

# GERI NOTES

Academy of Geriatric Physical Therapy

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**Publication Title:** *GeriNotes*

**Statement of Frequency:** 5x/year; January, May, July, September, and November

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

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

**Newsletter Deadlines:** March 10, May 10, July 10, September 10, November 10

**Editorial Statement:** *GeriNotes* is the official magazine of the Academy of Geriatric Physical Therapy. It is not, however, a peer-reviewed publication. Opinions expressed by the authors are their own and do not necessarily reflect the views of the Academy of Geriatric Physical Therapy, APTA. The Editor reserves the right to edit manuscripts as necessary for publication. Copyright 2017 by the Academy of Geriatric Physical Therapy, APTA.

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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: Escalators

*William H. Staples, PT, DHS, DPT  
Board Certified Geriatric Clinical Specialist (GCS)  
Certified Exercise Expert for Aging Adults (CEEAA)*



Do you like to ride escalators or are you apprehensive? Most people including me say no big deal, or I used to. For a young child it is fun to ride up

and down those long moving staircases. Almost like a carnival ride! When you ride an escalator, you might not realize that it is probably one of the biggest and most expensive machines you use regularly. Despite their size and cost (I'm sure some due to liability), though, they are actually fairly simple machines.

According to Wonderopolis (<http://wonderopolis.org/wonder/who-invented-escalators>), escalators are basically just long conveyor belts. They have rotating chains that pull a set of stairs in a constant cycle that creates the moving staircase. This basic circular motion enables the escalator to move many people through a short distance quickly. Escalators are often featured in areas where many people need to move between two areas quickly but where elevators would not be practical. For example, escalators are commonly found in department stores, shopping malls, hotels, airports, subways, stadiums, and other public buildings. Unfortunately, many stair cases are essentially hidden from view despite the importance of physical activity recommendations.

So who came up with this great idea to move large numbers of people quickly, usually with no waiting in line? There were actually many people who thought of the idea over time, but many of them never acted on it. Nathan Ames patented the first "escalator" in

1859 when he came up with the idea for "revolving stairs." However, he never actually made a working model of this concept. Thirty years later, Leamon Souder did patent 4 separate ideas for escalator-like devices. Like Ames, though, Souder never created working models of any of his ideas. Finally, in 1892, Jesse W. Reno not only patented the "Endless Conveyor Elevator," he produced the first working escalator and installed it along the Old Iron Pier at Coney Island in New York City in 1896.

So OK enough history. I am writing about the escalator to discuss my recent apprehension. Certainly many of us have seen patients who may have been injured on an escalator. Escalaphobia is a common specific phobia affecting hundreds of thousands of individuals all around the world. According to the CDC ([http://www.cpw.com/sites/default/files/publications/elevator\\_escalator\\_BLSapproved\\_2.pdf](http://www.cpw.com/sites/default/files/publications/elevator_escalator_BLSapproved_2.pdf)), there are 7,300 escalator injuries requiring hospitalization per year, 75% due to falls and 20% from entrapment, 5% for other reasons. Only 34 injuries resulted in death. So escalators can be dangerous, especially as we age.

Think of the motor-cognitive-spatial skills required to step on and off an escalator and to maintain balance on a dynamic surface. I have recently become more aware of the challenges to "riding the stairs." I have a crushed L3-4 disc that had been tolerable but it recently shifted causing intermittent loss of innervation to the quadriceps. This weakness lead to occasional knee buckling upon weight bearing. Walking down a staircase and holding onto a railing "just in case" did not require much additional cognitive input to perform safely. But add a moving platform to a moving

handrail and significant cognitive planning is required. Imagine having your knee buckle while your upper extremity support is also moving. The fall potential increases substantially! I used to walk onto an escalator and just walk up or down as the stairs moved. Now I have to consciously judge speed on the stairs/handrail, judge my step and available strength, coordinate hand and foot placement, and if I am in an airport, I also need to coordinate my roller bag.

So please consider some additional training for your patients that travel or go to a mall. This experience was eye-opening for me, to see what riding the stairs actually meant for someone with even a mild disability.



# Editor's Message: A Goodbye Message from the Editor

Meri Goehring, PT, PhD  
Board Certified Geriatric Clinical Specialist (GCS)



Hello wonderful *GeriNotes* readers and contributors. Since November has a special Guest Editor this year, this issue provides me with my last chance

to write an Editor's Message for *GeriNotes*. I would like to take this opportunity to thank the many people who have helped me along the way.

First, a thank you to our President and Vice President, Bill Staples and Jill Heitzman. They also serve on the *GeriNotes* Editorial Board. They have provided great leadership to our academy and have been instrumental in writing wonderful copy and suggesting ideas for contributions to *GeriNotes*. I would also like to thank the previous Editor, Melanie Sponholz. She set up many changes to *GeriNotes* and provided important direction. Then, a special shout out goes to Jennifer Bottomley, who continues to serve on the Board of Directors and was able to provide a good number of well written, meaningful articles at a point where I was so short of copy that I was not sure I would be able to continue to serve in the role of Editor. Since then, I have learned a great deal about how to recruit copy, but at that time, her help was much appreciated.

Also, a hearty thank you goes out to Lucy Jones, the Director of Publications. She has always been there for me when I had any questions or problems. Her ability to communicate clearly and recommend valuable solutions in a timely and efficient manner have been most welcome.

Of course, I could not do my job without the significant help and support of Sharon Klinski, our Managing Editor, and Karen Curran, our Executive Direc-

tor. They have each taken time to meet with me personally and have offered more help than I can possibly describe. *GeriNotes* is truly a team effort, and I lean on these two to help me frequently. Thank you for your skills, your frequent communication, and your eye for detail.

Finally, I would like to thank the entire Board of Directors for their support. Without these wonderful people, *GeriNotes* would not be the well-read publication that our members continue to value--Patrice Anthony, Kathy Brewer, Chris Childers, Helen Cornely, Jill Hietzman, Ken Miller, Michele Stanley, and Ellen Strunk. I would also like to thank Lise McCarthy, who will serve as our Guest Editor for the November focus issue. She has provided me with a wealth of articles and was so gracious in her offer to serve.

I started my term as Editor some time ago, with my first issue being in January 2014. How time flies! I have learned a great deal about patience, change, communication, deadlines, and persistence. I have had more than a few pleasant surprises. One reader saw me at a conference and told me that I look much better in person than I do in my *GeriNotes* photo. That was nice. I have also come to realize that people really do like to see their words in print and are anxious to know when their copy will be published. I am sensitive to their needs and try to inform them that the system in regards to publishing hard copy is often slow. Mentoring new writers is something that I know will continue to happen as the next Editor comes on board. I hope some people who are reading this now will consider writing for *GeriNotes* in the future. The new Editor, as well as the entire Editorial Board, are happy to help.

Time moves, things change, and the world sometimes pulls one in a direction he or she does not expect. It has done so

for me, and I am looking to the future with a sense of nervous anticipation. Look for the new Editor to introduce him or herself in the January 2018 issue of *GeriNotes*. I plan to assist the new Editor and hope to continue to serve in some other capacity for the Academy of Geriatric Physical Therapy. Time will tell when and where the next opportunity will arise. Nevertheless, I am going to miss every one of the *GeriNotes* Board of Directors, but I am especially going to miss hearing from *GeriNotes* readers who appreciated the work we have tried to do and took the time to say so. And, I sincerely apologize to anyone I may have forgotten to thank personally for their work on *GeriNotes*. But, most importantly, thank all of you great readers!

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Academy  
of  
**Geriatric  
Physical  
Therapy**

# 2017 Academy of Geriatric Physical Therapy Election

Those elected will take office at the AGPT Member Meeting in February 2018 at CSM in New Orleans, LA. Online voting will begin on October 1, 2017. Please watch your email and [www.geriaticsppt.org](http://www.geriaticsppt.org) for more details. Contact [karen.curran@geriaticsppt.org](mailto:karen.curran@geriaticsppt.org) to request a paper ballot. Per bylaws, only PTs and PTAs are eligible to vote.

## PRESIDENT (Vote for 1)

### Greg Hartley, PT, DPT



Dr. Hartley received his masters and doctoral degree in physical therapy from the University of Miami. He is a Board Certified Geriatric Clinical Specialist and a Certified Exercise Expert for Aging Adults. He is presently Assistant Professor of Clinical Physical Therapy at the University of Miami Miller School of Medicine, Department of Physical Therapy. Previously, he was Director of Rehabilitation for a large post-acute care provider specializing in geriatric rehabilitation. He is the founding Program Director of the first APTA accredited geriatric physical therapy residency in the U.S. Greg has served as Director and Secretary on the Board of Directors of the Academy of Geriatric Physical Therapy (AGPT), and was the Chair of the AGPT Practice Committee from 2007-2017. Clinically, he has practiced in home health, outpatient, sub-acute rehab (SNF), long-term care, acute care, and rehabilitation hospital settings. Dr. Hartley's clinical and research interests are in geriatrics, exercise prescription for aging adults, functional assessment, fall prevention, interprofessional models of care, residency/fellowship education, health policy/administration, and rehabilitation outcomes in post-acute care.

### What 3 agenda items would you like to accomplish in your term as President?

As President, I can think of many important objectives I'd like to accom-

plish. Among them, the following 3 rise to the top:

1. First, I would like to see the Academy (AGPT) take a strong stance on elevating practice in sub-acute and long-term care. I believe AGPT has already done a tremendous amount of work in this area, specifically with regional education courses like the Certified Exercise Expert for Aging Adults (CEEAA™). However, there is more we can do. I would like to see the companion course for physical therapist assistants (already in development) become an educational cornerstone for career development among PTAs working in sub-acute settings. In addition to the educational offerings AGPT can provide to elevate care among PTs and PTAs, I'd like to see AGPT work with APTA and other organizations to advocate for meaningful payment reform in sub-acute settings, which I believe will have an impact on the provision of care, work-force issues, and quality of care. Efforts at reforming payment methodologies need to focus on value, outcome, and long-term costs; not single episodic encounters. I would also like to see AGPT collaborate with large sub-acute/long-term care therapy providers to discuss issues and future strategies related to employee productivity. Quality and outcome sometimes seem to take a backseat to productivity and payment. This is a complex issue and won't be solved by AGPT. However, I believe this professional association (AGPT) can represent *all* of its members' interests while working with business partners to promote value (ie, high quality, better patient outcomes, and reduced systemic costs) in this large sector of the health care industry.
2. While AGPT's historical roots are in the long-term care/sub-acute setting, the Academy has, for many years, had its mission and values focused on the aging adult across the continuum of care. However, this seems to be a

“secret” only shared by and among current members of the Academy. My second objective would be to enhance and expand the perception and image of the AGPT to be inclusive of PTs/PTAs practicing in all current and future settings where aging adult health care is managed. Future models of care delivery will evolve towards prevention and management of chronic disease and disability, and not focus solely on episodic care after an accident, injury, or illness. As certainly everyone who is reading this must know, the aging adult is the fastest growing segment of the US population. This growth is not expected to slow down for another generation. In my opinion, PTs and PTAs are better positioned than other health care professionals to manage issues related to movement in this huge segment of the population and there is great opportunity for us, if we take advantage of novel approaches to patient management. Everything I read lately points to the benefits of exercise, movement, and physical activity in managing chronic disease and improving quality of life...from osteoarthritis to cognition. We, as a profession, must shift our treatment paradigm to one that manages ‘movement’ and prevents disability before patients end up in hospitals and other traditional health care settings. This means embracing direct access (already permissible under Medicare), not ‘discharging’ patients (assuming we will most likely never see them again) but ‘concluding an episode of care’ instead, and managing patients for much longer than we typically do in an effort to leverage the long-term benefits of physical activity. Why do we write a plan of care for an outpatient for “2-3 times a week for 10-12 weeks” or “2 times a week for 4 weeks?” Why don't we write plans that span 6, 10, or 12 *months*, seeing patients more frequently in the beginning (if necessary) then cutting back to

once a month, eventually curtailing down to once every 6 or 12 months? Wouldn't this give us an opportunity to really monitor the long-term impact of our intervention and education on health? Wouldn't this enable us to have a real impact on wellness, prevention, and the avoidance of unnecessary hospitalizations or readmissions? I think we have huge opportunity here. And we (the AGPT) need to get the word out that therapists who work with aging adults are extremely capable of managing these issues in the community, medical homes, outpatient clinics, and in patient's homes. We should work collaboratively with other professionals and with other PTs/PTAs who have expertise in orthopedics, neurology, oncology, and other areas of clinical practice, to demonstrate the value therapists and therapist assistants practicing in geriatrics can provide in the lifelong prevention and management of chronic disease in *all* settings, including the workplace and the community.

3. Third, I would like to see the AGPT attract more students and early professionals to its membership. I believe the AGPT can work with PT and PTA education programs to garner increased membership among students and to demonstrate value in an effort to retain them as early professionals. The AGPT could develop an early professionals SIG (or similar group) to provide creative leadership opportunities to foster interest and innovation among new therapists/therapist assistants. The AGPT could do more related to stimulating interest among students and early professionals that could impact the workforce and patient access to experts and highly skilled therapists who are genuinely interested in geriatric physical therapy. AGPT has done more recently to expand its presence on social media, and to enhance its website. These are steps in the right direction. There can be more expansion here, including creation of a YouTube channel, Podcasts, and partnering with other high profile groups and individuals on social media to create our own media (instead of sharing media created by others). I believe we have an opportunity to be

a leader in this arena, particularly if we harness the skills and enthusiasm among our early professionals.

### **How do you see yourself and the Academy interacting with the entire APTA?**

As mentioned above, I think APTA and AGPT can partner on a number of issues related to the elevation of clinical care for aging adults and on payment initiatives. I would also like to see the APTA seek input from the AGPT more frequently for APTA-wide initiatives. For example, when APTA advocates for changes in Medicare/Medicaid policy or legislative efforts that impact aging adults, I'd like for AGPT to explicitly (and publically) contribute to the Association-wide position as a primary partner. Another example would be to continue collaborating with APTA on the [Physical Therapy Outcomes Registry](#) and [PTNow](#), while enhancing representation of AGPT in all areas of practice that have to do with aging adults, not solely areas commonly thought of as pertaining to geriatrics (eg, falls, cognitive health). I'd like to see APTA and AGPT work collaboratively on issues where we have common interests, like persistent pain and the opioid epidemic. This epidemic impacts aging adults as much (if not more) than other groups. AGPT should be included as an integral partner within APTA's overall strategy. Personally, I'd interact with APTA by attending APTA Board meetings, Component Leadership meetings, and assigning liaisons to work closely with their APTA counterparts. For example, AGPT Board members and Committee Chairs would be expected to routinely liaise with their APTA counterparts to explore ways in which the two organizations can and should collaborate. I also see opportunity in collaborating with other Sections and Academies, particularly with regard to the development of clinical practice guidelines, other evidence-based documents, conference programming, and educational offerings.

### **What do you perceive as the most important interpersonal skills that are needed by the President of the Academy?**

The most important interpersonal skills needed by the President are the ability to listen non-judgmentally and to synthesize issues, concerns, or opportu-

nities succinctly. In addition to this, the President must be able to identify and foster collaborative relationships among AGPT members and among individuals, groups, and organizations external to AGPT in order to reach its goals and achieve its mission. I see the role of President similar to that of a conductor of an orchestra; listening to individual instrumentalists, hearing the brass, percussion, and woodwind sections, and guiding them all to produce a symphony. A President, like a conductor, is 100% reliant on its members' contributions. Nurturing collaboration between members, and harnessing the contributions generated by members to reach Academy goals is paramount among the President's skills.

### **What is the greatest challenge facing the profession in terms of geriatrics at this time?**

I can't limit my answer to just one. There are two that really surface for me. As I write this, the US Senate is debating legislation that could impact every American, and could have significant implications for aging adults, especially those who receive Medicaid benefits. At the same time, the Centers for Medicare and Medicaid (CMS) is steadily implementing new payment methodologies for outpatient care under MACRA that will impact virtually all PTs by 2019. Meanwhile, APTA is actively working to end the so-called "Medicare Therapy Cap" with the potential to finally eliminate this archaic rule this year. So, my first answer, given the issues highlighted above, is "*legislative policy*." Policy changes that are happening now, or will happen in the near future, stand to impact physical therapist practice for decades. More importantly, these changes will impact our *patients*. But these policy changes absolutely impact the *profession*. For example, if 'rehabilitation' is eliminated as an 'essential health benefit' (EHB), as is one proposal under the Senate health care bill currently being considered (at the time of this writing), our profession could lose a lot. Therefore, advocacy at the Federal level is more important now than at any time in my 27-year career. AGPT should have a loud, unwavering voice when it comes to advocating for our patients. In the end, patient advocacy impacts our profession. The Academy needs to aggressively collaborate with APTA and

many other organizations to ensure the preservation of access to quality care for aging Americans.

The other major challenge for our profession related to geriatrics is the dearth of students who enter the profession with a desire to work with aging adults. Ultimately, I believe this stems from *cultural ageism*. I think we can and should do more to combat ageism and stimulate interest among primary and secondary school students, PT/PTA students, and early professionals so that we can increase the number of graduates who are genuinely interested in caring for what amounts to the largest segment of patients PTs and PTAs treat on any given day in this country. Shortages in the workforce impact every facet of health care delivery for aging adults. Even in the absence of a workforce shortage, having the 'right therapist in the right job' impacts our patients and our profession. The AGPT has a lot to offer these current and future therapists. Sadly, many students and therapists/therapist assistants have not been exposed to the AGPT. They are missing out on the wonderful resources and opportunities AGPT can provide them to improve patient care. Patients, our profession, and the AGPT could benefit from a targeted effort to end ageism (especially within our own profession) and attract students to caring for aging adults across the full continuum of care. We have tons of opportunity here.

### **VICE PRESIDENT (Vote for 1)**

**Cathy Haines Ciolek, PT, DPT**  
**Board Certified Geriatric Clinical Specialist (GCS)**  
**Certified Exercise Expert for Aging Adults (CEEAA)**



#### Education:

- Bachelors of Science in Physical Therapy, Ithaca College
- Graduate Certificate in Gerontology, University of Delaware
- Doctor of Physical Therapy, AT Still University, Arizona School of Health Sciences

#### Position/Employer:

Regional Director- Pennsylvania Restraint Reduction Initiative, Kendal Outreach

### **What are the most pressing concerns facing the Academy at this point in time?**

The Academy of Geriatric Physical Therapy (AGPT) is a vibrant group of individuals who are passionate about working with older adults. Joan Mills, AGPT founder, was quite specific in not naming us the "long term care" section, but the image still holds true for many non-members as we approach our 40th anniversary. We have an image problem. Far too often decisions about physical therapy are made by people who do not have an understanding of the aging process and how it impacts older adult's health and well-being and the delivery of our services in all settings. Yet at the same time, we are the only section of APTA that is a voice for those who work in the skilled nursing setting. We need a multipronged approach to being a stronger advocate with APTA and external organizations to represent and educate SNF providers and at the same time be the voice for older adults as we reach across the continuum of their health care needs. APTA national is actively promoting the theme "better together" and as the fourth largest section in APTA (2nd with PTA members but 9th with student members) the members of AGPT should be "loud and proud" of working with older adults and actively influencing APTA policy and practice in this area. Generationally, we need to start investing in students and new professionals now, so they can continue this work long into the future.

### **What experiences would you bring to the position of Vice President that make you a strong candidate for this position?**

As your Vice President, I would bring over 20 years of leadership experience within APTA to this role. Having served this association within the academy as Secretary, Delegate, and in numerous committee appointments, I have seen it mature and develop into a professional practice focused organization that looks at the physical therapy needs of the older adult from wellness through frailty. Additionally, I bring a wealth of knowledge of how APTA works at a national and chapter level having served on several national committees/task forces as well as having been Chapter President and Chief Delegate for the Delaware Chapter. The

leadership skills I have developed having just completed a term on the APTA Leadership Development Committee will be key for our Academy during these chaotic and uncertain times. One of my goals for using these skills is to enhance the leadership development of AGPT members so that we are all prepared to take more active roles and opportunities to transform PT practice and society.

### **What do you see as the most important function of the office of Vice President?**

The Vice President of the AGPT has 3 distinct roles in our organization: (1) to be liaison and work with the special interest groups (SIGs), (2) to serve on the executive committee, and (3) to be able to step in as President if needed. All 3 are important and I feel prepared for each, however, the role as liaison to the SIGs is particularly exciting. We now have 6 SIGs: Balance and Falls, Bone Health, Cognitive and Mental Health, Global Health for Aging Adults, Health Promotion and Wellness, and Residency and Fellowships. The expansion to add more SIGs represent an opportunity for more members to get involved in areas that mean the most to them and allow us to expand the resources available to members in each of these areas. With this many groups working at once, the Vice President needs to be an active conduit of information from these groups to the AGPT Board and vice versa, as well as supporting their work within the mission of the Academy.

**Myles Quiben, PT, PhD, DPT, MS**  
**Board Certified Geriatric Clinical Specialist (GCS)**  
**Board Certified Neurologic Clinical Specialist (NCS)**



#### Education:

- Master of Science in Clinical Investigation; University of Texas Health Science 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 of the APTA Education Leadership Institute (ELI) Program, 2016
- Fellow of the Texas Physical Therapy Association, Tom Waugh Leadership Program, 2016
- Fellow of the Castella Faculty Geriatric Research Fellowship, University of Texas Health Science Center at San Antonio, TX, 2011-2014

#### Advanced Training:

- Comprehensive Simulation Instructor Training, Center of Medical Simulation, 2015
- TeamSTEPPS Master Trainer Certification, Agency for Healthcare Research and Quality (AHRQ)- University of Texas HSC at San Antonio, 2013
- Certified Exercise Expert for Aging Adults (CEEAA), AGPT-APTA, 2011
- Credentialed Advanced Clinical Instructor Trainer, APTA, 2010
- Advanced Clinical Instructor, APTA, 2008
- Board Certified Neurologic Clinical Specialist (NCS), ABPTS, 2006
- Credentialed Clinical Instructor Trainer, APTA, recertified 2009
- Board Certified Geriatric Clinical Specialist (GCS), ABPTS, 2004
- Credentialed Clinical Instructor, APTA, 2004
- Arkansas Geriatric Education Mentors and Scholars; 2003 - 2004
- Neurodevelopmental Treatment (C/NDT) Certification, NDTA, 2001

#### Employer/Position:

- University of North Texas Health Science Center, Department of Physical Therapy; Associate Professor
- Baylor Institute of Rehabilitation; Physical Therapist PRN

#### **What are the most pressing concerns facing the Academy at this point in time?**

The Academy is in a distinct position to promote physical therapists as the geriatric practitioner of choice by educating geriatric practitioners on the use of current evidence to advocate for patients, acknowledging practice issues, increasing efforts to promote clinical specialization (GCS), and continuing to have conversations about aging and our key role in an aging society. I see two critical concerns facing the Academy, both of which are related to my passion: the promotion of PTs as geriatric practitioners of choice; the

concerns are correlated to the Academy's role: first, in education, and second, in advocacy. Over the past couple of years, we have brought more attention to issues important to older adults, including health care, resources, and the role of the physical therapist in healthy aging. As your Director of Education, I have tirelessly served to promote PTs as geriatric practitioners of choice - this entails the need for vigorous education at the entry- and at the post-professional levels. While AGPT has provided courses specifically to promote healthy aging and appropriate exercise prescription, for the AGPT to become a *premier* resource in education pertaining to physical therapist care of older adults, there is a need to intensify efforts to provide more quality educational initiatives that advance physical therapist practice for the aging adult. This requires addressing education at 3 tiers: for academicians who teach entry-level, future geriatric PT practitioners, for clinicians (new and seasoned PTs and PTAs) who need to keep current with contemporary geriatric practice, and for associations and health care professionals who need information about the PTs role in healthy aging. The Academy has started on this path with the CEEAA (which now coming on its 10th year of post professional education), 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 so much more to be done. The Academy needs robust and efficient processes to develop advanced courses to continue the growth of PTs who have a passion for caring for older adults. We need to look into multiple platforms to reach a wider audience with webinars, podcasts, and technology-based offerings in addition to traditional regional courses. Working closely with other academies, we can tap into the expertise of our colleagues and work collectively. I am currently exploring these avenues and I would like to see these initiatives into fruition as your VP.

The second concern is related to the current health care environment for older adults. With pressing issues on reimbursement, access to medical resources and health care, there is a persistent and stronger need to speak on

behalf of those we serve. We need to be more vocal advocates for the older adults – having a stronger voice, a stronger stance, and a stronger presence. Let's have a strong voice in external entities and associations that shape public policy. Let's get a seat at the meeting table and contribute to the critical dialogues at the national level about issues that impact our profession and our older patients. With the Academy's active membership and leadership, we can together advance our practice and advocate for older adults.

#### **What experiences would you bring to the position of Vice President that make you a strong candidate for this position?**

I bring to the AGPT a breadth of knowledge and skills in geriatric physical therapy practice, and leadership skills critical to advancing geriatric physical therapy practice. In my diverse roles, I speak the language of the clinician, researcher, educator, and student alike. As a clinician, I am keenly aware of the issues faced in clinical practice with reimbursement, productivity, difficulties advocating for the best discharge placements for our patients, and a whole myriad of administrative issues. As an educator, I am very much aware of the financial and political issues in higher education, and the challenges with geriatric and interprofessional education. I engage closely with a dynamic group of professionals within and external to our profession who support the PT geriatric practitioner and older adults; these interactions provide me with rich insights I bring to the position. More importantly, the “why” I seek your support, is what makes me stronger candidate for the position: I have a passion for geriatric care, for optimizing the function and quality of life of older adults, and for promoting physical therapists as the geriatric practitioner of choice. This is my vision.

Throughout my career, I have been a proponent of lifelong learning and strongly support the initiatives to address the unique educational needs of the PT geriatric practitioner towards the path of being the geriatric practitioner of choice. It has been a privilege to diligently serve the Academy as a Director, during which I actively engaged and worked collaboratively with talented members to address continuing education ventures. Those with whom I've worked would

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

Central to the Vice President's role are critical communications externally with associations significant to aging and geriatric care, and internally with Special Interest Groups. I bring a fresh perspective with administrative experiences in establishing and strengthening relationships, conflict management, and supervision of projects that involve multiple stakeholders. These are honed by a history of service to the profession, serving in the American Board of Physical Therapy Specialties, Geriatric Specialty Council, Credentialed Clinical Instructor Program, Federation of State Board of Physical Therapy Specialties, and service in my academic institutions. These experiences that provide a holistic insight to the profession, coupled with my commitment to excellence, work ethics, and enthusiasm to move the Academy forward, make me a compelling candidate for the position.

I would be honored to have your support and have the opportunity to serve the profession and the Academy in VP capacity.

**What do you see as the most important function of the office of Vice President?**

The VP is tasked to assist the President in moving the vision and initiatives of AGPT forward, in addition to roles in communicating with external agencies and with the Special Interest Groups. Trust that as your VP, not only will I dependably support the President; I too, will be the other voice in President's ear, ensuring that all sides are heard as we move initiatives forward. I believe that being the other voice, presenting alternate views, as well as providing a sounding board, is the most important function of the VP.

It is critical that leaders have varying inputs both supportive and probing, and I will serve loyally while preserving a separate identity from the President. I will continue to engage membership in advocating for older adults, the PT geriatric practitioner, and educators. I humbly ask for your vote because I want to continue building and developing programs to further the objectives of the AGPT and the APTA to advance the practice of geriatric physical therapy with your support and active involvement.

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

**DIRECTOR (Vote for 1)**

**William Scott Doerhoff, PT, MS  
Board Certified Geriatric Clinical  
Specialist (GCS)**



Position/Employer:  
Physical Therapist,  
Central Arkansas  
Veterans Health  
Care System

**What experiences  
would you bring  
to the position of**

**Director that makes you a strong candidate?**

Professionally, I have worked as a Physical Therapist for over 23 years and in almost every aspect of care. From a staff clinician to founding and owning a rehab therapy contract company, I understand in detail the value of every individual's role in delivering quality service in a health care market. Besides my professional background, I have experience as an elected governmental official, a member in an appointed State Board in service of my Governor and as an Executive Director of a nonprofit organization. I understand the importance and benefits of remaining true to an organization's mission while being creative enough to accomplish the goals for its members. Simply put, as my experience shows, I can partner with others to make informed and positive choices to move forward.

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

I feel, without a doubt, the greatest challenge facing Geriatric practitioners today is the risk of having their expertise marginalized in employment and practice environments such as skilled nursing, long-term care, and home health. I have heard numerous stories over the past 2 years of therapists with Doctorate, entry level degrees and clinical specialties in Geriatrics being placed under the management of Physical Therapy Assistants for sake of profits. In my opinion, there is no circumstance where this should occur. I feel the Academy of

Geriatric Physical Therapy must be proactive in developing a strategic plan and partnerships with stakeholders such as CMS and others in allowing therapists who are credentialed as clinical specialists to be valued, monetarily as much as clinically, in these areas so we retain our leadership roles with employers looking at their bottom line.

**Frances E. Kistner, PT, PhD  
Certified Ergonomic Assessment  
Specialist (CEAS)**



Current Position:  
Director, Doctor of  
Physical Therapy  
Program, Associate  
Professor, School of  
Rehabilitation Sci-  
ences, MCPHS Uni-  
versity, Worcester,  
MA

Education:

- Doctor of Philosophy, Physical Therapy, University of Miami, School of Medicine, Coral Gables, FL, 2011
- Master of Science, Physical Therapy, University of Miami, School of Medicine, Coral Gables, FL, 1993
- Bachelor of Science, Psychology, University of Massachusetts, Amherst, MA 1990
- Certified Ergonomic Assessment Specialist
- Certified in LSVT Big, 2017

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

I welcome the opportunity to run for the position of Director. While I am not (yet) certified as a Clinical Specialist in Geriatric Physical Therapy, I have worked with the elderly population since graduating PT school 20+ years ago. I was introduced to physical therapy when my grandmother had her hip replaced in the late 1980s. I watched as the therapist worked with her and restored her function and mobility, and facilitated her return to being my "Nana." That was my "Aha" moment which led to my Bachelor's degree in Psychology and then my admission to the University of Miami for PT school. Both degrees have proven invaluable for working with patients of all ages, especially the elderly. As the general population of the United States ages, it is imperative that physical therapists be prepared with the best, and most current evidence in order to provide (as per the strategic plan) the

“best physical therapy practice for optimal aging.” I look forward to the day when rehab facilities routinely provide not only traditional physical therapy, but innovative, evidence-based complementary therapies that reduce use of medications for behaviors in dementia, or exercises for strengthening programs that are fun and relevant for the participants! I am looking forward to taking the Certified Exercise Expert for Aging Adults courses in the Spring of 2018, as should all PTs who work with the aging population. As an academician, I recognize the importance of quality geriatric education in the entry-level programs as well as post-professional continuing education courses to minimize variations in practice and promote healthy aging. I believe the APTA Vision of “optimizing movement and improving the human experience” also involves transforming the aging experience and optimizing movement for our geriatric community and involves Academy support for the therapists who treat the aging population. While I believe quality research is important to progress our profession, timely dissemination of the research outcomes is imperative so that practitioners can use that information with patients and improve their function sooner (especially with reimbursement challenges!). As a researcher and academician, I love knowledge and believe that all PTs should be life-long learners, always updating their own mental database of assessment and intervention techniques, always practicing new methods, and always educating patients, families, and other health care providers about geriatric health, fitness, and more.

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

Geriatric practitioners face two major challenges. The first is the challenge of being well-prepared to identify, address, and keep up with the varied and ever-changing needs of our aging patients. This requires access to current evidence-based resources, knowledgeable interdisciplinary teams, and other essential resources. The AGPT has a tremendous amount of information to guide geriatric clinicians through changes in health care, reimbursement, and documentation as they work to address the health care needs of the aging population. We

must increase the awareness of these resources for non-AGPT members. The second major challenge is to increase the awareness of geriatric physical therapy to the general public and other health care providers and make it clear that for the aging population, the geriatric physical therapist is THE “autonomous practitioner of choice for exercise, physical activity, prevention and optimization of function in all settings” (2020 Geriatric Position Statement). To support both of these challenges, the Academy must continue to provide high quality education for practitioners and patients, disseminate quality research focused on the geriatric population, and promote the breadth and depth of geriatric physical therapy to the general public and to the greater health care community.

**Jacqueline Osborne PT, DPT  
Board Certified Geriatric Clinical  
Specialist (GCS)  
Certified Exercise Expert for Aging  
Adults (CEEAA)**



Credentials:

- Initially Board Certified in Geriatric Physical Therapy (GCS) from the American Board of Physical Therapy Specialties: 6/2007
- Recertified in Geriatric Physical Therapy: 6/2017
- Certified Exercise Expert for Aging Adults (CEEAA) from the Academy of Geriatric Physical Therapy of American Physical Therapy Association: 2012
- APTA Member since 2000
- AGPT Member since 2003
- Secretary of AGPT Residency and Fellowship SIG: 2015 to present

Education:

- Doctorate in Physical Therapy – Arcadia University, Glenside, Pennsylvania, May 2003
- B.S. in Business Administration (concentration in Operations Management) – University of Delaware, Newark, Delaware, May 2000

Employer/Position:

- Brooks Institute of Higher Learning Geriatric Residency Coordinator; Jacksonville, FL. 2010 to present

- Brooks Institute of Higher Learning Residency & Fellowship Programs Faculty Member and Mentor; Jacksonville, Florida. 2010 to present
- Adjunct Professor, Doctor of Physical Therapy Program, University of North Florida; Jacksonville, Florida. 2015 to present

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

I have had the privilege of directing the Brooks Geriatric Residency Program in Jacksonville, Florida since 2010. I was given the challenge in 2010 to create a geriatric residency program from the beginning. The program was initially accredited in 2012 and reaccredited in 2017. I have grown tremendously through this process which has included staying current with best practice for older adults, understanding the challenges and barriers that exist regarding health care policy and access to care for older adults, and refining my ability to communicate with my colleagues and the community as an educator and an advocate.

I have spent most of my career as a clinician. I continue to maintain a clinical practice because face time with older adults is my absolute motivator. However, I have had several recent non-patient care experiences that have helped to shape my leadership capabilities. First, I have served in district leadership within the Florida Physical Therapy Association (FPTA) as the Secretary of the Northern District since 2014. I am also the founding Chair of the Fall Prevention Taskforce of the FPTA which will become a more permanent effort with the creation of the Geriatrics Special Interest Group within the FPTA in the fall of 2017. The Task Force received an APTA Community Awareness grant in 2015 to promote the value of physical therapists as part of the important team in an emergency department setting. This effort continues today in addition to the mission of the Task Force which is to sustain fall prevention efforts across Florida on a continuous basis and to empower FPTA members and not-yet-members to carry out this mission. I also served on the Florida Injury Prevention Advisory Council from 2013 to 2016. This experience allowed me to connect, collaborate, and coordinate

with other key stakeholders advocating for services for older adults across the state of Florida. I believe that my advocacy for older adults can continue on a national level as an AGPT Board member.

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

If the physical therapy profession is not able to provide the rehabilitation and prevention services that are needed for the growing older adult population, other professions will. I believe that an important opportunity exists for physical therapists during this time of unprecedented growth that I would equate to the opportunity that existed during the polio epidemic. We need to position ourselves as a profession to show the value we bring to the well-being of older adults and to those who will become older adults. Failing to show our value to older adults and the health care community at large not only places geriatric clinical specialists at risk, but poses a risk to the entire physical therapy profession. We have made excellent strides educating others about “choosing PT 1st.” However, the AGPT has an opportunity during this time to not only ensure that physical therapists are prepared to provide the front-line rehabilitation services that older adults need, but to also ensure that our non-physical therapist colleagues are aware of the expertise we bring to the interdisciplinary team in place for an older adult. If we are not able to do that for the older adult population where have we really grown in the 7 decades since the polio epidemic?

Undoubtedly, physical therapists need to have didactic knowledge and skill to be able to provide physical therapy services at a high quality level for older adults. But to really have an impact on this growing population, physical therapists have to be at the health care policy table for health policy discussion and decision making at the state, national, and even international levels. The Academy can lead this effort by identifying where physical therapists should be present to help shape health care policy for older adults. It is time that we as a profession have an equal voice at the health care policy table. I hope to continue to work towards this goal with the AGPT as a member of the Board. Thank you!

**NOMINATING COMMITTEE  
(Vote for 1)**

**Jill Heitzman, PT, DPT, PhD-ABD  
Board Certified Geriatric Clinical  
Specialist (GCS)  
Board Certified Neurologic Clinical  
Specialist (NCS)  
Certified Wound Specialist (CWS)  
Certified Exercise Expert for the Ag-  
ing Adult (CEEAA)  
Fellow of the American College of  
Certified Wound Specialists  
(FACCWS)**



Position/Employer:  
Interim Program  
Director, Alabama  
State University,  
Montgomery, AL

Education:  
Received my PT  
degree from St Louis University, Post  
Professional Doctorate degree from  
Creighton University and finishing the  
Research Doctoral degree in PT from  
NOVA SE University.

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

I have been a member of APTA since 1976 when I joined as a student. I joined the Section of Geriatrics early in my career and became more active as my children grew up. Since 1988, I have held positions at the state level, the national level, and in various sections. I became more active in the Section on Geriatrics in 1994 and have been an active member since that time. My career has taken many turns along the way from clinician in acute care, home health, outpatient, and academia. Due to my husband's job, we have moved and lived in 13 places around the United States. This has given me the opportunity to meet therapists from various geographic areas and experiences. With each move, I learned more about my profession, myself, and how to be a good mentor. The various roles I have had with APTA, the state chapters, and the sections have also added to this experience. Currently, as a faculty member of the AGPT CEEAA, I am always interacting with new clinicians of all ages and experience. These interactions have made me aware of how to get more people involved within our organization and profession. I believe my ability to talk to people of all backgrounds and motivate them with the energy to move the profession

forward will enable me to find quality candidates for office as well as mentor new emerging candidates to continue to move the Academy forward.

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

There is never a time when we can say we no longer need mentors. There is no age requirement to be a mentor or be mentored by others. While many focus on the new graduates and residents to engage them within the profession (and I do agree this is important), we must not overlook those that have been working in the field and need encouragement to bring their experience to the professional organization. Helping those who have recently taken the GCS, or planning to in the future, is a hallmark to move the profession forward. We need to reach out to these clinicians on a personal level and ask them to be involved in committees, projects, and various offices of the Academy. Personal invitations to be involved work so much better than general announcements. We need to work at our state level with our state advocates to invite therapists to come to state meetings and have events to meet others who work with the aging adults. Bringing new members to the Academy will bring new ideas. Working with members who are coming but not taking that next step will be a challenge but a personal growth for all. We need to get out of our own social circle and meet others. That new person coming to conference for the first time, that member who comes regularly but sits alone, those who volunteer but are never followed for future activities all have something to contribute. Only by personally meeting members and finding out their interest/strengths can we become stronger as an association.

**Lucy Jones PT, DPT, MHA  
Board Certified Geriatric Clinical  
Specialist (GCS)  
Certified Exercise Expert for the  
Aging Adult (CEEAA)**



Education:  
Doctor of Physical  
Therapy, Univer-  
sity of Indianapolis,  
Masters of Health  
Administration,  
University of Mis-  
souri, KC, BS Physi-  
cal Therapy, Univer-  
sity of Pennsylvania, Geriatric Certified

Specialist, Recertified, APTAnj member since relocation 2008-current, New Jersey Chapter

Employer/Position:

Rehabilitative Therapy Services, owner, Therapy Choice, Geriatric Specialist in the home health setting

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

I have had the privilege of serving the Academy through the years, serving on the Nominating Committee until 2010. My role included identifying members to be nominated with varying backgrounds, ages, and experience with the Academy. We actively searched for those who would enhance our efforts to provide optimal board composition to fulfill our AGPT mission of promoting best practice and to advocate for older adults. I have had the opportunity to be on the Finance Committee, question reviewer for Specialist Accreditation for Certification Exams, APTAnj member of Geriatric Special Interest Group at inception in 2010, and facilitating Geriatric Specialty Exam study groups. The participation in and exposure to the AGPT membership continues as CEEAA faculty, coordinating the AGPT website redesign, the Academy Web Media Group facilitator, AGPT Board member, Task Force for Partnership, student resume review, and current Board of Director for Research and Publications. I continue to involve and match members to investigate openings and tasks to challenge and promote their leadership development within the Academy. I know the AGPT has exciting forward-thinking students and members ready for a new challenge within the Academy.

I have worked as a Geriatric Certified Specialist in various settings for over 20 years throughout my practice serving the older adult. I have had networking opportunities through my involvement with AGPT, participation at CSM, NEXT, and CEEAA, and connections with members and potential members. Working with 17 Committees and 6 Special Interest Groups to review and revise their content accurately for a year gave me the opportunity to become more familiar with each Committee Chair, the positions ideal skill set, and

how that relates to the strategic plan for their group. As a Director for AGPT, I met with the *JGPT* and *GeriNotes* Editorial Boards, and our Research Chair at CSM as they planned and developed their plans and strategy for the following year. My colleagues in New Jersey are interactive, and leadership capabilities are numerous.

The Academy has exciting days ahead, and as a member of the Nominating Committee I will continue to interact with our membership on social media, in person, at CSM and NEXT, and at the CEEAA courses. Seeking qualified leadership has been a passion of mine since I first became involved with the Academy. I will strive to intersect with members to cultivate expertise, involve them in moving practice forward, encourage advocacy, promote a desire to collaborate, and to have a passion and willingness to be stretched as our next leaders. We all are on a continual learning and growing journey in life, and I hope to serve the AGPT and you, the members, in this exciting way.

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

The word Mentor, according to the Merriam-Webster dictionary, comes from the Greek character in Homer's *Odyssey*, being a trusted friend of Odysseus, whom he entrusted with education of his son. It is a personal picture of a mentor as an experienced, wise, and trusted advisor. Mentoring involves observing passion and drive, encouraging practice development, capitalizing on the mentees successes, and promoting confidence for reaching new challenges. There are numerous roles in the AGPT that would appreciate members to step up in an area of interest. This is the beginning of recognizing your own leadership skills as you take the next step to your own leadership development.

Three ways to mentor come to mind immediately as we reach out to fellow members. First, the AGPT offers a congratulatory breakfast the morning after the GCS installation ceremony. This is an opportunity for relationships to solidify and mentors to be identified as these candidates return to their practice setting. Secondly, to expand cultivating relationships, AGPT can initiate a leadership development team, facilitating a path forward for those

interested in training, expanding their service, expertise, and knowledge of the leadership challenges facing AGPT. This could facilitate committee involvement, and assist members to see a way they may engage in service to the Academy. Thirdly, the State Advocates are a wonderful resource and reference for interested members to connect with Committees, SIGs, and Academy leaders by involvement at various levels.

My strongest talents are the ability to engage and encourage others to collaborate, create an enthusiastic environment, follow the contribution a member makes to the Academy, and recognize the leadership skills they possess in this process. Some of the leaders put forward during my past tenure on the Nominating Committee have remained active and furthered their expertise, leadership, and knowledge to pass on to those who came after them. I believe identifying new leaders is much more than filing a slot on the ballot, it is honing a craft to see potential leaders that carry a passion and drive to pursue their knowledge, proficiency, and a desire to continue to develop and expand their leadership and knowledge base throughout their years of practice. Through my time in the Academy and the various roles in which I have served, Committees and Special Interest Groups have been a unique area of leadership development. Our SIGs have been very active and each have been affiliated with an outside organization that takes the group an additional step in to move the Academy forward as the practitioner of choice for the older adult. The study groups that have been initiated for the Geriatrics Specialty Exam, and the dedication of those participants in the CEEAA courses are exciting ways to see people grow in their personal practice and leadership as they return to their clinics to share resources. These participants are those we will look to for leadership roles in the future.

I can lead you on your journey. Come talk to me, whatever the election results, and you can be on your way to your personal leadership challenge.

# The United States Health Care System: One Patient's Experience

Bonni Kinne, PT, DHS

## PROLOGUE

The following first-person account is based upon the experience of an actual patient. Throughout this account, you will see references that relate to the topic being discussed. As you read through this article, please consider ways in which you could have made a positive difference in the final outcome.

## FIRST STAY IN AN ACUTE CARE HOSPITAL (10 DAYS)

When my story began, I was a relatively healthy 80-year-old male with a medical history of diabetes mellitus and bilateral knee osteoarthritis as well as a surgical history of a triple cardiac bypass and several cardiac stents. Because I hadn't been feeling well for a couple of weeks, I made an appointment with my primary care physician. During the appointment, my physician ordered several laboratory tests. Later that day, I was told the laboratory tests revealed high potassium levels and that, because of my previous heart problems, I needed to be seen in a hospital emergency room right away.<sup>1</sup> I was subsequently admitted into the hospital where I was diagnosed with a kidney infection secondary to an enlarged prostate. I had an indwelling urethral catheter inserted, and I began receiving intravenous antibiotics. I also had to discontinue my Etodolac, the nonsteroidal anti-inflammatory drug that had been prescribed for my knee osteoarthritis, because it is often contraindicated in individuals with kidney problems.<sup>2</sup> A couple of days into my hospitalization, I spiked a high fever and had to be packed in ice. As a result of the fever, I was confined to my hospital bed for several days. After the fever had subsided, I attempted to resume my normal daily activities. However, I found that I required maximum assistance, even to transfer from supine to sitting, because of extreme weakness and severe bilateral knee pain. I was

also surprised to discover I had already developed a pressure ulcer over my right hip.<sup>3</sup> The urologist decided to delay my prostate surgery until I had regained my original strength and had returned home. Although I physically qualified for inpatient rehabilitation at that time, Medicare would not pay for this level of service.<sup>4</sup> Therefore, I was transferred to a subacute rehabilitation facility.

## FIRST STAY IN A SUBACUTE REHABILITATION FACILITY (10 DAYS)

My ability to participate in physical and occupational therapy was negatively affected by the persistence of my severe bilateral knee pain. Because the facility's physician wouldn't re-prescribe my Etodolac, the nursing staff was attempting to treat my pain with Voltaren gel during the day and with a Lidoderm patch at night.<sup>5</sup> I also began to experience increased cognitive problems that had initially appeared during my hospitalization. Although these cognitive problems may have been related to the original upper urinary tract (kidney) infection, I may have also developed a lower urinary tract (bladder) infection because of the continued presence of an indwelling urethral catheter.<sup>6</sup> As a result of my cognitive problems, I didn't know how to feed myself, use the call button, operate the television, use the telephone, or operate the lights. In addition, I fell 3 times because I thought I could get out of bed on my own.<sup>7</sup> My family was told that, unless one of them could be physically present with me 24 hours per day, I would not be allowed to remain in the facility. When my family asked why my bed could not be equipped with bed rails instead, they were told that bed rails are considered a type of restraint.<sup>8</sup> Therefore, they decided to call an ambulance and have me transported back to the hospital.

## SECOND STAY IN AN ACUTE CARE HOSPITAL (10 DAYS)

In the hospital emergency room, a urinalysis revealed a bladder infection. The infection had not been detected in the subacute rehabilitation facility because, despite my increased cognitive problems, a urinalysis had only been performed upon admission. I was subsequently re-admitted into the hospital where I again began receiving intravenous antibiotics. By this point, I was sleeping most of the time. In addition, because my family could not be physically present with me at every meal, I was becoming malnourished.<sup>9</sup> And on top of everything else, I developed severe diarrhea due to a clostridium difficile bacterial infection.<sup>10</sup> Although I don't remember much of what happened during this period of time, I do remember praying to die. My family asked the urologist if I could have my prostate surgery before I was discharged from the hospital. They were afraid I would continue to have recurrent bladder infections if the indwelling urethral catheter was not removed in the near future.<sup>11</sup> As was the case during my previous hospitalization, the urologist suggested the surgery take place after I had regained my original strength and had returned home. Therefore, I was transferred back to a subacute rehabilitation facility upon discharge from the hospital.

## SECOND STAY IN A SUBACUTE REHABILITATION FACILITY (113 DAYS)

Because of the problems I experienced in the first subacute rehabilitation facility, my family insisted that I be placed in a different subacute rehabilitation facility this time around. I again experienced difficulties participating in physical and occupational therapy. This time the difficulties were due to both a persistence of my severe bilateral knee pain and a continuation of my signifi-

cant cognitive problems. Fortunately, my family was able to convince the facility's physician to inject both of my knees with a corticosteroid.<sup>12</sup> This type of intervention had not been previously employed because corticosteroids have been known to increase blood glucose levels in individuals with diabetes mellitus.<sup>13</sup> Because urinalyses were frequently administered at this facility, my recurrent bladder infections were also able to be treated before they became severe. As a result, I slowly began to regain my normal cognitive function. Despite my decreased knee pain and my improved cognitive abilities, though, I still had a long way to go. I continued to experience severe diarrhea due to the clostridium difficile bacterial infection, and I also developed pneumonia.<sup>14</sup> Then, approximately 2 months into my ordeal, I lost my Medicare Part A benefits. Therefore, my family was told that they would have to pay an out-of-pocket cost of \$350 per day for my room and board and that my rehabilitation services would now be covered under Medicare Part B. This situation created 2 new problems. First, my family had to pay exorbitant legal expenses so Medicaid could be used to cover the cost of my room and board. Second, I received both physical and occupational therapy less frequently under Medicare Part B than I did under Medicare Part A. The only bright spot was when the urologist finally realized I might never again regain my original strength or return home. So...nearly 3 months after I had walked into a hospital emergency room under my own power, I underwent a successful prostate surgery and was transported back to the subacute rehabilitation facility later the same day.

## EPILOGUE

I finally came home 143 days after my entry into the health care system. Although I'm grateful to be home, I now have a ramp to enter my house, a rolling walker to ambulate household distances, a wheelchair to travel longer distances, a portable urinal for bladder management, and a 3-in-1 commode for bowel management. I also purchased a lift chair. I sure hope nobody else has to ever experience what I went through. After all, isn't the United States health care system supposed to be the best one in the world?

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Bonni Kinne, PT, DHSc, is a full-time Associate Professor in the Department of Physical Therapy at Grand Valley State University (Allendale, MI). She also works part time at C. Weaver Physical Therapy (East Lansing, MI) where she services the needs of patients with vestibular disorders. She has previously published 4 systematic reviews in *Physical Therapy Reviews*, a case report and a systematic review in *Physical and Occupational Therapy in Geriatrics*, a research report in *The Journal of Laryngology and Otology*, a book chapter entitled "Benign Paroxysmal Positional Vertigo," 5 articles in *GeriNotes*, and 8 articles in an international publication associated with the "Vestibular Disorders Association."

# Dedicated Courses in Geriatrics versus Pediatrics in Entry-level Physical Therapy Programs: Survey Results

Carole B. Lewis, PT, DPT, GCS, GTC, MPA, MSG, PhD, FSOAE, FAPTA

Peter J. Schmidt, PT, DPT

## INTRODUCTION

The APTA published a study that showed the percentage of therapists working with older adults is above 50% in most settings.<sup>1</sup> Larry Nosse's study showed that a quarter of the respondents, as students, intended to work with older patients, but as practitioners, over 60% worked with this population.<sup>2</sup> Finally, demographic projections indicate population growth among those 65 and older. In the next several decades this segment of the population will most likely increase more than any other group.<sup>3-9</sup> Just these few facts highlight the importance of adequate training for students in the area of geriatrics. Armed with these statistics, we set out to explore the educational training in physical therapy schools across the United States.

## METHODS

Data was attempted to be collected from all the physical therapy schools in the United States. The list of schools was obtained from the American Physical Therapy Association website. Phone and email attempts were made to all the physical therapy programs in the country from information obtained on the schools' websites. When a person was reached, they were asked if the program had a course dedicated specifically to geriatrics and if they had a course dedicated specifically to pediatrics. In addition, the contact was asked if the course had been taught for the last 10 years.

Responses were noted on an Excel spread sheet with the name of the contact person noted. Responses that noted a dedicated course received a positive mark on the Excel spread sheet as well as how long the course was taught. Responses that stated no courses received a negative mark. Responses that said that either pediatrics or geriatrics were part

of a life span or other courses were not considered as a dedicated course and received a negative mark.

When there were no responses to the phone and email attempts, the information was obtained from the website listing of courses. Again, responses that noted a dedicated course received a positive mark on the Excel spread sheet. Responses that showed no courses received a negative mark. Responses that said either pediatrics or geriatrics were part of a life span or other courses were not considered as a dedicated course and received a negative mark.

The Excel spread sheet was tallied and the percentages calculated.

## DATA ANALYSIS

A total of 217 schools were questioned in 2015 as to their educational offerings in geriatrics and pediatrics. Fourteen schools verbally responded. Eighty-four schools actively responded in writing. One hundred nineteen schools' information on educational offerings were gathered from the websites. Seventy-seven schools offered information on the length of time the courses were taught. The information was compiled and percentages were calculated.

## RESULTS

Schools that had a dedicated course in pediatrics was 64.5% and 42.4% of schools had a dedicated geriatric course. Of the 77 schools that offered information on the length of time the programs were in place, 68.8% had pediatric programs before 2005 and 46.7% had geriatric programs before 2005. Of 217 schools, 31.8% have neither a dedicated geriatrics or pediatrics course, while 38.7% have both. Schools have a dedicated geriatrics course was 3.7%, but did not have a dedicated pediatrics

course, while 25.8% have a dedicated pediatrics course, but did not have a dedicated geriatrics course.

## DISCUSSION

This survey clearly shows that geriatrics does not receive the same priority as pediatrics and most likely much less than orthopedics or neurology. Yet with the substantial growth of the older population and the increased consumption and benefit that physical therapy can offer to older persons, more education at the entry level should be mandated.

## CONCLUSION

In 2015, 64.5% of the schools had a dedicated course in pediatrics and 42.4% of schools had a dedicated geriatric course. Many of the schools with programs in geriatrics began them within the last 10 years, whereas the pediatric programs had been in place much longer. Geriatrics is one of the largest areas where our profession works. Yet, we are not adequately training our therapists in our entry-level programs to work with our older population.

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# VOTE



## 2017 AGPT Election

### IMPORTANT INFORMATION:

As in past years, the election will be online and take place this fall.

Please watch your email and [www.geriaticsppt.org](http://www.geriaticsppt.org) for more details.

If you do not have an email address on file with the Academy office, or you requested not to be contacted via email, please contact [geriatrics@geriaticsppt.org](mailto:geriatrics@geriaticsppt.org) to request a paper ballot.

Those elected will take office at CSM in February of 2018. As per AGPT Bylaws, only PTs and PTAs vote in Academy elections.

# 2017 House of Delegates Update

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

The 2017 session of the House of Delegates was held June 19-21, 2017, in Boston, MA. There were 14 main motions considered during the session. As the AGPT's elected Delegate, I am reporting to the membership the actions taken in this year's House of Delegates. Please be aware, however, that the "official" results of this year's business will not be available until September 1, 2017. Therefore, this report is considered "unofficial" but in the interest of getting the information out to the membership timely, it is provided.

The governance of the Association is a year-round process. As an elected Delegate, I participated in virtual town halls, meetings of the Southern Caucus (determined by my home state), and collaborated with other State and Section delegates. As my first time as an "official" delegate, I very much appreciated the opinions and support of other delegates who are also AGPT members, as well Patty Brick, Steven Chesbro, and Cathy Ciolek, who each served as AGPT's delegate before me.

Motion:	Title/Topic and Intent:	Result:
RC-1-17	<p><b>ADOPT: BOARD RESPONSIBILITY FOR ASSOCIATION MISSION STATEMENT</b></p> <p><b>Intent:</b> The APTA Board of Directors creates and maintains the mission statement for the association. This mission statement shall align with the vision for the physical therapy profession created by the House of Delegates.</p>	Passed
RC-2-17	<p><b>AMEND: THE ASSOCIATION'S ROLE IN ADVOCACY FOR PREVENTION, WELLNESS, FITNESS, HEALTH PROMOTION, AND MANAGEMENT OF DISEASE AND DISABILITY (HOD P06-16-05-06)</b></p> <p><b>Intent:</b> To include partnering relationships with individuals as well as organizations, and add as a <b>priority:</b> <i>"Collaborative relationships that have the potential to advance the vision for the physical therapy profession and leverage efforts to develop and implement effective population health management strategies."</i></p>	Passed
RE-3-17	<p><b>AMEND: THE ASSOCIATION'S ROLE IN ADVOCACY FOR PREVENTION, WELLNESS, FITNESS, HEALTH PROMOTION, AND MANAGEMENT OF DISEASE AND DISABILITY (HOD P06-16-05-06)</b></p> <p><b>Intent:</b> To modify the statement to include that Advocacy includes.... activities that promote regular physical activity and exercise, <i>"and safe use of transportation to enhance health, prevent or reduce disease and disability, and decrease preventable injuries and death."</i></p>	Defeated



RC-4-17	<p><b>AMEND: PHYSICAL THERAPISTS AS QUALIFIED TO DETERMINE MOBILITY STATUS FOR PATIENTS AND CLIENTS APPLYING FOR DISABILITY PLACARDS, DISABILITY LICENSE PLATES, OR PARATRANSIT SERVICES (HOD P06-14-14-19)</b></p> <p><b>Intent:</b> Amend the position by striking out the words “consumer access ... for paratransit services” and adding the words “societal access to and recognition of physical therapists for disability evaluation and determination for health, recreation, employment, legal, regulatory, and insurance purposes.”</p>	Passed
RC-5-17	<p><b>ADOPT: PHYSICAL THERAPIST’S SCOPE OF PRACTICE</b></p> <p><b>Intent:</b> Adopt the following language: “An individual physical therapist’s scope of practice is influenced by professional, jurisdictional, and personal scopes of practice. Over the course of the physical therapist’s career, scope of practice evolves based on considerations, including but not limited to, societal needs; progressive professional development activities of the physical therapist; modifications to jurisdictional laws and regulations; advancements in knowledge, research, clinical skills and technology; and the evolving health delivery system.”</p>	Passed
RC-6-17	<p><b>ADOPT: DEFINITION OF PROFESSIONAL SCOPE OF PHYSICAL THERAPIST PRACTICE</b></p> <p><b>Intent:</b> Adopt the following: “The professional scope of physical therapist practice is grounded in basic, behavioral, and clinical sciences. It is supported by education, based on a body of evidence, and linked to existing and emerging practice frameworks. The professional scope evolves in response to innovation, research, collaboration, and changes in societal needs. The professional scope consists of patient and client management, which includes diagnosis and prognosis, to optimize physical function, movement, performance, health, quality of life, and well-being across the lifespan. In addition, the professional scope includes contributions to public health services aimed at improving population health and the human experience. The jurisdictional scope of physical therapist practice is established by the practice act governing the specific physical therapist’s license, and the rules adopted pursuant to that act. The personal scope of physical therapist practice consists of activities for which an individual physical therapist is educated, trained, and is competent to perform.”</p>	Passed
RC-7-17	<p><b>ADOPT: PROMOTION OF AMERICAN PHYSICAL THERAPY ASSOCIATION MEMBERSHIP BY RESIDENCY AND FELLOWSHIP EDUCATION PROGRAMS</b></p> <p><b>Intent:</b> As stated</p>	Passed
RC-8-17	<p><b>CHARGE: TRANSFORMATIONAL INNOVATIONS IN PHYSICAL THERAPIST PRACTICE</b></p> <p><b>Intent:</b> Charge the APTA to explore and, if feasible and advisable, develop model(s) of innovation centers to expedite the creation and growth of effective transformational innovations that revolutionize physical therapist practice and positively impact society.</p>	Passed
RC-9-17	<p><b>CHARGE: SPECIAL COMMITTEE TO REVIEW HOUSE DOCUMENTS</b></p> <p><b>Intent:</b> As stated</p>	Passed
RC-10-17	<p><b>ELECTION TO HONORARY MEMBERSHIP IN THE AMERICAN PHYSICAL THERAPY ASSOCIATION: T. RICHARD NICHOLS, PhD</b></p> <p><b>Intent:</b> As stated</p>	Passed
*RC-11-17	<p><b>CHARGE: INCREASING PROFESSIONAL DIVERSITY</b></p> <p><b>Intent:</b> By June 2018, the APTA identify and begin to implement best practice strategies to advance diversity and inclusion within the profession of physical therapy.</p>	Passed
*RC-12-17	<p><b>CHARGE: PLAN TO AMELIORATE THE ADMINISTRATIVE BURDEN ON PHYSICAL THERAPIST PRACTICE</b></p> <p><b>Intent:</b> The APTA explore the administrative burden of providing PT services. By June 2019, APTA shall develop and implement a plan to ameliorate the burden.</p>	Passed

*RC-13-17	<p><b>AMEND: BYLAWS OF THE AMERICAN PHYSICAL THERAPY ASSOCIATION, ARTICLE IV. MEMBERSHIP, SECTION 4: CHAPTER ASSIGNMENT</b></p> <p><b>Intent:</b> Allows members who are active uniformed services personnel, and members who are spouses or partners of active uniformed services personnel, to choose the chapter they are assigned to.</p>	Passed
RC-14-17	<p><b>BYLAWS OF THE AMERICAN PHYSICAL THERAPY ASSOCIATION, ARTICLE V. COMPONENTS: CHAPTERS, SECTIONS, ASSEMBLIES, AND THE AMERICAN COUNCIL OF ACADEMIC PHYSICAL THERAPY, SECTION 1: CHAPTERS, D. STRUCTURE, (4)</b></p> <p><b>Intent:</b> Allows chapters to determine their own method of apportioning representatives of Physical Therapist Assistant, Retired Physical Therapist Assistant, and Life Physical Therapist Assistant members in their representative body.</p>	Passed

As stated earlier, the official minutes of the House of Delegate’s proceedings will be posted on the APTA’s website by September 1, 2017. The 2018 House of Delegates is scheduled for June 27-30, 2018, in Orlando, FL. As your state begins to develop concepts for new motions in 2018, please feel free to share those issues with me. As the Academy’s Delegate, I represent all members.

# Academy of Geriatric Physical Therapy

## STATE ADVOCATES

Did you know that AGPT has State Advocates working locally in many states, advocating for older adults, promoting geriatric-related issues, courses, meetings and AGPT SIGs and being a liaison between AGPT and state chapters?

**We are actively looking for new State Advocates in the following areas:**

Alaska, Connecticut, Indiana, Hawaii co-chair, Kansas, Massachusetts, Nevada, New Hampshire, New Mexico, New York co-chair, Ohio, Oregon, Rhode Island, South Carolina co-chair, South Dakota, Utah, Vermont co-chair, Wisconsin, and DC

***From another state than is listed above?***

Find out your State Advocate contact info at [www.geriaticspt.org](http://www.geriaticspt.org). Select “Members” tab, then “Contact Your State Advocate”

If you are interested in being your State Advocate, or want more info about the program, contact AGPT Advocate Coordinator **Beth Black, PT, GCS**, at [BBlackPT@gmail.com](mailto:BBlackPT@gmail.com).



# A Geriatric Resident's Reflections on His Service Learning Experience

Samuel Vukov, PT, DPT, GCS; Becky Olson-Kellogg, PT, DPT, GCS, CEEAA

*The University of Minnesota's geriatric clinical residency began in September 2010. Now in its seventh year, we have graduated 10 residents, with 2 more in training. The work seemed endless, the details were immense, and the outcome was unknown. The rigor of the curriculum is intense, yet the most gratifying element for me is to read the residents' service learning journals each semester. They are required to volunteer in the senior apartments on the campus where they practice clinically. The purpose is social and personal engagement, the rare opportunity for them to enter the daily lives of older adults. All residents have chronicled their unique interactions, some humorous, some confusing, some sad, but all memorable. Samuel Vukov entered the residency in 2014 and immediately immersed himself in the lives of the women in the memory care suites. This was a natural fit for Samuel as he had been deeply connected to older adults his entire life – entertaining them, advocating for them, and affirming them. His insights were touching and I knew they needed to be shared.*

## MY FIRST NIGHT

I stayed tonight after 2 (of the 4) had gone to bed. While the third was getting her weekly bath, one of the women who had already gone to bed, woke up, and was looking for a way to get home. The lady, who I was entertaining, stood up and offered to help her. They wandered around the suite until they found a picture of the sleepy woman's family next to a bed. They figured this was probably her bed. Thus, a simple act of kindness meant more to the onlooker (me) than to either of them.

## WISDOM

I posed a question to the women, "What amazes you about life?" The answer that will stick with me was, "No

matter what happens today, tomorrow you can always make it right." Someone who doesn't know what happened yesterday is trying to make everything right in the world. Nothing can sum up a life goal better than that. Try to take all the bad things from yesterday and make them right today.

## FORMING A FRIENDSHIP

On a busy day this week, I was between patients, looking for my next client. One of my ladies from memory care came out of the hair salon, next to the physical therapy gym, with her son. I politely said hello and thought the interaction would be limited to that greeting. Her eyes went from not knowing what was happening to seeing a friend. This moment was more important than if I lost 5 minutes towards my daily efficiency. I introduced myself to her son. He stated he was glad to finally meet me. She had already told him about my visits. I never realized the impact of being present for someone could have on their entire family. These ladies are more than my clients. They are my friends.

## THE DANCE

I am rarely surprised by anything. This week was an exception to the rule. I was doing activities with the ladies of suite 502. I was not really listening to the background music, but I was chatting with the ladies and telling stories. One of the women stood up suddenly and grabbed my hands, asking, "Sam, can I dance with you? This is my favorite song." I stood up to complete a slow 2-step. She started twirling and dancing like she was 20 again, with smiling eyes. For that 2.5-minute song, she was no longer restricted by age or memory. She was transported back to a happier time. Some moments I will never forget; this being one. I was reminded that a person is only as old as they think they are.

## IMPORTANCE ON A MEMORY

I discussed Christmas memories with the ladies this week, with two of them sharing. One started her detailed story about getting her first bike. The second lady followed with her story about her mother making new pairs of pajamas for her and her siblings. As soon as she finished, the first lady told the exact same story with different details. Then the second woman told her story with different details. This continued at least 4 times before I changed the topic. It made me think; both of the stories were from their childhoods. Once I had primed the pump with my question, they seemed to have a need to tell the story. Not realizing they had told the story, their feelings of the memory prompted them to relive that moment over and over again. This is one reason to focus on positive memories when working with people from memory care. Good memories bring such joy, where bad memories bring just the opposite.

## BUILDING TRUST

Trust is a great thing; it needs to be earned. Trust does not necessarily need to be remembered. I have been working with the women for 4 to 5 months now. Some of them will still ask me who I am. Some always greet me as though they have never met me at the beginning of every session. Each one of them trusts me though. They know I am there for their benefit. They now let me help them do tasks, which they would not let me do in the beginning. Some of these are basic tasks, washing their hands or leading them to their favorite spot on the couch. They may not recognize me, but they trust me. Trust is a deep-rooted feeling that can only be earned.

## TIME TOGETHER

Tonight I stayed up with one of the women to watch Carol Burnett on

DVD. I was somewhat familiar with the TV show, but had never watched a full episode. It is strange how some humor transcends generations. It might have been just the joy to laugh with someone else, but we both enjoyed the hour-long show. Humor is always more fun when you are able to laugh with someone else. We built off each other and commented on what was happening. Time spent together is one thing, but laughing together is an entirely new level of bonding. Like I have said before, it is not necessarily about entertaining each other, it is about spending time together.

### FALSE MEMORY

This evening when I was visiting with the women, one of their daughters came in to check on us. We visited for a good 45 minutes while another woman took a nap in her chair. Or, this is what I thought at the time. When I noticed her move and her eyes open, I asked how she was doing. She usually does not make sense when she speaks, but the words flowed out like they should. She began telling me a story that included all the topics the group had been visiting about. The story did not make any sense, but it did include all of the topics spliced together. I always ask questions to keep the conversation going and dig deeper. She answered all of the questions with details the other women had already shared. Strangely enough, all of the information had somehow registered in her brain and had internalized without her realizing it. I learn so much about the human mind and relays of the brain when I visit with these women.

### CONNECTION BUILT

Tonight there was a new nursing aide. I thought it was interesting because the residents all were very excited to see me and the worker could not figure out who I was for the first few minutes. She understood the women trusted me and I knew the code to get into the room so I was a safe person. When I introduced myself, she then made the connection. She had heard of me coming, but we had never overlapped times. I still find the fact that the women trust me so interesting. One of the women in the room would not look at me for the first 3 months I visited in the suite. I was told she took time to warm up to people. Although we had not talked about her

family or life history (as I had with other residents), she now looked at me and answered simple questions. More importantly, she gets a sparkle in her eye when I talk to her. We have a friendship now.

### TRUST CONTINUES TO BE BUILT

Another week and I learned more about trust. The woman with the lowest cognition was very emotional today. Her family had come and spent time with her earlier in the day. She did not remember this, but she knew she missed them dearly. She had a desire to go home and spend more time with them. While the main NAR was out on her supper break, a substitute came in. This substitute has been spending a half hour with the women every day for 6 months, but tonight she was not able to calm her down. I knew the resident trusted me. I was able to calm the woman down and get her situated in a safe place until the main NAR came back. I found it interesting I have built trust with a woman by coming every other week. I believe it may be my gender that the woman trusts. I may remind her of a past friend. All I know is I have built a connection. In life, we must build connections with others in order to get through life. In closed settings like memory care suites, connections are limited due to not being able to leave the environment. We must remember to enter these closed environments with both vigor and caution. Vigor due to building connections, but caution to make sure the connections do not fall apart. The women do not need people wandering through for a month or two. These connections are built and broken. Connections have to be strong and able to withstand a test of time. I am already planning ways to keep in touch with these women after my residency ends.

### CONVERSATION

Today the women needed someone to talk to. I planned to play a game with them or watch Wheel of Fortune, but they wanted to talk. I find it interesting because most of them are 60 years older than me, but they all seemed flirtatious today. When one woman found out I did not have a girl friend, she told me that as much as she would love to go out on a date with me, she thought she was too old for me. I thought this was very sweet. The women get talked *to* every-

day, but I wonder how many times they get talked *with*. Each person needs to feel important in a conversation.

I have always tried to fight the barriers of conversation. I have a voice that is easy to hear and understand. I usually sit close to the women so that they can see me. I always make sure I provide a caring touch with each of them. Most importantly, I talk to the women as I would to a friend. I call them by their names and talk to them as adults. One of the things I never do is talk to the women as if they were children. I do not like when others do this.

### READING A MAGAZINE

The women wanted to watch TV today. One of the women was still sitting at the dinner table watching from a distance. I decided to share something special with just her. I found a magazine, and the two of us went through it page by page. We discussed recipes, and I read her quotes from famous people. It was not much effort for me, but I believe she really enjoyed being able to go through a magazine. Sometimes the simple pleasure of reading a magazine is cherished, especially if you are not able to do on your own.

### DEATH AND KNOWLEDGE OF DYING

One of the women went on hospice tonight. The other women did not realize that one of their own was no longer eating with them. Death is very difficult, but the closeness to death is even harder. Knowing someone is close to death gives a strange feeling. It is never a black and white issue until it is done. I never want someone to pass away, but I also do not want them to suffer. I believe life would be simpler if I did not remember, but in the same way not remembering makes the person's legacy not seem as important. Each week I wonder if memory is important to happiness. The truth is I do not know. I do not think that ignorance is bliss, but perhaps forgetfulness is bliss.

### IDENTITY

Personal identity is something that interests me. I don't think personal identity is fully lost with dementia, but I also do not think it is fully retained either. This week, I was visiting with one of the women who is very pleasantly con-

fused. Knowing that human touch is a very important form of communication, I decided to hold her hand while we chatted. One thing I have learned is the importance of touch with people who have dementia. The woman and I were discussing something, but I had no idea what. She rarely makes sense, but she can string together sentences that sound like they should. I just asked generic questions to make myself sound active in the conversation. All of a sudden, she looked down at her hand and asked what she was holding, and I responded it was my hand. Looking more confused, she asked where it came from. I replied it was attached to my arm. She stated this explanation made sense, and then moved along with the disoriented conversation we were having previously. It was very interesting she had trouble identifying she was holding something. In the same way, she could identify the logic of my explanation.

### WALK BY THE POND

I was given the pleasure today of taking one of the women out on a walk. I really should not call it a walk, as she had a change in her transfer status and she is now wheel chair bound. I never know quite what she is thinking due to her cognitive status, but I could tell she was happy. We looked at the many water fountains around the property. I positioned her beside a bench and then sat next to her. We sat there like two ordinary people just watching life go by. I could tell I had triggered some memory of her youth that occurred in a park with a band playing. She became very focused on this memory, but was not able to fully articulate it. All I knew was she was happy, which is all I wanted.

### TRUSTING THE RESIDENT

This happened many weeks ago, but it has taken time to develop into something that has really made me think. One of the residents stated earlier in the day a man was wandering around the suite and was up to no good. She told as many people as she could, saying she was frightened and concerned for everyone's safety. The aides reassured her it would be taken care of. I realized they were not going to tell anyone and just write it off as her dementia. I realize nothing did become of this, but what if there *had* been a man wandering around

the suite causing trouble and she was the only person to see it? When and how do we trust people who are older? Does a diagnosis of dementia decrease this trust? It sounds like the start of a blockbuster thriller, but it has given me many nights of deep thoughts. Trust is a delicate thing. If people trust us to keep them safe, should we also trust them? Again, I have more questions than answers.

### ROUTINE

I have found myself looking forward to volunteering in suite 501. I truly think they do not remember me from week to week, but innately they know me. Routines are so important when the memory is altered. The person who has the most consistent routine seems to be the top of the pecking order. Even if it is a scheduled nap after supper, a routine maintains regularity. One woman insists on watching the news and Wheel of Fortune each day. She does not care what is happening in the world nor will she ever be able to guess the words on the show, but the routine of watching these two items are so crucial to her balance in the world. She is able to dictate what happens during these times because she makes sure it is on the schedule. Life is the easiest when we have a schedule and a routine.

### MY LAST NIGHT

I was able to take the woman who is wheel chair bound out for a walk again. Although she never makes sense and rarely puts together a single solid thought, she told me she knew what I was doing and greatly appreciated it. I am not sure if she knew what she had actually said, but it meant a lot to me. Did I complete this volunteering to be loved and appreciated by the residents? No. Did it break my heart that I would no longer be seeing her? Yes. Will I remember the lessons learned while working with her? Absolutely! I have learned one of the last reactions to leave someone in dementia is their handhold. If I place my hand in hers, she holds it and gives a gentle squeeze. I believe as a society, we are averted from human touch. With older adults, I think we need to challenge our comfort zone and touch them. A hand on their shoulder or our hand in theirs could change their day. It is sometimes so easy to make someone happy, so why do we not do it? Fear.

### FINAL THOUGHTS

Normalcy is a strange thing to think about. We all strive to have a normal routine, but should this be set up for us or decided by us? We are raised with the concept of routine is best. We go to school, where everything is scheduled. We then start a job from 8 until 5, eat dinner, do something before we go to sleep, and then wake up and repeat. As humans in the western world, we are used to having things scheduled Monday through Friday and then having the weekends to be free. In memory care, should things be planned like the week or the weekend? I can see things both ways. Structure sometimes eases the mind, but it takes away the freedom. Personally, I would want to live life, as if everyday was the weekend when I go to memory care in the, hopefully, distant future. Freedom is important for people who are stuck in one suite for the rest of their lives.

One of the big discoveries I made this semester was about the need for human intimacy. I am not talking romantic, but everyone's need to be touched and feel they are cared for. People are rarely touched when they are in the institutionalized system. I should clarify; people are touched due to nursing cares or physical assist, but not for the sole purpose of personal physical contact. I have realized human touch can be as healing as the treatment we are giving our patients. In today's society, health care workers are so scared of being reported for misconduct that we minimize our touch with our patients. I realize there does have to be a line, but I do not think we should be so scared.

Another thing I have learned is these women want to experience life events with me. I was their excitement. They were always excited to hear the newest story. I could have told them the same story every week and they would be just as happy to hear it. They want to feel included. They are isolated and nothing new or exciting happens with them. The women were able to live out my life with me. The women had a need for a story. I encourage people to go and read to people in memory care units. The story is important.

This year has gone by too quickly. The volunteer experience has been an immersion experience. I dove in head-first and hoped for the best. I never

guessed it would end as it did; not only did I care for the women, but they ended up knowing me. Will they ever remember my name? No. Will they recognize me in a crowd of people? Maybe. Will they remember the fun we had? Probably not. But the true question: Was it worth the experience? Yes!



Samuel Vukov, PT, DPT, GCS, is a 2014 graduate from St. Catherine University's Doctorate of Physical Therapy Program. Sam completed the geriatric

residency at the University of Minnesota in 2015 and went on to earn his GCS the following year. He currently works at Colonial Acres in Golden Valley, a part of Covenant Retirement Communities. Sam has many years of experience working with and befriending older adults and he is a model advocate for them.



Becky Olson-Kellogg, PT, DPT, GCS, CEEAA, is the Program Director of the Geriatric Clinical Residency, and an Assistant Professor and Associate Director in the Division of Physical Therapy at the University of Minnesota.

She has 25 years of experience working with older adults, teaches continuing education courses nationwide, and is serving as a Board Member of the Residency Fellowship Education SIG of the Education Section, a member of a national group working on research outcomes for residency and fellowship trained physical therapists, and also serves on the task force seeking specialization for vestibular rehabilitation through the Academy of Neurologic Physical Therapy.

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## The Value of Advocacy

*Sarah Dalton Ortlieb, PT*

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I was privileged on behalf of the Academy to join over 270 colleagues and students in Washington, DC recently for the APTA Federal Advocacy Forum. The Forum included education on current health care and physical therapy government and regulatory issues, as well as a day spent meeting with individual members of Congress. Attendees were organized by state and when possible, by district to best align meetings between constituents and their appointed leaders. We were briefed on co-sponsors and voting history for active physical therapy related issues and provided educational materials to leave behind.

As a part of the Ohio delegation, our meetings were primarily aimed at advocacy for specific APTA supported legislation—repeal of Medicare B therapy caps, the inclusion of PTs in the National Health Services Corp and Sports Medicine legislation. Fundamentally, however, our goal was to compel our elected leaders to make decisions that

value physical therapy as much as both we and our patients do. Value is defined as the relative worth, merit or importance; or to consider or rate highly.<sup>1</sup> Hundreds of Hill visits were made and while not all can be considered “wins” for the value of physical therapy; there are some objective measures that give merit to our advocacy efforts. Since the Forum, the legislation promoted gained co-sponsors in both the House and the Senate, an important step in moving a bill closer towards law:

**Medicare Access to Rehabilitation Services Act** (H.R. 807/S. 253-Repeal of Medicare B caps)-Gained an additional 31 House co-sponsors and 5 additional Senate sponsors;

**Sports Medicine Licensure Clarity Act** (H.R. 302/S. 808)-already passed by the House, this bill was introduced in the Senate following the Forum and has gained 12 co-sponsors;

**Physical Therapist Workforce and Patient Access Act** (H.R. 1639/S. 619)-Gained an additional 31 House co-sponsors.

In addition to speaking on specific policy issues, our group encouraged our Congressional leaders to maintain Rehabilitation Services as an essential health benefit in any potential legislation aimed to repeal and replace the Affordable Care Act. Since our visits, we have seen the passage of a bill in the House that could allow states to opt out of mandating that insurers cover physical therapy as one of the 10 essential health benefits in health care plans. There are also proposed Medicare rules for many post-acute care settings that could further limit access to physical therapy services to many of the patients we serve.

Overwhelmingly, the Hill meetings our Ohio group had were positive. The leaders or their aides requested further information on certain issues

and responded with genuine interest. Following our visits, it has been personally rewarding to find that many of the Representatives we met with decided to co-sponsor the bills we discussed. That is great news! However, it made something very clear—we need more voices!

“Value over Volume” has become one of the most prevalent themes in health care reform, but relative to advocacy, our motto must be “Volume generates Value.” Our voices in large numbers, with real stories about quality and cost-savings, research and outcomes, patient satisfaction and improved quality of life clearly demonstrate the value of physical therapy. Just as you feel it is important to your profession and practice to be a member of the APTA and the Academy, I encourage you to value advocacy as an essential responsibility of your role as a physical therapist. Together our voices will define physical therapy as worthy and an important part of our health care continuum.

## REFERENCE

1. “Value.” *Merriam-Webster.com*. Merriam-Webster, n.d. Web. 5 May 2017.



Sarah Dalton Ortlieb, PT, serves as the Vice President, Rehabilitation Services for National Church Residences, a provider of senior living housing and

health care services. In this role, she is responsible for the management and development of rehabilitation services including physical, occupational, and speech language pathology provided at the organization’s skilled nursing, assisted living, independent living, home health, and outpatient care levels.



# Scenes from APTA NEXT June 21-24, 2017–Boston, MA

## Congratulations to our APTA 2017 Honor and Awards Program Recipients!

Ethel Frese, PT, DPT, FAPTA, Catherine Worthingham Fellow of APTA  
 David M. Morris, PT, PhD, FAPTA, Catherine Worthingham Fellow of APTA  
 Cheryl Resnik, PT, DPT, FAPTA, Catherine Worthingham Fellow of APTA  
 Tamara N. Gravano, PT, DPT, Lucy Blair Service Award  
 Ellen R. Strunk, PT, MS, Lucy Blair Service Award  
 Cathy Haines Ciolek, PT, DPT, Marilyn Moffat Leadership Award  
 Deanna Wanzek, PT, Henry O. and Florence P. Kendall Practice Award  
 Myles Quiben, PT, PhD, DPT, MS, Dorothy Baethke-Eleanor J. Carlin Award for Excellence in Academic Teaching  
 Brendon Larsen, SPTA, Mary McMillan Scholarship Award for Physical Therapist Students  
 Leah Huber Wright, SPTA, Mary McMillan Scholarship Award for Physical Therapist Assistant Students



Award recipients were recognized during the Honors & Awards Ceremony at NEXT. Pictured above are Ellen Strunk, Cathy Ciolek, Tamara Gravano, and Myles Quiben.



The Foundation presented the 2017 Premier Partner in Research Award to the Academy at the Foundation Awards Luncheon. Accepting the award on behalf of the Academy were President, Bill Staples and Vice President, Jill Heitzman.



AGPT Membership Chair, Ron Meade and Tamara Gravano.



Academy of Geriatric Physical Therapy Delegate, Ellen Strunk represented us well at the APTA House of Delegates.



The Academy booth at NEXT 2017.

# CALL FOR NOMINATIONS

## Academy of Geriatric Physical Therapy AWARDS 2018



### **Student Research Award**

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

### **Clinical Educator Award**

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

### **Fellowship for Geriatric Research**

Recognize physical therapists pursuing research in geriatrics which may be conducted as part of a formal academic program or a mentor ship.

### **Excellence in Geriatric Research Award**

Honor research published in peer-reviewed journals based on clarity of writing, applicability of content to clinical geriatric physical therapy, and potential impact on both physical therapy and other disciplines.

### **Adopt-A-Doc Award**

Recognize outstanding doctoral students committed to geriatric physical therapy, provide support to doctoral students interested in pursuing faculty positions in physical therapy education, and facilitate the completion of the doctoral degree.

### **Clinical Excellence In Geriatrics Award**

Recognize a physical therapist for outstanding clinical practice in geriatric health care settings.

### **Distinguished Educator Award**

Recognize an Academy of Geriatric Physical Therapy member for excellence in teaching.

### **Outstanding Physical Therapist Assistant Award**

Recognize a physical therapist assistant who has significantly impacted physical therapy care in geriatric practice settings.

### **Lynn Phillippi Advocacy for Older Adults Award**

Recognize projects or programs in clinical practice, educational, or administrative settings which provide strong models of effective advocacy for older adults by challenging and changing ageism.

### **Volunteers in Action Community Service Award**

Recognize the exceptional contribution of a physical therapist or physical therapist assistant in community service for older adults.

### **Joan Mills Award**

Presented to an Academy of Geriatric Physical Therapy member who has given outstanding service to the Academy.

**Nominations are due November 15, 2017 and all awards will be presented at the Academy Membership Meeting at CSM in February of 2018.**

For additional information on the criteria and selection process for academy awards, please visit the Academy of Geriatric Physical Therapy website at [www.geriatricspt.org](http://www.geriatricspt.org) or contact the office by email at [karen.curran@geriatricspt.org](mailto:karen.curran@geriatricspt.org) or by phone at 866/586-8247

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