the geriatric physical therapist, and working to provide them the past environment possible to work within. As I see my retirement in the next decade, I wish to invest some time now to share wisdom of 35+ years to make an impact on my profession. Thank you.

2. What is the greatest challenge facing the geriatric practitioner and how can the Academy of Geriatric Physical Therapy help?

The greatest challenge facing the geriatric practitioner is two-fold: the huge influx of older adults entering Medicare

– 10,000/day for the next several years – with the continuing increase of demands for documentation, billing, and productivity in an environment of diminishing reimbursement. We spend way too much time defending and describing what we do rather than providing our best evidence-based care. In many clinical settings, much of the continuing education time is devoted to administrative issues (changes in billing, EMRs, etc.) rather than to clinical issues. Gone are the days of providing community service and outreach during the work day which has now moved to evenings and weekends for the few warriors willing and able to continue on their own time. Until we awaken to a single-payer system, the future is not any different. Clinicians need advocates at AGPT that are able to facilitate those needed changes while they concentrate on providing excellent care.



Director:
Sue Wenker, PT,
MS, GCS, CEEAA

Education:
PhD Individualized
Interdisciplinary
Program - Public

Health Policy /Geriatrics /Physical Therapy, University of Montana 2011; DPT, University of Montana, 2011; Certificate in Public Health, School of Public & Community Health Sciences, University of Montana, 2010; MS, Allied Health Education/ Neurosciences, University of Connecticut, 1984; BS Physical Therapy, University of Vermont, 1977

Employer/Position:
Clinical Coordinator, Montana Adaptive Equipment Program
MonTECH Programs of the Rural Institute, University of Montana

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

Please consider me as one of your AGPT Directors! Not only do I bring a passion for older adults but I also have been involved in the Geriatric Section since 1991. Positions have included: 1) item-writer for Specialty Council (2004-2006), 2) editor of the Geriatric Home Study Course (2006-2008) and, 3) most recently, the AGPT Programming Co-chair (2010-2015). Additionally, I am currently involved in

research regarding factors contributing to physical therapists’ decision to work with older adults. I want to continue my involvement in the AGPT because of the dynamic people that compose the membership. Through my experiences I have been fortunate to be surrounded with engaged, active, and energized members! I hope to continue to contribute in a positive, pro-active manner.

2. What is the greatest challenge facing the geriatric practitioner and how can the Academy of Geriatric Physical Therapy help?

One of the greatest challenges facing clinicians is the balance between reimbursement guidelines, productivity, and quality of care. Pressures to provide quality care to older adults continue to grow. We need to meet the needs of the burgeoning baby boomers, yet infrastructures are required to provide this quality care for complex conditions. Thus, a critical question is how will the AGPT help clinicians balance productivity requirements and provide quality care?

To address these changes the AGPT must continue to communicate and be actively involved with legislators, reimbursement parties, other APTA sections and health care providers who are also managing these same stressors. Research is also important in developing guidelines, interventions, and outcome measures which best support care of the older adult. An example of this is - “Management of Falls in Community-Dwelling Older Adults: Clinical Guidance Statement from the AGPT” – which was recently published. These types of guidelines will facilitate clinicians choosing the most appropriate examination tools, outcome measures, and interventions. Finally, AGPT needs to continue to support and engage members to continue to advocate for policy change, provide quality education opportunities, and resources when questions arise. As the Academy grows so do the needs of the membership and the people it serves. The Academy must maintain a strong infrastructure with flexibility to meet the demands of society and members.

(Nominating Committee candidate continued on page 20)

NOMINATING COMMITTEE



Nominating Committee:

Anne Coffman, PT, MS, GCS, CEEAA

Education:

University of Wisconsin-Milwaukee, Master of Science, Educational Psychology, 1995; University of Wisconsin-La Crosse, BS Physical Therapy, 1992; Board Certified Geriatric Clinical Specialist, APTA, 1998, 2006

Employer/Position:
RehabCare Group, On-Call Physical Therapist

Employer/Position:

RehabCare Group, On-Call Physical Therapist

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

I have served on the Board for the Academy for 14 of the past 15 years as a Director, Vice President and Treasurer. Prior to being on the Board, I was a committee chair for CSM and Awards

beginning in 1997. I have been at CSM every year since 1996 and have had the opportunity to meet many members through my service to the Academy. I have had the privilege to mentor new Board members, new committee chairs and to encourage members to become active within the Association. I am easily approachable and am also comfortable reaching out to new potential leaders. As I step off the Board in 2016, I hope to continue identifying members who can serve as leaders within the Academy by serving on the Nominating Committee.

2. How would you identify and mentor new leaders within the Academy?

Being active on the Board, within CEEAA, being at the GCS ceremony/breakfast and attending CSM are all ways that I will identify potential new leaders. Following GeriNotes to watch for contributors and students/faculty who are getting involved with writing is another way to tap into potential leaders. As my mentor, Lynn Phillippi, told me, it is all about the power of one. One person asking another person to do one thing for the Academy and leadership

development begins. Getting involved at the committee level is one of the easiest ways to contribute and develop leadership skills. I believe the Nominating Committee should not only identify candidates but also should network at all CSM functions and follow the list-serve to look for people who could get involved with projects or committees as an initial step. When I first got involved at the chapter level, people said Nominating Committee is a good place to start getting involved. After 15 years of active leadership, I have the opposite viewpoint. Former leaders who know the younger/newer active members are the best fit for Nominating Committee as they have a broad view to identify leaders. I hope to serve the Academy as I step off the Board by helping grow and develop the future leaders for the Academy as a member of Nominating Committee.

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“POLICY TALK: TEN...NINE...EIGHT...PREPARING FOR IMPACT: PART 1”

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

Patients who are cared for in post-acute care (PAC) settings often transition between multiple sites of care, moving among their homes, hospitals, and PAC settings when their health and functional status changes. With almost one in every 5 Medicare beneficiaries admitted to the hospital each year, approximately 40% are discharged to one of 4 PAC settings for additional nursing or therapy services. In 2008, almost half (47%) of this group entered into a skilled nursing facility (SNF), followed by 37% going to home health care (HH), 9% going to inpatient rehabilitation facilities (IRF), and another 9% going to ambulatory therapy providers (such as hospital outpatient departments and therapist’s offices).¹ Furthermore, many of these patients are then discharged to a second PAC provider setting during their episode of care.² For example, 32.7% of patients discharged from SNFs received home health services, and of those patients 20% returned to the acute hospital within 30 days of discharge from the home health agency.³

In general, we assume the 4 PAC settings differ in the type and intensity of services provided, effectively

providing a “continuum of care.” After all, that is the way Medicare intended it to be when they set up the conditions of participation for each, and those are the ‘technical’ standards that we, as providers, are held to (Table 1). However, recent information proves that these provider’s services are not mutually exclusive. Past research has shown that the types of patients admitted to these settings and treated by physical therapy professionals do overlap.^{4,5}

These patients are particularly vulnerable and costly to the system, given their clinical complexity and the frequency with which they transition between settings. Currently, performance measurement across PAC settings is fragmented due to the heterogeneity of patient populations, as well as the varying performance measurement obligations and reporting mechanisms across settings.

Over the last 10 years, the Centers for Medicare & Medicaid Services (CMS), with direction from Congress, has begun to transform itself from a passive payer of services into an active purchaser of higher quality, affordable care. Future efforts will certainly link

payment to the quality and efficiency of care provided and will shift Medicare away from paying providers based solely on their volume of services.

This concept is known as Value-Based Purchasing (VBP) and it is grounded in the creation of appropriate incentives encouraging all healthcare providers to deliver higher quality care at lower total costs. The cornerstones of VBP are the development of a broad array of consensus-based **clinical measures, effective resource utilization measurement, and the payment system redesign.**

While private payers have collected a variety of measures for many years, the largest healthcare provider in the nation—Medicare—has only just begun to implement requirements that would change the focus of payments from purely quantity to that of incentive payments for quality reporting and performance, efficiency and, eventually, value. The Deficit Reduction Act of 2005 (DRA), the Tax Relief and Health Care Act of 2006 (TRHCA), the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) and the Patient Protection and Affordable Care

Table 1.

Setting	Skilled Services Requirement	Intensity of Rehabilitation Requirement
Long Term Acute Care Hospitals	3 to 6 concurrent active diagnoses and an acute episode on top of several chronic illnesses and co-morbidities that cannot be effectively treated in an alternative setting	No minimum level of rehabilitation services required for qualification
Skilled Nursing Facility	Need for daily skilled services by either nursing or rehabilitation; must have a three night qualifying hospital admission	5 levels of rehabilitation services intensity involving at least one rehab discipline
Inpatient Rehabilitation Facility	Need for daily (5) skilled services by more than one rehabilitation discipline	Average of 3 hours/day of rehabilitation services on 5 different days of the week ¹
Home Health Agency	Need for intermittent skilled services by either nursing or rehabilitation	No minimum level of rehabilitation services required for qualification

In lieu of 5 days per week, an average of 15 hours per week may be provided, but reasons for this variance must be documented in the medical record. (CMS Coverage Policies for Inpatient Rehabilitation Services; May 2012.)

Table 2.

Highest Leverage Areas for Performance Measurement	Core Measure Concepts
I. Function	<ul style="list-style-type: none"> • Functional and cognitive status assessment • Mental health
II. Goal Attainment	<ul style="list-style-type: none"> • Establishment of patient/family/caregiver goals • Advanced care planning and treatment
III. Patient Engagement	<ul style="list-style-type: none"> • Experience of care • Shared decision-making
IV. Care Coordination	<ul style="list-style-type: none"> • Transition planning
V. Safety	<ul style="list-style-type: none"> • Falls • Pressure ulcers • Adverse drug events
VI. Cost/Access	<ul style="list-style-type: none"> • Inappropriate medicine use • Infection rates • Avoidable admissions

Act of 2010 (PPACA) each included key provisions that required CMS to establish quality reporting mechanisms for all provider types and settings. Hospitals, physicians, home health (HH), skilled nursing facilities (SNFs), and End Stage Renal Dialysis (ESRD) facilities are priorities.

The roadmap for moving from identification of quality measures to pay for reporting includes the following components, although each component may not be necessary for every provider setting:

- Payment for quality performance
- Measures of physician and provider resource use
- Payment for value - promote efficiency in resource use while providing high quality care
- Alignment of financial incentives among providers
- Transparency and public reporting

CURRENT QUALITY INITIATIVE STRATEGIES

CMS has a variety of Quality Initiative Strategies underway, and more information can be found at <http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/index.html>. They are all based on CMS’ Three-Part Aim for improving US health care. The Three-Part Aim comprises 3 objectives:

1. improving the individual experience of care,
2. improving the health of populations, and
3. reducing the per capita cost of care for populations.

Other groups to watch include the Measure Application Partnership⁶ (MAP) and the National Quality Forum (NQF)⁷. The MAP is a public-private partnership convened by the National Quality Forum (NQF) with statutory authority from the ACA. The ACA directed the Department of Health and Human Services (HHS) to contract with the NQF to “convene multi-stakeholder groups to provide input on the selection of quality measures” for various uses.⁸ The MAP is responsible for providing input to the HHS on selecting performance measures for public reporting and performance-based payment programs, and for other purposes. Five workgroups make up the MAP structure in order to ensure appropriate representation for providers, specific care setting and patient populations. These workgroups include a Hospital Workgroup, Clinician Workgroup, PAC/LTC Workgroup, Dual Eligible Workgroup, and the Ad Hoc Safety Workgroup. More than 60 organizations representing major stakeholder groups, 40 individual experts, and 9 federal agencies are represented throughout the workgroups.

In February 2013, the MAP issued a report to CMS with its recommendations on measures currently under consideration by the Department of Health and Human Services for use in federal programs. After reviewing over 500 measures for use in 20 federal programs, the report identified priority measure gaps and proposed solutions to fill those gaps.⁹

For PAC providers, the MAP reiterated the need to align performance measurement across PAC settings, as

well as with other acute settings, such as hospitals. MAP suggested robust risk adjustment methodologies to address the variability of patients across these settings. Admission, readmission, and transition of care measures were named as examples of measures that MAP recommended should be standardized Act of 2010 (PPACA) each included key provisions that required CMS to establish quality reporting mechanisms for all provider types and settings. Hospitals, physicians, home health (HH), skilled nursing facilities (SNFs), and End Stage Renal Dialysis (ESRD) facilities are priorities.

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As Medicare and other payers have

moved toward transparency in reporting clinical performance measures, the post-acute care rehabilitation industry has moved a little slower. The biggest challenge is often trying to consolidate the information in a manner that is useful to the provider. These settings have a multitude of costs, and if the provider uses a contract therapy provider, it may be extremely difficult to gather the information necessary to analyze it in a way that assists providers in changing their performance and efficiency. For example, a nursing home that utilizes contract staff and pays an invoice each month may not understand the full costs of delivering those services. Therefore as an industry, it is very difficult to compare one facility to another and practically impossible to compare one setting to another. CMS encountered this in 2005, when a Technical Expert Panel for the Nursing Home Value-Based Purchasing program was assembled to discuss measures. Nursing hours per patient were proposed, as were therapy hours per patient. Unfortunately, the latter was abandoned because CMS realized nursing homes could not report this information easily, especially in rural areas. In 2012, CMS began reporting therapy staff hours per resident per day, but only for physical therapy, rather than for all therapy disciplines. Furthermore, the number is calculated from survey and certification reports and divided across total patient days, instead of using a denominator of only therapy patient days. The result is a number that is difficult to interpret and use in a meaningful way for consumers or providers.

The same is true when trying to compare clinical performance measures. The reporting systems currently in place for nursing homes and home health agencies are largely focused on “medical” information, such as severity of condition. The information is collected from the Minimum Data Set (MDS) 3.0 and the Outcome and Assessment Instrument Set (OASIS), and therefore the change in condition is due to the composite of care provided to the patient. There is no direct provider-type cause and effect relationship that can be measured, and while rehabilitation is an integral part of the “composite of care,” there is no way to differentiate how much of the improvement (or decline) was a direct effect of the intensity (or lack) of rehabilitation provided.

As a result of the increase in

rehabilitation utilization in all PAC settings over the last 10 years, providers are facing increased scrutiny from Medicare Administrative Contractors and Program Safeguard Contractors. CMS has begun to question the value of intense rehabilitation. The rehabilitation industry is struggling with how to justify our services to entities that are primarily interested in the burden of cost it has imposed on the health care system. While each therapy discipline utilizes standardized clinical performance tools specific to their own professional literature and some rehabilitation companies have their own proprietary tools, there is not one tool or measure that all providers have accepted as “the” measure of quality rehabilitative care in these settings. The result is an absence of industry-accepted metrics, and therefore, the industry must find ways to overcome these present and future challenges, detailed below.

1. Much of the rehabilitation provided in PAC settings is interdisciplinary.

In other words, physical therapy working with occupational therapy and speech therapy to improve the patient’s functional abilities in a holistic and integrated manner. This interdisciplinary aspect is integral to both the regulatory and payment context of care. Conditions of participation and survey guidelines in these settings focus on building and promoting a care plan that is holistic and meets all the needs of a patient.

2. Patient characteristics are diverse.

No two patients who utilize PAC services are alike. In fact, most of them have a diverse set of rehabilitation, nursing, and psychosocial needs. These patients present a wide variety of impairments, and may require different models of care. Therefore, finding one, 2, or even 3 clinical performance measures that represent such a diverse population is extremely difficult.

3. Lack of a defined clinical performance benchmark.

What is a “good clinical outcome” of rehabilitation? Ask 10 different people and you will get 10 different answers. Most people will agree on a few things: it depends on the patient, their primary condition, co-morbidities, and their prior level of function. Another critical issue to tackle is how to measure the “outcome of rehabilitation” regardless

of how many and what type of therapy disciplines received. Discharge to community and transitions of care are two such measures that have been used as a proxy, but so far, no one has the answer.

4. No “universal” rehabilitation measure exists. The inpatient rehabilitation facility utilizes the FIM™ to measure a patient’s motor and cognitive score at admission to the facility and again at discharge. This proprietary measure has been in place since 1996, and quickly became one of the most widely accepted functional assessment measures in the rehabilitation community. While it is considered a strong measure of progress for inpatient rehabilitation, it has not found widespread applicability in other PAC settings. Skilled nursing facilities, HH agencies, and LTCH’s cannot point to one measure that is universally accepted by those who practice within their setting, as well as by those who pay for their services.

In an attempt to fill the gap, professional associations have developed clinical performance measures:

- The American Speech-Language Pathology and Hearing Association developed NOMS™, but this system is not used consistently by speech therapists across all settings.
- The American Physical Therapy Association is developing OPTIMA™, but this system is primarily applicable to community-based patients and clients.
- The professional literature for OT, PT, and SLPs has an extensive list of standardized clinical outcome tools available to use, such as the Katz ADL scale, the Berg Balance Test, and the Western Aphasia Battery. While important for clinical practice, most of these tools are intended to measure improvements in certain aspects of function, such as self-care, balance, and aphasia respectively.

Many rehabilitation companies have developed their own clinical performance measurement tools, but these are usually proprietary and come with their own specific definitions and applications. Therefore, therapists must learn the definitions to use with each employer’s tools, which may or may not be consistent with the professional

associations and/or measurement tools they used in other settings.

TEN...NINE...EIGHT... PREPARING FOR IMPACT

On October 6, 2014, the Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014 was signed into law. It is a bi-partisan bill introduced in March of 2014 that would require standardized patient assessment data for assessment and quality measures, quality care and improved outcomes, discharge planning, interoperability, and care coordination. It will implement significant changes to each of the PAC settings and their applicable assessment instruments. There was immediate attention paid to this bill for two reasons: (1) the bill spent less than 7 months in discussion, flew through both houses of Congress and was signed into law in record time; and (2) the timeframes it implemented are immediate (at least in terms of government regulations).

The IMPACT Act requires CMS implement the use of standardized assessment data no later than October 1, 2018 for SNFs, IRFs and LTCHs, and no later than January 1, 2019 for HH agencies. What are these data categories?

1. Functional status
2. Cognitive function and mental status
3. Special services, treatments and interventions
4. Medical conditions and comorbidities
5. Impairments
6. And other categories required by the Secretary of Health and Human Services.

CONCLUSION

There is a lot of information being gathered, analyzed, and disseminated

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

THE EFFECT OF MULTISENSORY BALANCE TRAINING ON BALANCE AND FALL RISK IN COMMUNITY-DWELLING OLDER ADULTS: A SYSTEMATIC REVIEW

Amy Starkey, SPT; David Skolnik, SPT; Katelyn Kaya, SPT; Ann Wilson, PT, MEd, GCS

INTRODUCTION

Falls are a significant cause of adverse health events in the elderly population. Falling in the older population can lead to a snowball effect involving immobility, reduced confidence, and physical incapacity. These adverse changes present significant negative consequences on an individual's social capacity and overall quality of life,¹ as well as increased risk of early mortality.² One out of every 3 community dwelling adults aged 65 or older experiences at least one fall each year. Of those older adults who report experiencing a fall, half report that they have fallen repeatedly in the last 12 months.^{3,4} The Administration on Aging, a division of the Department of Health and Human Services, reported that in 2009 the older population in America (age 65+) totaled 39.6 million people, or about one in every 8 Americans. That number is predicted to be 72.1 million in the year 2030.⁵ Presently, fall prevention programs are a major component of health care budgets both domestically and worldwide.⁶ As the number of older Americans escalates, so too does the number of individuals at increased risk of falling, making efforts to identify the most effective fall prevention programs pivotal.

Presently, the only interventions that are supported in the literature to positively affect balance and falls prevention are exercise, Tai Chi, and vitamin D supplementation.⁷ The response to Tai Chi is generally positive; however, the research reveals considerable variability in dosage of the interventions ranging from 8 weeks to 48 weeks.⁷ Vitamin D supplementation has had beneficial effects on strength and balance, but not on gait.⁸ This is concerning since a signifi-

cant number of falls in the elderly occur while walking^{9,10} and are associated with gait disturbances.^{11,12} The literature has shown variable, and not altogether positive, results with respect to compliance with either exercise programs¹³ or vitamin D supplementation.¹⁴ In addition to falls during ambulation, older adults are also more likely to fall when performing concurrent, multisensory tasks such as walking while simultaneously performing another motor or cognitive task.^{15,16}

There are a number of outcomes measures commonly used to assess balance and fall risk in the elderly, including the Timed up and Go (TUG), Berg Balance Test, and Functional Reach Test.¹⁷⁻¹⁹ In addition to tracking the number of falls experienced and performance on standardized balance measures, both "fear of falling"²⁰ and gait speed²¹ appear frequently in the literature related to balance and fall prevention. Fear of falling is generally described as the exaggeration of concern about falling, or as low perceived self-efficacy for avoiding falls.¹⁷ Fear of falling is recognized as a health problem for the elderly, and may even be present in older individuals who have never experienced a fall.^{22,23} It is associated with depression, decreased quality of life, and limited activity, as well as being directly linked to changes in gait parameters, including gait speed and stride length.²⁴ Fear of falling can affect a person's confidence in the ability to complete many activities of daily living (ADLs) or instrumental ADLs such as going to the store, bending down to get something off the floor, and reaching for objects overhead. In a recent article by Dias et al,²⁵ 45% of participants who reported high fear of falling also reported reduced participation in ADLs over the previous 5 years. As fear of falling increases, individuals become increasingly likely to restrict activities, possibly contributing to deconditioning and decreased muscle function, furthering the risk of future falls. Literature suggests

that balance training and exercise programs can reduce the fear of falling and increase activity levels in older adults.^{26,27}

As individuals age, gait speed becomes slower and step length shortens.²⁸ Individuals over the age of 70 experience decreases in gait speed of 12% to 16% per decade.²⁹ It is unclear whether these declines are a result of the physiological changes of aging, such as compensation for weak muscles or attempts to reduce energy cost during ambulation, fear of falling, or a combination of these factors. Slower gait speeds have been directly connected to increased fall risk and decreased scores on clinical balance assessment measures, with research indicating that a decrease in gait speed of one standard deviation can increase fall risk 4-fold.³⁰ Slow gait speed has been indicated as a predictor of not only an initial fall, but also recurrent falls in the older population.³¹ Walking has great importance to ADL performance, social capabilities, and overall quality of life. It is also an activity during which a high percentage of falls occur. Effective fall risk assessment and intervention must incorporate gait analysis and modification to maximize positive outcomes.

Recently, interest in multisensory balance training as an effective fall risk intervention has increased. Multisensory balance training incorporates stimulation of sensory systems, including proprioceptive and visual stimulation, as well as stretching and resistance exercises for the major muscles involved in ambulation. It may also include motor coordination training and audio stimulation.³² The foundational premise for multisensory balance interventions is that the majority of falls occur under multisensory conditions. Activities of daily living, including ambulation, often occur in concurrence with a cognitive task. The competing task may be an interpretation of an auditory stimulus, attention to a visual stimulus, or the requirement to perform a corresponding upper extremity task

while maintaining standing balance. Maintaining balance under multisensory conditions is a daily requirement. The everyday significance of dual-task demands, along with questions about the efficacy of current fall-risk interventions, supports the need for a review of the current literature on multisensory balance training, and its effect on fall risk in older adults. Therefore, the purpose of this systematic review is to determine the effect of multisensory balance training on balance and fall risk in community-dwelling, older adults.

For the purpose of this systematic review, balance is defined as the ability to locate and maintain the center of gravity within or over one's base of support.³³ A fall is defined as an event that results in a person unintentionally coming to rest on the ground, floor, or other lower levels.^{1, 34} A multisensory balance training or multisensory exercise program is defined as one incorporating stimulation of sensory systems, including proprioceptive and visual stimulation, as well as stretching and resistance exercises for the major muscles involved in ambulation. It may also include motor coordination training and audio stimulation.³⁵ Dual tasking is defined as the ability to perform two tasks simultaneously. Older adults are individuals > 65 years old, and community-dwelling individuals reside in one's own home or an independent living facility.

METHODS

Search Strategy

A literature search was performed to identify published studies evaluating the effect of multisensory balance training on balance and fall risk in community-dwelling older adults. The databases of PubMed, CINAHL, Cochrane Library, and PEDro were searched from May 2013 to August 2013, using a combination of the following key words: *multisensory balance training, dual tasking, functional balance training, balance training, balance exercise, maintaining balance, AND falls, falling, fall risk, fall prevention, functional mobility, postural control, AND elderly, older adults.*

The initial database search resulted in 6455 articles. Of these, 6420 articles were eliminated based on title and abstract, and 7 duplicate articles were also eliminated. Twenty-eight potential articles were identified and retrieved, 14 of which did not meet the established inclusion and exclusion criteria. Decisions to

eliminate articles based on inclusion and exclusion criteria were resolved by way of discussion and general consensus.

Inclusion and Exclusion Criteria

Inclusion criteria were as follows: studies written in English, included both males and females who were over the age of 65 years, and subjects ambulated independently with or without an assistive device. Studies must have included at least one outcome measure for fall risk, fall incidence, or balance such as TUG, Berg Balance Test, 400 meter walk test, Barthel Index of ADLs, etc.

Studies were excluded if they were published before 2000 or were pilot studies, included subjects with a major medical or psychiatric condition that posed a risk for safety or intervention compliance, included subjects with an inability to follow directions and complete a balance task, or if they that did not include a measure of mental state and cognitive ability to determine participation eligibility.

Scoring Strategy

Three researchers independently evaluated the methodological quality of the 14 studies using the PEDro scale and resolved discrepancies in scores by way of discussion to establish a final consensus score for each article. Articles with a PEDro score of $\geq 7/10$ total possible points were included in this review. The researchers extracted data for the 6 qualifying studies concerning study methods, quality, and outcomes. Figure 1 displays details of the article retrieval process.

RESULTS

Six studies involving a total of 637 subjects were included in this review. The studies reviewed were all randomized control trials, allowing the use of the PEDro scale to rate the quality of each study. Two of the 6 studies received a PEDro score of 8/10 and the remaining 4 studies scored a 7/10 (See Table 1). Table 2 summarizes the study characteristics and main outcomes for each study. Different types of multisensory balance training were used among the 6 studies. Five studies examined the effectiveness of dual-task balance training in comparison to a structured exercise program, single-task training, and/or control.^{1,2,4,36,37} One study compared visuo-vestibular rehab incorporating postural training and virtual reality balance exercises to a control group.⁶ The dual-task balance

training methods included combinations of balance training with a simultaneous cognitive task, a music-based multi-task exercise program, and functional balance exercises embedded in ADLs. The studies used various outcome measures associated with falls or fall risk, including number of falls, fear of falling, gait speed, and standardized balance and cognitive tests. Overall, 5 of the 6 studies demonstrated that multisensory balance training is an effective way to improve balance and reduce fall risk in community-dwelling older adults; the sixth study found no significant difference in balance between intervention and control groups.

DISCUSSION

The purpose of this study was to determine the effectiveness of multisensory balance training on balance and fall risk in community dwelling older adults. Two main intervention categories were identified: dual-task training and virtual reality training. This discussion considers the effectiveness of the each type of intervention used.

Dual-task Training

Clemson and colleagues created a home-based Lifestyle Integrated Functional Exercise (LiFE) intervention with a traditional balance and strength-training group and a control group.¹ The dual-task intervention required participants to complete balance tasks while performing ADLs. Researchers found a 31% reduction in fall rate in the LiFE group compared with the control group. In addition, both the LiFE and strength-training groups significantly improved their Activities-specific Balance Confidence (ABC) Scale scores, compared with the control. Adherence was significantly lower in the structured program than the LiFE group or control group. Since the ABC scale contains few multisensory items, it is possible that it may not accurately reflect the improvement in balance under dual-task conditions. The higher adherence rate observed in the LiFE group suggests that this type of intervention may provide better outcomes simply from increased practice.

Halvarsson and colleagues use a similar dual-task intervention involving progressive functional balance tasks, such as buttoning a blouse or walking with a tray. Researchers found a statistically significant reduction in fear of falling measured by the Falls Efficacy Scale-International (FES-I). The dual-task group

also significantly improved their ability to initiate a rapid step during dual-task conditions, increased their cadence at their preferred gait velocity during single task conditions, and increased their cadence and speed during “fast velocity” ambulation. These results suggest that dual-task balance training can positively impact fear of falling, stepping reactions, and gait speed.

Hiyamizu and colleagues³⁷ compare dual-task balance training to standard balance training. They found no significant difference between groups for outcome measures of strength, static balance, postural sway, and gait. This may be attributed to the fact that both groups received a balance intervention, and the outcome measures used do not have a multisensory element. To test balance during dual-tasking, researchers measured the rate of the Stroop task during standing. The Stroop task is a timed cognitive measure requiring attention and visual comprehension. Scores in the intervention group were significantly higher than those in the control group. These results suggest that dual-task training can improve cognitive task performance during standing postural control.

Silsupadol and colleagues³⁶ randomized participants into single-task training and one of two dual-task training groups. Participants in all groups improved on the Berg Balance Scale and walked significantly faster after training, but only the dual-task participants demonstrated improved gait speed when a cognitive task was added. This suggests that single-task balance skills may not transfer to dual-task conditions. The single-task training group showed a significant increase on the ABC scale after training, but the dual-task groups did not. One possible explanation for this finding is that the balance and cognitive tasks given to the dual-task training groups were much more difficult than those given to the single-task group. Their balance skills were continually challenged and may have resulted in reduced confidence. It is also possible that the researchers progressed the exercises too quickly for the subjects, resulting in decreased confidence. Changes in confidence and self-efficacy may not change at the same rate as physical function. Despite the disparity in balance confidence between groups, the study supported dual-task balance training as a means to improve gait speed under dual-task conditions.

Trombetti and colleagues⁴ used music to create a multisensory balance intervention in which participants walked in time to music and responded to changes in the music’s rhythm. Subjects in the intervention group significantly increased their gait velocity and stride length under single-task conditions, compared with the control group. Under the dual-task condition, the intervention group significantly increased stride length and decreased stride length variability. The intervention group also improved their Tinetti Performance-Oriented Mobility Assessment and TUG scores and stance time for one-legged stance task. Compared with the control group, the intervention group experienced 54% fewer falls during the first 6-month follow up and a reduction in the number of subjects with at least one fall. Although the TUG scores were significantly different after the intervention, the average change was less than one second, which is not enough to be considered minimal detectable change. Despite the limited change in TUG scores, the data suggests that multisensory balance training incorporating music may be an effective way to improve gait parameters under dual-task conditions as well as to reduce falls.

Virtual-reality Balance Training

Duque and colleagues⁶ compared Balance Rehabilitation Unit (BRU) virtual-reality training to a standard balance protocol. The BRU training consisted of visual-vestibular rehabilitation and postural training virtual reality exercises. Both groups showed a significant reduction in the incidence of falls. However, BRU-training subjects reported a significantly lower number of falls compared to the untrained controls. The BRU-training subjects reported less fear of falling as demonstrated by a significantly lower Survey of Activities and Fear of Falling in the Elderly score compared with controls. These results suggest that dual-task training involving visuo-vestibular input and virtual-reality training is effective in reducing number of falls and fear of falling.

The studies in this review demonstrate that dual-task balance training is an effective intervention for reducing fall risk. Specifically, dual-task training promotes increased stability under dual-task conditions.^{2,4,36,37} Dual-task training can also reduce incidence of falls^{1,4} and reduce fear of falling.^{1,2} One study did find

that the single-task balance group reduced fear of falling, while the dual-task group did not.³⁶ This may be attributed to the high level of difficulty of the tasks performed during the training. Dual-task training incorporating visuo-vestibular stimulation also demonstrated reduced number of falls and fear of falling.⁶ Trombetti’s⁴ intervention demonstrated improvement with the TUG, while Hiyamizu’s study³⁷ did not result in a significant difference between groups. This may be explained by the variation in experimental design, as Trombetti’s control group was not receiving balance training, while Hiyamizu’s control group was receiving single-task balance training.

LIMITATIONS

Although the studies included in this review are systematic reviews of good quality according to the PEDro scale, it is difficult to draw definitive conclusions regarding a single best balance training method. Because of the limited number of studies included, this review may not have enough power to draw a definitive conclusion. The studies all used some form of multisensory balance training; however, their training protocols and outcome measures varied considerably. Intervention duration varied from 45 to 60 minutes and frequency ranged from once per week⁴ in a group setting to daily without supervision.¹ In addition, the multisensory conditions included virtual reality, music, ADLs, and cognitive tasks. Balance outcome measures included TUG, falls, fear of falling, stepping reaction, and gait speed. There was not a common outcome measure used in all studies. The use of a common dual-task outcome measure such as the TUG-Cognitive³⁸ may have increased the strength of this review. Further, the relative correlational strength of each outcome measure to balance and fall risk has not been determined. Based on the available research, the optimal outcome measures for evaluating fall risk could not be determined, making it difficult to come to a definitive conclusion about the most effective type of multisensory balance training method.

CONCLUSION

The results of this systematic review suggest that multisensory balance training, particularly one involving dual-task exercises improves participants’ ability to perform dual-task activities. Since many falls occur during conditions involving

multitasking or multisensory input, it is worthwhile to incorporate dual-tasking or multisensory input into traditional balance training to promote reduced fall risk among community dwelling older adults. Further research into multisensory balance programs is warranted before we can make a definitive conclusion.

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The *A Club* is here!

Are you ready to join?

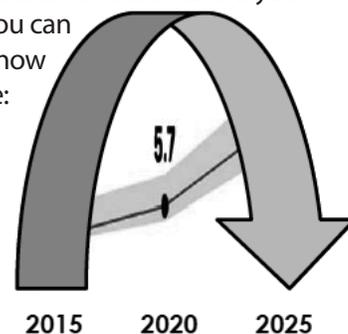
The year 2020 is expected to bring 5.7 million people with dementia into our healthcare system. To help focus attention on dementia care issues across our country the **Cognitive and Mental Health Special Interest Group** (CMH SIG) of the APTA's Academy of Geriatric Physical Therapy (AGPT) is launching a country-wide campaign called the **A Club**. The "A" conveys the concept of achieving excellence in assessing the whole person. The **A Club's** 2015 six-month mini-series highlights physical therapy assessment and care management of cognitive health, hallmark behaviors in different stages of dementia, and pain in people with dementia.

We invite you to join the **A Club** and engage your colleagues in discussions about these topics. If you want to provide thoughtful feedback to the leaders of the CMH SIG, please contact your APTA State Advocate. If you are in a state that does not yet have an APTA State Advocate, please help where you can and join our contingency of volunteers at your local or state level. If you want to show your support of our efforts, become a member of our CMH SIG by signing up here:

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ASSESSMENT OF FUNCTIONAL STATUS IN PATIENTS FOLLOWING CORONARY ARTERY BYPASS SURGERY USING A SHORT FORM OF THE HEART SURGERY SYMPTOM INVENTORY

Tanya Kinney LaPier, PT, PhD, CCS

INTRODUCTION

Coronary artery bypass (CAB) surgery is commonly performed on older adults to revascularize the heart and physical therapy during recovery is common in a variety of settings including acute care, home health, and inpatient rehabilitation.¹⁻³ Even patients in their 80s and 90s are commonly considered candidates for CAB but they may have poorer outcomes than younger patients.⁴⁻⁶ Following CAB surgery, older patients may have greater decrements in physical function acutely than younger patients, but over time they tend to show improved health-related quality of life (QoL).⁵⁻⁸ Zimmerman et al⁹ examined symptoms and QoL in patients 2, 4, and 6 weeks after CAB surgery and found that shortness of breath, fatigue, and pain were common and related to function.

Therefore, outcome measures that reflect symptom impact in patients following coronary artery bypass surgery (CABS) are important for evidence-based clinical decisions such as prognosis and intervention selection. Traditional medical-based outcomes reported in research typically include mortality and morbidity rates; however, it is increasingly common and important to also consider

patient reported outcomes, including quality of life and symptom impact.^{8,10,11} Qualitative studies evaluating QoL following CAB surgery suggest that many surgery specific factors interfere with patient function.^{12,13} The impact of symptoms on function following CAB surgery is often measured using generic, self-report QoL instruments, such as the Medical Outcomes Study Short Form 36 (SF-36).¹⁴ However, a potential disadvantage of generic health-related QoL instruments is an insensitivity to disease-specific health-related QoL parameters.^{14,15} Furthermore, cardiac-specific patient reported outcome measures may rely on a concurrent diagnosis of angina (Seattle Angina Questionnaire) or heart failure (Minnesota Living with Heart Failure Questionnaire), which are not universally experienced by patients who have undergone CAB surgery.^{8,15}

Symptom inventories have been used to provide disease-specific information on patient perceived QoL.¹⁵⁻¹⁷ The Heart Surgery Symptom Inventory (HSSI) was developed to provide a disease-specific outcome measure for patients following CAB surgery.^{15,17,18} This instrument contains 76 items that use a 5 point scale and are subdivided into 5 categories

including cardiac, general, trunk, lower extremity, and upper extremity. A disadvantage of using this instrument is the response burden associated with its comprehensive nature and length. Therefore, an abbreviated version of the HSSI was developed specifically focusing on general surgical and sternotomy related symptoms. The purpose of this study was to evaluate the psychometric properties of a subset of items from the HSSI that focus on general surgical and sternotomy-related factors.

METHODS

Subjects

This study included 28 people (age 66.6 ± 10.5 years, 70% male) who had recently undergone CAB surgery. Subjects were recruited from two outpatient cardiac rehabilitation programs. Criteria for study participation were < 6 months post-CAB surgery, >35 years of age, able to read English, and currently participating in an outpatient cardiac rehabilitation program. Patients with significant cognitive deficits or who had sustained a cerebral vascular accident following surgery were excluded from study participation.

Procedures

Patients were given a packet of questionnaires to take home, complete, and return 2 days later at their next cardiac rehabilitation session. The participants were instructed to answer the questions in order, not to go back and review previous answers, and to finish the questionnaires in a single session. No time limit was specified but participants reported needing between 1-2 hours to complete all assessments. First, patients completed a history form, HSSI, SF-36, and lastly a second HSSI.

Instruments

The original HSSI was developed and refined using data from previously published qualitative studies, subjective information from clinicians and

Table 1. Correlations between the HSSI-21 and SF-36 scores. *P < 0.05

SF-36 Subcategory	r
Physical Function	-0.39
Role Limitation due to Physical Function	-0.36
Bodily Pain	-0.49
General Health	-0.38
Vitality	-0.41
Social Functioning	-0.56
Role Limitation due to Emotional Health	-0.43
Mental Health	-0.55
Physical Component Summary	-0.39
Mental Component Summary	-0.58

patients recovering from CAB surgery, and finally feedback from a panel of content experts.^{15,17,18} The short form of the HSSI (HSSI-21), contains 21 items pertaining to general surgical and sternotomy-related symptoms. This instrument uses a 5-point Likert scale with higher scores indicating greater severity of symptoms than lower scores. Figure 1 shows the HSSI-21 items, instructions, and rating scale.

In addition to the original HSSI, the SF-36 was used to assess concurrent validity of the HSSI-21. The SF-36 is a self-report instrument that measures generic health-related QoL and is widely considered the criterion measure of QoL; it has well documented and acceptable degrees of reliability, validity, and sensitivity. The SF-36 has been used extensively to study generic health-related QoL in patients with cardiac problems.¹⁴

Data Analyses

Scores from the original full HSSI were compared to scores generated on the HSSI-21 using correlations. Scores obtained during two trials of the HSSI-21 were evaluated for test-retest reliability, using correlations and t-tests. Lastly, HSSI-21 scores were compared to SF-36 scores to evaluate concurrent validity, using correlations. The alpha level was set at < 0.05.

RESULTS

We found a significant correlation ($r = 0.91$) between original and short form HSSI scores. The test-retest reliability of the HSSI-21 was $r = 0.97$. The correlations between the HSSI-21 and all SF-36 scores were significant and negative since there is an inverse relationship between scores on the HSSI-21 and the SF-36. The correlation values between the HSSI-21 and the SF-36 subcategories are outlined in Table 1.

DISCUSSION

The results of this study indicate that the HSSI-21 can be a useful clinical and research tool to evaluate functional status related to general surgical and sternotomy-related symptoms in patients following CAB surgery. The test-retest reliability of the HSSI-21 was excellent ($r > 0.90$), suggesting good repeatability of measurements. In addition, there was a strong relationship between scores on the original and short form of the HSSI. Data comparing the HSSI-21 scores to scores on the SF-36 suggest that the concurrent validity of the HSSI-21 is

similar to the original HSSI.

In older adults using a self-report outcome measure of symptom impact along with performance-based outcomes (ie, Timed Up and Go) can give a more complete picture of a patient at baseline and help to evaluate intervention effectiveness.¹⁹ Older adults may experience the presence of more symptoms and slower recovery after CAB surgery than younger patients.^{20,21} Abbott et al¹³ reported that during the early recovery period following CAB surgery (< 3 months) older patients with greater symptom burden had lower physical function and cardiac self-efficacy than patients with less symptom burden. Clearly, patient QoL and symptom impact are important determinants of successful recovery from CAB surgery. Interventions such as patient education may help with the transition from hospital to home, especially in older adults. Zimmerman and colleagues⁹ found that an educational intervention reduced symptom influence with physical activity in elderly patients during the first few weeks following CAB surgery.

Due to the design of this study, the results need to be interpreted with some caution. Since all testing took place in a single session lasting 1-2 hours, it is possible that the subjects remembered answers they provided on the first trial when completing the second trial of the HSSI. This effect was probably minimal because subjects were not allowed to review previous answers and there were a high number of responses. Due to the dynamic nature of many symptoms, it was necessary to administer repeated trials of the HSSI relatively close together. Only participants in an outpatient cardiac rehabilitation program were included in this study, which may have resulted in a biased sample. Lastly, study participants were in the subacute stage of recovery and therefore use of the HSSI-21 with patients < 1 or > 6 months following CAB surgery should be done with caution.

In conclusion, a standardized instrument to assess the presence and impact of disease-specific symptoms will help better elucidate the process of recovery from CAB surgery.^{8,10,11} The HSSI-21 may be useful in evaluating the influence of surgical techniques, rehabilitation, or premorbid factors on patient outcomes following CAB surgery. Understanding and minimizing surgery-related symptoms in patients

recovering from CAB surgery may help to hasten recovery, enhance QoL, and improve adherence with lifestyle modifications.

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(Continued on page 34)

HSSI Health Survey

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This survey evaluates what type of problems you are having following heart surgery. The information will help us understand how much specific symptoms, or feelings, affect your everyday life. You may only need to complete some of the sections depending on your type of heart surgery.

For each item try to determine how much you have been bothered by the problem during the past week. Think about how the problem has made you feel and how it has influenced your daily activities. Rate how much the problem has bothered you on a scale of 0 to 4 with 0 being “Not at all” and 4 being “Very Much.”

During the past week, how much have you been bothered by:

(Check one answer for each question)

	Not at all	A little bit	Some-what	Quite a bit	Very much
1 difficulty breathing when lying down?	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
2 difficulty breathing during activity?	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
3 general fatigue?	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
4 whole body weakness?	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
5 difficulty falling asleep?	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
6 waking multiple times at night?	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
7 feeling sleepy / tired?	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄

→ → Please continue on next page

Figure 1. Questionnaire format of the HSSI-21.

During the past week, how much have you been bothered by:

(Check one answer for each question)

	Not at all	A little bit	Some-what	Quite a bit	Very much
8 neck pain / soreness?	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
9 upper back pain / soreness?	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
10 shoulder pain / soreness?	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
11 chest incision pain at rest?	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
12 chest incision pain during deep breathing?	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
13 chest incision pain during coughing or sneezing?	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
14 chest incision pain during activity?	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄

During the past week, how much have you been bothered by:

(Check one answer for each question)

	Not at all	A little bit	Some-what	Quite a bit	Very much
15 chest incision tenderness / irritation / itching?	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
16 difficulty with wound healing at chest incision?	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
17 neck stiffness?	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
18 numbness / tingling around the chest incision?	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
19 how your chest incision looks?	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
20 worrying about your chest incision opening?	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
21 popping / grating / clicking of your breastbone?	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄

Figure 1. Continued

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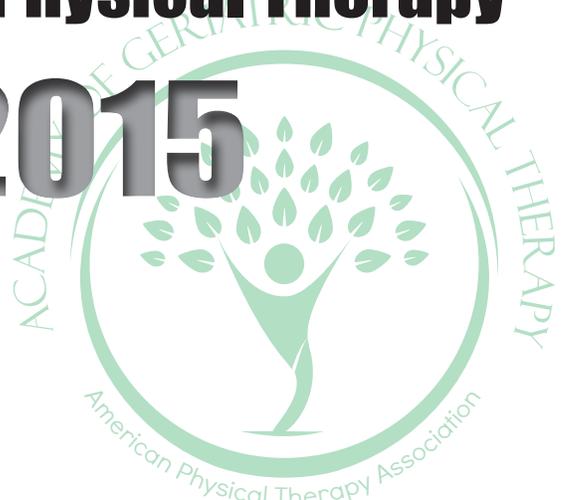
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