

# GERI NOTES

Academy of Geriatric Physical Therapy

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## IN HONOR/MEMORIAM FUND

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

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

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

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

# President's Message

Greg Hartley, PT, DPT, GCS



"If you're not at the table, you're probably on the menu." This memorable quote is believed to have originated around 2000 in Washington, DC, but its true

origin is unknown. It has been popularized by Sen. Mike Enzi (R-WY), Sen. Elizabeth Warren (D-MA), and others. Its meaning is clear...if you are not represented at the decision-making table, you are vulnerable, left out, or worse.

The term *advocacy* has multiple connotations. As physical therapists (PTs) and physical therapist assistants (PTAs), we advocate for our patients individually by talking with caregivers, physicians, nurses, case managers, insurance representatives, durable medical equipment vendors; or simply by writing high quality treatment notes that justify continued skilled care. That is a routine part of our professional lives, yet it is also implicit advocacy. We advocate for specific conditions, syndromes, or foundations--like Alzheimer's disease, falls prevention, bone health, or Parkinson's disease--by fund-raising or holding events that increase public awareness. We advocate for change within our profession and our association via the House of Delegates. And we advocate for changes in policy, rules, regulations, or laws via the legislative process.

It is this last piece I want to focus on. Congress has the power to change or create legislation. Most times, these types of changes come after years of advocacy. The perfect example is the recent permanent repeal of the "therapy cap." This legislation, included as a part of a budget act, repealed the arbitrary hard cap on therapy services under Medicare Part B. After more than 20 years of advocating for change, the permanent "fix" was passed into law this year. But it came at a price. Last minute negotiations added a payment differential for PTAs (and OTAs) that will become effective in a few years. This issue has al-

ready become another point of advocacy.

Congress also passed legislation requiring the Department of Defense (DOD) to create a rule that allows PTAs to treat patients with TRICARE (active duty military and their covered dependents). This legislation simply mandates that DOD create the rule. It did not automatically add PTAs to the list of providers authorized to treat these patients. So now, the DOD must write the rule, seek public comment, and get various agency approvals before it can implement the change.

The Department of Health and Human Services (HHS), which oversees the Centers for Medicare and Medicaid Services (CMS), has broad authority to make policy changes that do not require Congressional approval. The CMS issues proposed payment rules annually for all settings like skilled nursing, inpatient rehabilitation, home health care, acute care, and outpatient. When initially released, the rules are "proposed" and, like the DOD mandate, are open for public comment. These comments can result in changes to the proposed rule before it becomes final. Recent payment proposals that have been changed as a result of active public comment include those for home health and skilled nursing.

My point is this...your advocacy matters. Your comments matter. Your input makes a difference. But without that input, we tacitly permit all of these changes to occur. Sometimes the changes are good. Sometimes our patients suffer as a result of those changes. Sometimes we, as professionals, suffer as a result. But being silent, and not advocating for your patients and your profession is ignoring the potential the changes stand to make on the delivery of quality care. As much as we talk about "patient centered care," "payment centered care" is looming in the background. I would argue we all can identify with that. I would also like to believe that we can agree this is not how it should be.

There are several issues on the horizon that should be of interest to AGPT's members including legislation

related to Medicare private contracting, telehealth, essential health benefits, health information technology, quality payment programs, Medicaid reform, Medicare post-Acute Care reform, skilled nursing facility payment changes, home health payment changes, and more! See all the federal legislative and regulatory issues at <http://www.apta.org/FederalIssues/>.

I challenge AGPT members to do more. Since we focus on treating aging adults, at least part of the time, our patients are perhaps the ones most affected by federal policy and legislative changes since nearly all of them are impacted by CMS in one way or another. While the advocacy we do on an individual level should continue, and the fundraising we do on behalf of wonderful foundations should not stop, we need to become accustomed to advocating by making comments when requested, contacting our Representatives and Senators, and/or donating to **PT-PAC** (<http://www.ptpac.org/home.aspx>). Simply put, this is how things get done. We have a voice on Capitol Hill. But our profession could have a much louder voice if we were all advocates. Do not have time to write comments? Don't feel comfortable calling your congresswoman? Use **APTA's Action App** (<http://www.apta.org/ActionApp/>). In 3 or 4 clicks, *BAM!*, you are an advocate! *It cannot get much easier than that!* Do not want to download the App? Then donate to the **PT-PAC**. If every PT and PTA in the United States gave just \$20 a year to **PT-PAC**, we would have the largest health care PAC in the country! So, make comments. Call your legislators. Use the **Action App**. Or give whatever you can to **PT-PAC**. Our patients, our profession, and our future depends on it. Remember, *if you're not at the table, you're probably on the menu*. Please join me at the table.

# Editor's Message: Words Matter and the Word of the Day is "Volunteer"

Michele Stanley, PT, DPT



“Summer is so busy!” And it is. “Documentation ruins the fun of being a therapist.” Certainly, this can also be true—especially when you are eager to leave the

job and get on the lake, golf course, bike trail...during this brief and coveted summer time. This issue looks at two very critical issues for our profession from several different perspectives. Health care is undergoing tremendous changes, particularly with regard to issues of payment, federal regulations, and the burgeoning needs for service as the population ages. There are things that each of us can, should, need to do to continue to make our profession viable and, more importantly, to truly serve the needs of our clients who depend on us. The President’s Message spells out the urgency of this as well as giving specific and easy ways to start by being an advocacy volunteer. Tamara Gravano gives a blueprint for volunteering within this Academy and makes it look easy and fun. Patty Antony demonstrates the financial and networking gains to volunteerism. Ruth Meyer details a simple to implement volunteer-based program that sets up an EBM community falls reduction project. (It is time to plan *your* Fall Prevention programming). The Practice Committee (all volunteers) is working on insanely important advances to our evidence-based practice guidelines, reimbursement issues, and much more. Say “yes” and help make history if called upon to help with a quick micro-volunteer assist – even better, follow one of the links and pick something that you are interested in. Every single article or story in this issue is the result of volunteers. You are invited to write a report of your experiences volunteering within the APTA umbrella or as a

physical therapist or as an advocate for patients, family, and friends.

The electronic medical record, EMR, is both a blessing and a curse in the professional lives of most physical therapists today. We love that we do not have to worry about legibility and spelling, and hate that it consumes so much of the time that we would rather be working directly with our patients/clients. The words that we choose when documenting make the difference in funding our services, just as the words that we use make a difference in our ability to teach our clients (particularly if they have a cognitive deficit). Words color our relationships with the people with whom we work and our attitude regarding our own aging (like death, documentation responsibilities, and taxes...). Multiple articles in this issue deal with the importance of words and will, hopefully, help you change your approach to taking care of paperwork. The process of documentation helps each of us become better, more thorough therapists...see the well-reasoned articles by Jackie Osborne and Ken Miller’s group. If you are not fully aware of the problems of ageism embedded in popular lexicon or the FrameWorks project on aging, check out Cathy Ciolek’s summary and get more resources for yourself here: <http://frameworksinstitute.org/reframing-aging.html>.

I grew up in a small rural town and in a family tradition that values community service: I am a volunteer EMT, emergency services technician, for a different small town. This gives me a specific set of experiences with the opiate problem. I have administered Narcan (naloxone HCL) to those suspected of a narcotic overdose, generally with life-saving results. It is scary. The presumption, when addressing the opiate problem, is that this is a disease of the young/younger/mid-life adult. The reality is that narcotic overdosing is also

a frequent problem of the older adult. Cognitive/memory deficits and chronic pain syndromes often result in less than pristine self-medication administration, add poly-provider and poly-pharmacy to the mix and there is a disaster in the making that is every bit as devastating as the 20-something looking for a high from a bad batch of white powder. As a physical therapist, particularly when I worked in home health, the medication mistake overdose was the more common situation than intentional ingestion. Calling 9-1-1 is only as effective as your distance from the nearest dispatched station. In rural areas, particularly in the northern part of my state but anywhere that is affected by bad weather, traffic/road obstructions, the response time can be *too long* from discovery to rescue. I hope that none of you will ever be in that powerless situation. We cannot change where our patients live relative to the nearest fire/emergency medical station. You do not need to be powerless. Most states have offices of emergency management, OEM, that provide or can direct you to free or low-cost classes to teach lay people how to administer naloxone...and usually to provide you with a prescription for obtaining a kit. Some areas provide people taking the class (usually less than 2 hours long) with naloxone. I urge all of you to contact your local OEM (the county Sheriff’s office is another source of classes), take the class, and volunteer to be able to help your patients or community members or family should they be in the situation of an overdose where minutes count. Be safe out there.

*“Nobody can do everything  
but everybody can do something.”*

Find your something. Volunteer.

# Volunteering is Addictive

Tamara N. Gravano, PT, DPT, EdD

Volunteering is addictive. Don't say I didn't warn you. The first time I raised my hand to volunteer was in 2003; I was at a Florida Physical Therapy Association (FPTA) business meeting for the Southeast District, which covered the Keys to Palm Beach County. They were looking for an individual to take the place of the outgoing treasurer. I was a new graduate with my MSPT, just started my transitional DPT, and recently had begun my geriatric residency. I was enthusiastic about learning all I could about the American Physical Therapy Association (APTA) and desperately wanted in. So I raised my hand. I made it through graduate school and figured that I could learn accounting too. Turns out, accounting was the smallest part of what would become one of the best decisions I ever made.

## FPTA: SOUTHEAST DISTRICT TREASURER

I met with the outgoing treasurer twice to review the spreadsheets and banking details and made him promise to let me call if I had any questions. Then he handed me a large plastic storage tote filled with files. I was required to attend and report at all 4 Southeast district meetings as well as the state meetings. I had examples of previous reports to guide me, which were thankfully short, because I was a little nervous about speaking, but after the first couple of meetings, I continued to get more comfortable. I enjoyed being on the inside and felt like I was contributing to the direction of the FPTA. My experience as treasurer allowed me to network and begin to make connections that exist to this day. The support from the rest of the FPTA leadership gave me the confidence to speak up and voice my opinion in a venue that made a difference. Then I wanted more.

## NATIONAL PHYSICAL THERAPY BOARD EXAMINATION

One day I received an email from the APTA to its membership looking for volunteers to help write questions for the National Physical Therapy Board Examination. The APTA would provide hotel and travel to their headquarters in Alexandria, Virginia in exchange for one weekend of someone's time. It seemed like a fair deal to me; who could resist a trip to the Mecca for physical therapists?

Test items are written by a group of volunteers who have various levels of physical therapy (PT) experience and clinical expertise, and sessions are facilitated by expert item writers. The experts have years of item-writing experience and teach the group about how the examination is created, managed, and scored, as well as how to write exemplary test questions. I learned so much about the exam during that weekend and met some of the leaders in the field whose names I remember reading in journal articles and textbooks in PT school. I returned home with an even larger network of colleagues that I admired as well as a goal to write 30 questions in 6 months.

## JOURNAL OF GERIATRIC PHYSICAL THERAPY

It was a good thing I saved my textbooks, but also as a new academic, I had access to newer editions and journals, which helped me keep my questions current. When I was in PT school, one of my goals for professional growth was to read one journal article a week. Let us just say that I did not quite make it. However, after my residency, despite regularly receiving the *Physical Therapy Journal (PTJ)* and the *Journal of Geriatric Physical Therapy (JGPT)*, both would go on a shelf, usually unopened. I knew I should read them, but I never made time. When I saw the call for journal article reviewers, I seized the opportunity to meet my

goal, improve my practice, and serve my profession. After a brief training meeting at CSM, I was invited to log in to the reviewer's portal for the *JGPT*. After briefly setting up my profile with my content area interests, I was assigned my first article. Articles are assigned sometimes once a month, more or less, to 3 blinded reviewers with a two-week deadline. Before the articles are published, the reviewer receives copies of the feedback letters with all of the comments from all reviewers. Forty-three articles later, I am proud to say that this volunteering endeavor has been extremely educational. Not only have I brushed up on my evidence-based practice, but I have kept up with the *JGPT* over the years using this strategy.

## SPECIALIZATION ACADEMY OF CONTENT EXPERTS

After completing my transitional DPT and my residency, I passed the board examination and continued to practice clinically. It did not take long before a letter from the American Board of Physical Therapy Specialties (ABPTS) arrived, asking for volunteers to write questions for the GCS examination. The ABPTS would provide travel and one night's stay for this group of item writers or Specialization Academy of Content Experts (SACE) to meet at CSM one day before programming to write items for their specialty area. Having recently passed the exam, I wanted to discover how the specialty exam worked, as well as brush up on my own item writing skills, so I applied and was accepted.

The day of the SACE meeting was unlike anything I expected. There was well over 100 physical therapists, grouped together by specialty at round tables spread across a large ballroom. I was worried about walking into a room full of colleagues that were all smarter than me, that somehow they would find out and revoke my GCS. It was not like that at all. Again, there were

physical therapists with many more years of experience, but the atmosphere was supportive and non-threatening. After a presentation on how to write items for post-professional specialty practice, I noticed some differences in the test construction as well as the difficulty of the specialty questions compared to the National Physical Therapy Board Examination (NPTE). I enjoyed writing specialty items for SACE more than entry-level items for the NPTE. I could rely on my clinical experience to develop cases based on previous patients and weave meaningful questions that concentrated on the most important parts of my specialty. Compared to the NPTE, it felt more like home, and I adored it. I stayed on SACE for two years, and was thrilled to meet so many colleagues much smarter than me. I viewed it as a learning opportunity, and was building a large community of like-minded, passionate physical therapists to continue to grow with. More on this later...

### **AMERICAN BOARD OF PHYSICAL THERAPY RESIDENCY AND FELLOWSHIP EDUCATION**

Around the same period, I received an email from the American Board of Physical Therapy Residency and Fellowship Education (ABPTRFE), which, at the time, had a much shorter name, seeking volunteers to conduct accreditation site visits to developing residency and fellowship programs. Training would take place at CSM on how to review a program to determine if it met the accreditation standards for curriculum, patient variety, mentoring, and other requirements. As a residency graduate and now residency coordinator, I had a solid understanding and a firm foundation of how residency education worked—for me in my program. But I was intrigued with the idea of traveling to other sites to see how they did it, so I applied.

At CSM we were given thick binders, each with an application of a program that had volunteered its documents for training, then we were instructed how to compare its lengthy, narrative, written responses on the application to the minimum criteria expected. It was a real shock to see how many different ways there were to design a program and how different the paths to the same standards

were among and between specialties. After getting approval for my reports, which meant finding the areas where criteria were either met or not met, I was excited to shadow a mentor on my first site visit. Over the two-day visit, we toured the facility; observed a resident mentoring session; poured through their exams, meeting minutes, and other documents triangulating information provided in the application. We met with administration and program faculty and talked about how they found solutions to barriers.

I learned so much at that site visit. I wanted to keep learning more, so I accepted every assignment the ABPTRFE offered. The number of inspiring residency program directors, residents, and fellows that I have met continues to grow. Despite all of the hours of work put in to reading the applications, visiting the sites, and writing the reports, I felt connected with their dedication to improve patient care through post-professional education. Now, years later, I am on the Board of the ABPTRFE, and our pool of site visitors has grown considerably. Although I do not site visit as often, I relish helping to shape the future of our profession.

### **ABPTS GERIATRIC SPECIALTY COUNCIL**

My experience with SACE and NPTE helped open the door to the Specialty Council. The Specialty Council administers the specialty examination, and there is one council for each specialty. When I applied to join the Geriatric Specialty Council, it was a long shot, but I was having so much fun writing items, I wanted to get involved deeper. Surprisingly, I was chosen and began a 3-year journey of running the geriatric SACE meetings at CSM, teaching others to write items, reviewing and formatting test items, and meeting with the rest of ABPTS to shape specialty practice. The updated Geriatric Description of Specialty Practice (DSP) was due out that year and the 3 of us on the council worked together to get the final document published. We held regional item writing courses outside of CSM to help build the pool of test questions. In addition, we went to Philadelphia to determine the cut score for the examination, which is an enlightening experience in itself. Imagine taking the GCS exam all

morning with a group of peers, and then deciding on the passing score. Turns out there is a whole statistical process behind it all. The best part was CSM, where the council members get to congratulate the new GCSs on stage. I still remember shaking Dale Avers hand when I got my GCS. I wonder if the new GCSs knew how truly happy I was to shake their hands.

### **CERTIFIED CLINICAL INSTRUCTOR**

Besides my volunteering in the APTA, I also found myself seeking greater responsibility at work by training to be a Clinical Instructor and supervising several student interns over the years. I loved teaching in the clinic so much that I became a teaching assistant part-time at my alma mater, the University of Miami, in the neuro-anatomy labs, complex patient courses, and clinical skills labs. Fortunately, I was able to change my work schedule to Tuesday through Saturdays to accommodate Monday classes. Later, this turned into the experience I needed for a full-time role in academics. I enjoyed clinical education so much I trained with the APTA to teach Credentialed Clinical Instructor courses to individuals just like me, who wanted to ascertain how to better serve their students in the clinic. This all began by volunteering to take that first student, as well as a creative manager that valued professional growth and service to the profession.

### **ACADEMY OF GERIATRIC PHYSICAL THERAPY**

But wait, let us not forget about the Academy of Geriatric Physical Therapy. It was not until 2009 that I volunteered to be a member of the Membership Committee. As usual, at the AGPT, also known as Section on Geriatrics, business meeting at CSM, there was a request for volunteers for several committees. I selected the one that best matched my personality and skills at that point in my career 7 years post-graduation. One of the reasons I first started volunteering was to grow my professional network, and the Membership Committee was the perfect venue to meet other physical therapists who have a passion for geriatrics. While some physical therapists may have thought this too soon to join a national committee, I saw

it as a chance to jump in with both feet, learn a lot about my specialty area, and expand my network.

### AGPT MEMBERSHIP CHAIR

One year later the Membership Committee Chair stepped down and asked me to take his place. What a learning curve that was. The rest of the AGPT Board was so supportive and quickly helped me get up to speed. Right away, I was planning for and attending both CSM and NEXT, arriving early to set up the booth in the Expo hall and meeting physical therapists, physical therapist assistants, and students from all across the country who wanted to learn more about our Academy. Every year became easier and easier. Again I found a home with the AGPT and group of dynamic leaders in the field. I thoroughly appreciated the opportunity to work with the AGPT leadership. After 7 happy years, I was pleased to pass the torch to Ron Meade and take a mentorship role while I focused on other areas of professional development.

### AGPT RESIDENCY AND FELLOWSHIP SUBCOMMITTEE; R/FSIG

Right around the same time, the AGPT Practice Committee was looking for someone with experience in residency and fellowship, so I put my knowledge of the ABPTS and ABPTRFE to work to help the AGPT navigate the new educational landscape of post-professional practice. Chairing the Residency and Fellowship subcommittee was a natural fit and coordinated well with the other subcommittees, mostly because we had excellent leadership under Greg Hartley, now AGPT President. This subcommittee later became the Residency Fellowship Special Interest Group and has been growing as a resource for new and current geriatric residency programs. After two years, my plate was about to overflow as I was finishing my dissertation in leadership studies and I helped the R/FSIG transition to a new chair who could continue to move the SIG forward.

### AGPT CERTIFIED EXERCISE EXPERT FOR AGING ADULTS (CEEAA)

As you may know, many of the faculty of the CEEAA have or currently

hold leadership roles in the AGPT. Because I was deeply involved in the AGPT, I was highly visible when the CEEAA course needed more faculty to meet demand. Recently, I had received my own CEEAA certification and had been teaching geriatrics for a few years in my DPT program so I felt ready to commit to the training and travel required. Similar to the *JGPT*, I saw it as an opportunity to stay up-to-date in geriatrics and serve my profession. Teaching CEEAA has been one of the most gratifying experiences of my professional life. It is an honor to work alongside so many others who demonstrate their dedication and passion for geriatrics.

### IT ALL STARTS WITH YOU

Now you see that volunteering starts with you. Once you volunteer for the first time and give it your best, the opportunities come to you. Then you can begin honing the professional development that excites you. With so many different ways to volunteer, you can quickly enhance your own portfolio. I realize that not everyone can or wants to volunteer as much as I did, everyone has different reasons to give back. But, it is important that you choose committees that fit your professional goals and interests. Do not just ask to get involved because someone told you to. Also, you will not be left to figure it out alone; the AGPT and other APTA committees all have a vast support network of experienced members who can and will help you succeed.

Bottom line: It is easy to volunteer. The AGPT webpage links to available openings that are updated at least annually <https://geriatricspt.org/volunteer/>. You can also peruse the available Special Interest Groups, and if you have not already joined one as member, reach out to the Chair and express an interest to volunteer for a task or project. This works especially well at meetings, right when the action is being discussed. I can tell you that no one likes to hear the crickets when laying out a plan of action, so speak up, take on a small task and see how you like actually making a difference in your profession. Go to your local, state, and national meetings and look for ways to contribute that interest you.

Do not forget about social media. The AGPT is active on Facebook and Twitter and is a quick way to stay in the loop and to look for ways to help out. Comment or tweet back any interest you have in making your ideas happen. Take a continuing education course in geriatrics and you will meet physical therapists who share similar interests and may find ways to expand your network even wider. The greater your network, the more opportunities arise for you to collaborate on projects, perform research, provide community health screens, and more.

It is acceptable to leave a committee and pursue other interests. I, like many others, have benefited from stepping away for a while to mentor new leaders. Besides giving others a chance to develop this aspect of their career, an influx of fresh ideas is good for growth. Committee work is not a life sentence, but *life changing* when you find your fit.



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# The Art of Networking for Physical Therapists

Patrice Antony, PT, GCS

In this day and age of advanced technology, social media, and computer connection, I am still mind boggled at how little physical therapists seem to know about the art of networking. As a business owner, I have to be ever mindful of how to elicit referrals to stay alive. Networking, however, is a whole different animal. Whether you work as a private practitioner or even if you work under the employ of a company, EVERY physical therapist needs to know how to effectively network. There is no better way to get the word out about what we do than becoming a part of a network.

Networking can be defined as an arrangement of people crossed at regular intervals by other people, all of whom are cultivating mutually beneficial give and take, win-win relationships with each other. Please note that the key word here is relationships. Networking is NOT about soliciting business for yourself or your company. It IS about developing relationships with others to develop trust, friendship, and knowledge about each other's skill set. It is a known fact that people refer to people that they like, know, and trust. On the other side of that, the receiver of the referral has to be able to deliver on what they offer.

Relationships take time and contact to develop. You cannot go to one event one time and call it networking. To effectively network, you have to invest time to consistently have contact with the people you are trying to network with. This means repeated contact – the more often the contact, the more effective the networking. You will be surprised at how many networking groups there are in your community. For example, rotary groups are just about everywhere and meet weekly--whether it is breakfast, lunch, dinner, or happy hour. These are generally business owners in a community working together to better the community. It is not a requirement, however, to be a business owner to be a Rotarian. Anyone can join a rotary group. It is a

great way to see who the movers and shakers are in a community and become a mover/shaker yourself. It is also a way to give back to the community. There is an added benefit in that it presents a phenomenal way to get the word out to your community about who you are and what you do. In all the years that I have been going to networking meetings, I have yet to meet another physical therapist doing the same thing. Why is this? Do we just assume that everyone knows what a physical therapist does and where to get the service? Our profession is completely missing the boat here....

What are the benefits of networking? First and foremost, you build friendships. Just having breakfast or lunch with the same people every week will inevitably make you some new friends. With friendships, you find common ground to build trust with. You make connections with more new friends through those friends. You learn more and more about your own neighborhood and what is going on outside your own little working world. You learn about other industries and job openings. You learn about trustworthy people to call for things that you cannot do yourself. (As a single woman, I find this one of the best benefits of all.) You learn how to refer to others, and in turn, others learn how to refer to YOU.

Let's start with some networking group basics:

1. **The first step is to find a group that you feel connected with.** Research the internet to find networking groups and when they meet in your community. The website [www.meetups.com](http://www.meetups.com) might be a good place to look. Every town has a Chamber of Commerce, Elks club, or Rotary club. There are women's networking groups, men's groups, and networking groups for particular businesses or industries. (Physical Therapy has Pub Nights

for physical therapists who just want to network with each other.) The best rule of thumb is to look for a group that will offer you exposure to complementary businesses that could offer mutual benefits to your line of work. For example, if you are a geriatric physical therapist, you might want to look for a group that has hospital administrators, social workers, nurse practitioners, nursing home administrators, assisted living marketing people, elder law attorneys, etc as regular attendees to the meetings. There are generally group leaders that you can contact to discuss the format and purpose of the meeting as well as who is likely to be attending. Every group will allow you to visit for one or two meetings as a guest.

2. Once you find a group that you feel comfortable with, invest the time! Be an active member. Get involved. I cannot tell you how many patient referrals I have gotten because I flipped burgers with a financial planner at a Rotary fundraiser. When you have to spend a few hours flipping burgers, you have to talk about something. After talking about family and how we got into Rotary, we got more into what we each do for a living and how we could refer to each other. The friendship made during an act of serving the community led to referrals from a source I had never thought of tapping. That friendship led to introductions to other financial planners, and well, you can see where this is going. The main thing is that I made a friend. Someone I can trust sending my clients to and vice versa. I see my friend every week at our meeting so our faces are fresh in our minds when a client needs help...
3. Make sure that the group you choose to network with meets with realistic hours for your time availability. If your boss is not going to let you

leave for lunch once a week for an hour plus, then you may want to join a group that meets in the early morning before work starts or after hours. You may need to work with your employer on the benefits of networking. Consistent attendance at the meetings is crucial. People will not remember you if you are an infrequent visitor.

4. The more variety of backgrounds in a given networking group, the more opportunity you have to share what you do with more people who may have absolutely no idea what a physical therapist does. Do not worry about getting referrals from people who work in construction or are office clerks. We see these patients every day – do we not? The key thing is that they need to see YOU. They need to develop a relationship with you such that your name and profession is first on their mind when they know somebody in need of your services. YOU need to be able to do the same for them in their line of work. It is a two-way street.
5. Networking happens with ANY group – it does not have to be official business networking. It can be the PTA at your child's school, the soccer mom group, booster clubs, or even your softball team, golf group, or tennis club. In fact, these may be the best networking groups for a sports medicine physical therapist.

Now let's talk about the ART of networking for newbies:

1. Begin by observing the people in the room. Look to see who the influential people are. There will always be one or two people who seem to have a little group around them hanging on every word. These are ultimately the people you will want to know. If you are a little shy or uncomfortable, then introduce yourself to others who look a little lost themselves.
2. DO NOT run up to people with your business card in hand. This feels like a sales pitch strike and is a definite turn off. Instead approach softly and give your name with a warm handshake. Let this person know that you are a first timer to

the group. You will find that most people immediately take you under their wing and start to introduce you to others.

3. **Do not try to meet everyone in the group.** Pick one or two people to have some substantial conversation with. It is easier to remember their names, and you will be able to fit into the group better with one or two "friends" that you had time to talk to when you come back to the next meeting.
4. **This is very important! Try to lead the conversation by asking questions of your new acquaintance.** Questions such as, How long have you been with this group? How did you come to join them? What do you do for a living? These are all good ways to get someone talking. The important part is that you get the person talking about him or herself and *you listen*. Make mental notes to help you identify this person so you can greet him or her by name later. You do not want to interrogate them, but you do want to genuinely get to know them.
5. **If the person starts asking about you, be brief with your answers and try to flip it back to her.** People love to talk about themselves. They are flattered to have an audience. This is the best way to make an impression. They will remember your conversation better, ironically, if the conversation is all about them. You know you have really succeeded when the group is breaking up and your new friend says "But I don't even know what you do...."
6. **Try to find out as much as possible about what the new friend's business is and how you can send him or her referrals.** This is crucial. You do not want to force this too early in the conversation, so maybe start with the background and how they came to be selling "widgets." Once they tell you what they do, ask them what kind of referrals they are looking for and how you can help to find them. For example, an IT person might say – "look for someone with sticky notes all over their computer. That person needs my help." Note that you have not yet talked about your business. This can wait until the next meeting....

7. **The next crucial step is to ask for their business card.** This will help you cement the name and the business in your head. Hold onto the card. You will need it for follow-up. The friend may ask you for your card, and give it by all means, but know that your card will likely be discarded after this meeting.
8. **Develop a 30-second elevator speech.** You want to **describe what you do** as succinctly as possible. Many networking groups have an introduction time where everyone in the room gives their name and a 30-second description of what they do. DO NOT say "I am a physical therapist". That is a title – not a description. More appropriate might be "I help people with back injuries get out of pain" or "I help seniors and their families find solutions to falling issues." You will be amazed at how many people want to hear more with this type of teaser.

**Follow-up is crucial in the ART of networking:**

1. Once you get back to your office, try to **send a handwritten note to the new friend.** This is where that business card you got from them comes in. If you really want to make an impression, have personalized note cards printed with your business or your professional title and address printed. These can be done very inexpensively with an online printing service if your company does not have any available for your use. The note does not have to name your business if the business gets "hinky" about use of their name and logo. **It does need to identify YOU.** Hand write a note such as "Hey Joe. It was really great meeting you and getting to know a little about your company. Thanks for making me feel so welcome. I'm looking forward to seeing you at the next meeting. Sincerely, YOU." **Do NOT enclose your business card with this.** If you use a personalized notecard, your information is already on it. You really want to genuinely thank that person for his or her congeniality. You still are not ready to sell yourself. Think about it. How would you feel about getting such a note? Who does

this anymore? It makes a HUGE impression. You are already starting to stand out..... This should be standard practice with every new person you meet. It sounds time consuming, but it is really not for the benefits that come with that impression.

2. **DO NOT just email the person.** The email will get deleted. Hand written notes get remembered and often saved. Emails get caught in spaminators. Your information is far more likely to get into their contact list with just a personal thank you—and you have not even talked about yourself yet.
3. **DO email people to maintain the connection.** Let them know you are returning for the next meeting. They will be looking for you! Send them an article or website that is relative to THEIR business that you thought they may be interested in. Ask them if it is ok to share their information with people who are interested in their services. **DO NOT give solicitors their information and make sure that they know you would never do this.** You do not want new friends getting marketing calls that are coming from your referral. You only want to share the potential new business referral for the new friend. Better yet, call the new friend and describe the referral to be sure he or she really wants it. Ask permission to give the referral their information. This does 2 things: it puts you in contact with the new friend yet again and puts you in the spotlight as a referral source. Even if the referral is not one that they want, they will remember YOU for making the effort. That is huge. Do not force this if you really do not have anyone to refer.
4. **At the next meeting, greet your new friend by name.** Let the conversation flow. Your new friend is likely to ask you about yourself and this time feel free to talk about yourself. **Do NOT offer a business card unless one is asked for.**
5. **DO ask your new friend to introduce you to more new friends.** Repeat the same process as you did for the first new friend. LISTEN well. Follow-up with thank you notes and try to refer to the new

businesses. **DO NOT ask for referrals for yourself at this point.**

What's key with all of this is to learn to refer to others, NOT to sell yourself. **Your interest in their businesses will pique their interest in yours.** It all takes time and consistent contact to work, but it is the most effective marketing you can do.

#### **Positioning yourself as an expert:**

1. You will find that you may be the only medical person in your networking group. This puts you at a distinct advantage. People, as they get to know you, will start asking you for help with their medical issues. Like it or not, you will suddenly become the “411” for medical services for your friends. That is ok. Refer them the best that you can. The bottom line is that you will get to be a popular member of the group. All good!
2. Find out if the group has a guest speaker list. See what types of speakers they have and what they are looking for. See if you can get added to the list if appropriate. Wait until you have been a member of the group for a few times before you approach this. Ask your new friend how this works so you do not look pushy.
3. If you are invited to speak, pick a topic that is educational. The point is to get yourself seen as an expert, not to sell services. I taught a mini in-service on how to interpret medical labs for practical purposes. It was presented to primarily construction people. They loved it and still talk about it. It is ok to hand out brochures and cards if you are the speaker.
4. Write articles. The APTA has loads of opportunity for this so that you can publish among your peers. You do not have to be a research expert to publish an article. Any practical information that enhances a practice is much appreciated. There are many mentors within the professional organization to help you get started.
5. There are many local community publications that are always looking for interesting articles.
6. Speak with a school that has a physical therapy or physical therapy

assistant program and volunteer to be a guest lecturer. This is a great way to fine tune your teaching skills. Again, the instructors all love to have a guest lecture in their toolbox and will guide you in the process.

#### **Once you have established a relationship with your network:**

1. DO carry business cards with you at all times. Give them out when asked for or as a calling card if you make a stop and miss someone.
2. You will likely find your new friends asking for more information about what you do. Be ready for this. You need to be able to describe your services in short, concrete ways. Give a good example of the perfect client scenario but be brief. Be able to identify how you normally get your clients.
3. If the networking event is at a bar or happy hour, be VERY careful with drinking. Drinking tends to make you more talkative and you want to be more of a listener. Best to have one beverage that is lower in alcohol and nurse it. Better yet to skip the alcohol.
4. DO work the networking group. It is nothing but a social outing if you go sit with people you already know.
5. DO tell people who now know you, the kind of referrals you are looking for. Be specific. “A good client for me is the mom that is hanging on to furniture trying to walk to the bathroom” is much better than “people with balance issues.” “A good client for me is the friend that you notice wincing every time he pulls a shirt over his head” is much better than “people with shoulder injuries.” Put a picture in the person's head that makes him think of someone.
6. Send thank you notes to any and all who refer a client to you – even if it is not the right kind of client. Give the referral source some follow up after the meeting with the new client: “I saw your friend Jim today. I'm going to help him plan for long-term care for his mom. That's a perfect referral for me!”
7. Minimize promotional products. It is great to give out pens and sticky

pads – but who really reads them and refers from them? A carefully chosen thoughtful small gift that you hand deliver may have bigger impact: a humorous coffee mug or coffee shop gift card; a chocolate bar with a hand-written note, golf tees with the doctor's initials, movie tickets for the stressed out receptionist. Gifts should NOT be routine.

8. Health fairs are a great way to get exposure for your company name and brand, but referrals are rare. You can spend a lot of money on booths, candy, promotional products, etc but it rarely brings in new clients.
9. You can feed a lot of doctor offices but they will just ask for more free lunches for their staff. It rarely brings new referrals. It might be a nice thing to do when a new referral is sent but it can get very expensive. You do not want to buy your referrals.
10. Do ask your happy patients to send you referrals. We often overlook this – yet happy campers make walking billboards. I always give my clients a couple of extra business cards and ask them to give them to people they know in a similar situation to theirs.
11. Consider having a community “advisory board” to give you feedback. I will ask about 6 clients and 4 ancillary business owners to a dinner that I host at a local restaurant annually. At that meeting, I will fill them in on new directions that we are considering for the practice and ask their feedback/suggestions for ways to improve our service delivery. The payback on this is huge.

I make sure that 2 of the clients are people who have been UNHAPPY with our services at some point. Being asked to give their feedback changes everything. These people are generally so honored to be asked that they go out of their way to bring us referrals after the meeting. It does not have to be an expensive restaurant but do conduct the event as a meeting with a professional agenda. You want it to be productive, not a grievance session.

Please know that networking is a mindset. Keep service above self at the forefront of what you do; the rest will take care of itself. Networking is NOT about getting referrals, it is about building relationships with people. Referrals are a by-product of networking but not the goal. You do NOT have to be a business owner to benefit from networking. Career advancement and open-door opportunities abound when people know, love, and trust you. You can only develop those relationships by getting out there so people can see who you are, what you are made of, where you are located, and how to reach you. Do not confine yourself to just your work environment. We cannot expect the public to know that we are experts; we have to show them. Broaden those horizons...

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Patrice Antony is a Florida International University graduate who has been practicing physical therapy in the Central Florida area since 1981. Patrice became a Geriatric Clinical Specialist in 1992 and received the *Clinical Excellence in Geriatric Practice* from the Geriatric Section of the APTA in 1996, and the *Advocacy for the Older Adult* award in 2009. She taught as an adjunct instructor in the University of Central Florida physical therapy program for 4 years and has done extensive lecturing around the country on various topics relating to care of the elderly. She is owner and President of Elder Advocates Inc., a care management company founded in 1998 that is designed to meet the needs of the frail elderly and the medically complex client.

# Stepping On: A Fall Prevention Program

## A How-To Guide for Volunteers

*Ruth Meyer, PT, CEEAA*

“What?” you say, “It is not even close to September which is Falls Prevention Awareness Month! Why would you be starting to plan your Stepping On class in July?” Stepping On, an evidence-based fall prevention program that meets 2 hours once a week for 7 sessions, is appropriate for any time of the year. This multifaceted educational series (that includes a beginning exercise routine for leg strengthening and balance practice) takes a bit of forethought to put into production. However, once the pieces fit into place, the seemingly magical effectiveness of this workshop flows nearly effortlessly --accompanied by a great deal of fun.

I have selected Tuesday afternoons from October 2 – November 13 to start a Stepping On series in order to take advantage of the buzz following September 22, Fall Prevention Awareness Day (the first day of autumn or fall) and to be able to finish before the snow flies. I will notify my state and county aging agencies of the planned dates so the Stepping On Series can be added to the list available on their respective websites. These websites are often used by health care professionals and aging experts to assist community dwelling older adults (generally 65 years and older) who are cognitively healthy and who’s mobility is mostly independent (with perhaps the use of an assistive device for outdoor activity), in finding a fall prevention class near where they live. This is exactly the demographic the program was designed for. Stepping On offers older adults strategies for reducing falls while at the same time increasing self-confidence in situations where they are at risk for falling. Once the dates are set and made public, I am ready to screen perspective participants for appropriateness to the class as well as for other general health issues (such

as cardiac or orthopedic concerns or hearing and visual limitations) in order to ensure success and safety in the program.

Finding an accommodating community-based venue is one of the early steps in setting up a workshop. It must be accessible and close to public transportation. Bathrooms also need to be in proximity and the room must be spacious and uncluttered enough for a dozen people or more to stand and move during the exercise portion. It is recommended that the chairs in the room have arms on them. Tables arranged in front of the participants in a horseshoe formation support a group learning environment. Audio-visual equipment is required and it is important that this material can be set up in a way that all members will be able to see and hear. Examples of appropriate venues I have known are hospitals, clinics, senior centers, community centers, churches, senior housing, and libraries. With a little creativity, I am sure many other community sites can be made compatible.

Marketing occurs through the websites previously mentioned. Additionally, the Stepping On program provides a template to print brochures specific to the hosting venue. Often the staff supporting the venue can be very helpful with gathering participants as well. At the acute care hospital where I work, medical doctors, physical therapists, occupational therapists, care managers as well as cardiac or pulmonary rehab professionals have referred individuals to the class. Senior centers and senior housing staff often have individuals earmarked for such a program. One may need to submit press releases to local newspapers or senior newsletters in the vicinity. I have facilitated this class for church groups

working with parish nurses who will advertise the program through church bulletins as well as hand pick certain individuals who they know would benefit. The best recruitment strategy, however, is word of mouth. As the program has become more popular and beneficial in our community, it has become easier to fill the classes as time passes. Optimal class size is 12. If I find I am coming up short, I have had success calling registered individuals and inviting them to bring a friend.

Early and important preparation includes securing a peer leader and the “guest expert presenters.” A peer leader is an older adult who supports the conversation and activities of the class by modeling behaviors that emphasize the self-efficacy process. The class leader and peer leader work together to prepare for the sessions and then debrief after each session in order to create an optimal experience for the participants. Peer leaders are generally individuals who have completed a Stepping On series and who wish to continue to learn from the material while assisting others to do the same. They receive specific training from our county support agency and from the facilitator of the class. In our county, they also receive a stipend.

Guest experts, which include a vision specialist, a pharmacist, a physical therapist (if you are not a facilitator such as myself wearing two hats), and a community safety expert. If this is the first time presenting for any of these experts, the program materials include copies of the session outline, information from the session pertaining to their expertise, background information that pertains to their content, research article(s), and a copy of the corresponding handouts that the participants will be receiving for that session. Guest experts can bring their own handouts as well. So, some

copying and mailing will be in order once the guest experts have committed to their dates and times. Keeping guest experts happy and appreciated is critical because they can greatly enhance the value and enjoyment of the workshop through their content quality, their skill, and their experience. And the guest experts will be more likely to return and assist you with future programs if things go smoothly.

Perhaps now, after setting dates, finding a venue, marketing the class, and arranging for a peer leader and guest experts, there may be a lull while waiting for interested community members to register...but only if you have facilitated in the past. If this is a facilitator's first time, one must create a display board and amass a few items for the display table to enhance learning through all the senses--hearing, looking, doing, and touching. Fortunately, directions and reproducible items with helpful suggestions are all part of the program packet from Stepping On. This is where the facilitator can really get creative. Additionally, this little lull is also a good opportunity to print all the copies needed for participant handouts at each of the 7 sessions and the exercise manuals. If possible, having a relationship with a printing entity or a community entity that will finance and collate the printing can significantly expedite this process.

At 4 weeks before the beginning date of the workshop. I have 12 people registered and I am keeping a waiting list as well. Now is the time to initiate the enjoyable task of phoning those registered to obtain additional contact information (email users are increasing every year). Obtaining a sense of their mobility and state of general health specifically as it applies to their ability to exercise, and any limitations they might have around participation with the group, such as hearing and seeing, is important. At this time it is also helpful to accrue some data such as how they found out about the class, their age, and their fall history. I will share with them several points about the workshop, remind them of the dates, time and location, and offer logistics for parking. I will ease their anxiety by letting them know that all the information I am giving them will also arrive by mail two weeks prior to the start of class. Finally, I like to listen to any questions

or concerns they may have about the series. This is the time I might find that a member or two is not really suited to Stepping On for various reasons, and with my waiting list in hand, I can replace a participant if necessary.

Finally, two weeks before the commencement of class, a welcome letter is sent to each participant. I have also mentally prepared my snack menu for break time, which is just as important as formal group time to allow for continued processing of fall prevention principles in a more relaxed and informal way. Break time is built into the 2-hour session outline and is often anticipated favorably sometime around the midpoint of class.

I am now ready to begin the Stepping On fall prevention workshop with a two-week buffer to adjust and modify any unforeseen circumstances. Enthusiastically I look forward to meeting the new members and initially hearing their stories while witnessing them grow in knowledge, awareness, and confidence around safe mobility over the course of the series. At times, preparing for a Stepping On workshop can seem like a daunting task but like many things, the more experience, the easier the process. Supportive state and county offices as well as accommodating venues are great collaborative entities. In the end, it is the joy and satisfaction of bringing to light important information around fall prevention and safe aging older adults while observing them coalesce as a community in support and encouragement to each other. If this sounds like a process you might enjoy, I invite you to seek training to facilitate Stepping On in your location.

**Editor's Note:** The Stepping On program offers older people information, strategies, and exercises to reduce falls and increase self-confidence in situations where they are at risk of falling. The program is approved by the U.S. Administration on Aging and the Centers for Disease Control and Prevention. The program is the work of Dr. Lindy Clemson, an occupational therapist from Australia. It was brought to the United States and adapted for implementation in North America by Dr. Jane E. Mahoney, a geriatrician at the University of Wisconsin and Executive Director of the Wisconsin Institute for Healthy Aging

(WIHA). It was first implemented in community settings in the United States in 2006 and is currently offered in California, Nevada, New York, Montana, Utah, and Wisconsin. Stepping On requires specific leader qualifications: a professional (RN, NP, LPN, PA, OT, PT, PTA, COTA, Social Worker, Fitness Expert, Health Educator) with professional training related to older adults, who has facilitated CDSMP or another group program based on adult-learning or self-efficacy principles, and worked with older adults in a professional setting as well as completed 3-day training, conducted by the WIHA, its licensees or master trainers.

**Website:** WIHA provides training and technical support and issues the licenses for operation of Stepping On North America. (WIHA's website is under construction as this was going to press). For more information, contact Karen Beck at [Karen.beck@wihealthyaging.org](mailto:Karen.beck@wihealthyaging.org) or (608) 243-5690.

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Ruth Meyer is a staff physical therapist at SSM Health-St. Mary's Hospital in Madison, WI, a member of the Safe Communities Falls Prevention Task Force, and a veteran Stepping On facilitator.

# Practice Committee Update

Keith G. Avin, PT, PhD, Practice Chair

The AGPT Practice Committee is committed to promoting best practice among PTs and PTAs. Specifically, we are involved in providing resources for those who are pursuing Board certification as a Geriatric Clinical Specialist (PTs) or Advanced Proficiency Pathways recognition (PTAs). We are currently developing 3 different evidence-based documents (EBDs) on hip pain, falls in community-dwelling older adults, and osteoporosis. The Practice Committee is also coordinating the development of EBDs with the national physical therapy registry. We also help our members be aware of practice-related events by disseminating information publishing on the AGPT and APTA website and *GeriNotes*. As Practice Chair, I also meet quarterly with all other APTA state and component leaders to be apprised of current happenings within the APTA. Below are the most recent updates with the name of the appropriate contact person. There are many exciting things happening across the APTA from diversity initiatives to licensure compact to the registry.

## 1. PRIMARY CARE AND PREVENTION UPDATE

Hadiya Green Guerrero, PT, DPT, OCS  
[hadiyaguerrero@apta.org](mailto:hadiyaguerrero@apta.org)

- Council on Prevention/Wellness created 2018
  - o Can sign up here: <http://communities.apta.org/p/co/ly/gid=182>, APTA Community HUB with links and social media.
  - o 160 members
  - o Provide communication for APTA activities, work plans
  - o Individual groups on population health, education, best practices
  - o Get together at NEXT June 29, 11am-1pm
- Primary Care
  - o RC1915 Follow-up included a practice analysis
  - o Investigate possibility of Primary Care being a special practice

- o Survey of 1000 PTs completed and will share results
- o Presenting at Veteran's Administration Inter-professional Teleconference

## 2. PAYMENT AND PRACTICE MANAGEMENT ADVOCACY UPDATE

Wanda Evans, PT, MPH  
[wandaevans@apta.org](mailto:wandaevans@apta.org)

- Working with insurers and employers who are self-insurers
- Interacting with different groups on issues such as population health and wellness
  - o Business Group on Health to increase PT participation
- Utilization management working with private payers using this
  - o Developing toolkit, councils on different state entities to have a voice at the table
- Opioid Activities
  - o Making sure physical therapy services are seen as a viable alternative for pain management
  - o Partners with multiple groups and external stake holders
  - o Resources on web page and push to have reimbursement for physical therapy as an option over opioid usage
  - o Public Service Announcements developed, major launch of effort with Facebook live
    - Part of ProfessionalPulse: <http://www.apta.org/PTinMotion/2018/4/ProfessionalPulse/>
- Collaborating with Clinical Services Administration on workers Comp, Med Risk who are third party administrators
  - o Review of questions completed on a case-by-case basis

## 3. DIVERSITY INITIATIVES UPDATE

Johnette L. Meadows, PT, MS  
[johnnettemeadows@apta.org](mailto:johnnettemeadows@apta.org)

- Developing member committees/task forces with multiple components to increase diversity, participation, and inclusion at the component level
- Diversity efforts being re-energized with inclusion in Vision, Strategic Plan, and within the Mission
- Staff work group on diversity, equity, and inclusion to develop plan for presentation to the Board of Directors in November 2018 with plans in answer to RC 17 2018 to increase diversity in the profession of physical therapy
- 26th Annual Celebration of Diversity to Benefit the Minority Scholarship Fund scheduled for Saturday, October 13, 2019, at US Assure Club at Everbank Field, Jacksonville, FL
- For more information refer to <http://www.apta.org/celebrationofdiversity/>

## 4. MEDICARE PAYMENT AND REGULATORY ADVOCACY UPDATE

Kara Gainer  
[karagainer@apta.org](mailto:karagainer@apta.org)

- Working with CMS on multiple issues
  - o Medical administration contractors
    - RS modifier for denied claims
    - Probably more information in 6 months
  - o Direct provider contractors for feedback, APTA will provide input
    - Goal is to decrease costs for Medicare and Medicaid
    - Incentives to help decrease costs
  - o APM—working with AOTA and ASH to develop nonphysician providers feedback
  - o Information
  - o 2019 payment schedule for skilled nursing facilities to be released (information previously provided)
    - Will have member writing template for comment
- Other issues include the administration's effort to pare Affordable Care Act down, non-discrimination in health care, ERV fee rule in July

- Seeking nominations for Federal Committees, Task Forces. Send interest to [karagainer@apta.org](mailto:karagainer@apta.org)
- Insider Intel May 16. Sign up here <http://www.apta.org/InsiderIntel/>
- RCS1, Tricare PTA Rule—all being monitored

## 5. PHYSICAL THERAPY LICENSURE COMPACT UPDATE

Angela Shuman  
[angelashuman@apta.org](mailto:angelashuman@apta.org)

- Created a compact commission to implement how to work with states that are a part of the compact. Public entity, with public meetings and public access
  - o Have bylaws, budget
  - o Some issues with getting past FBI background checks and is working on this
- 17 states participating, 4 pending
  - o Others want to start with privileges starting in July
- Physical Therapy Compact Commission
  - o Public entity, each state has 1 representative
  - o Rules/bylaws go through a public process
  - o All meetings are public
  - o Compact privileges will be issued through [ptcompact.org](http://ptcompact.org)
- Process to follow if you are in a compact state and want to be licensed in another compact state using the compact commission and/or going through the regular licensure process for that state

## 6. PHYSICAL THERAPY OUTCOMES REGISTRY UPDATE

Karen Chesbrough, MPH  
Matt Elrod, PT, DPT, MED NCS  
[karenchesbrough@apta.org/mattelrod@apta.org](mailto:karenchesbrough@apta.org/mattelrod@apta.org)  
For more information: [registry@apta.org](mailto:registry@apta.org), [www.ptoutcomes.com](http://www.ptoutcomes.com)

- Topics covered
  - o Current health care environment
  - o Importance of knowing your practice/organization
  - o Registries and details about the PT Outcomes Registry
  - o Information collected by the Registry

- A clinical registry records information about the health status of patients and the health care they receive over varying periods of time
  - o Registry is information from the profession for the profession.
    - Profession identified standards that broadly represent all patients, setting, and reasons for visit
    - Incorporate adherence to best practice with inclusion of selected clinical practice guidelines
    - Identify areas of quality improvement and marketing opportunities
- Registry works by dealing with certain inputs that will provide certain outputs
  - o Data is transformed into meaningful, intuitive, and actionable feedback

– Data can be aggregated  
Therapist  
Clinic  
Facility

- Identification of variations in practice
  - o Benchmarking will allow for comparisons beyond your practice

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# Documentation Helps Clinicians Help People

Jacqueline Osborne, DPT

Many clinicians have a personal story that conveys why they chose a career in physical therapy. Some experienced sports-related injuries as high school athletes. Some experienced trauma as a child or young adult. Some experienced physical therapy through family members or friends. Regardless of the origin of the story, clinicians choose physical therapy to help people. The American Physical Therapy Association (APTA) certainly supports this notion. In March 2018 the APTA's Board of Directors approved the following updated mission statement: "Building a community that advances the profession of physical therapy to improve the health of society." So, physical therapists and physical therapist assistants help people.

Clinicians prepare themselves to help people by volunteering and shadowing, with entry-level education and clinical internships, and through pursuing advanced degrees, residency and fellowship training, and engaging in professional development. Clinicians adjust psychomotor and clinical reasoning skills as they pursue efficiency and expertise often specializing as they hone their craft. A crucial and necessary component of successful physical therapy practice is documentation. Yet, the pursuit of clinical excellence does not emphasize the significance of documentation to the same degree as a specialized knowledge-base, precise psychomotor skills, efficient clinical reasoning, and positive outcomes. In fact, documentation is introduced to students often during the first semester of the first year of physical therapy education and is reinforced only by clinical instructors during internships. Neglecting to integrate documentation throughout an entire physical therapy curriculum may be reinforcing the unintended message that documentation is not a component of physical therapy practice that requires skill and expertise. Documentation is often viewed as a constant distraction from patient

care rather than an essential driver of successful patient care. However, when viewed positively, documentation actually helps clinicians help people. Documentation substantiates the skilled services delivered in physical therapy practice. Good documentation results in reimbursement that guarantees the continued delivery of skilled services to patients who benefit from these services. Poor documentation results in the termination of skilled services and relays that the skilled services provided were not actually needed. Therefore, the focus of this article is to discuss how clinical reasoning can be applied to the practice of documentation so that it becomes elevated as an integrated component of a plan of care rather than disregarded as a tedious unfulfilling addendum to a plan of care.

## WHAT IS CLINICAL REASONING?

A recent survey investigating how clinical reasoning is defined, taught, and assessed in physical therapy educational programs indicated that a common definition of clinical reasoning is not used.<sup>1</sup> Inquiries into the meaning of clinical reasoning in physical therapy practice emphasize vigilant analysis of movement as well as identifying problems and associated consequences.<sup>2</sup> Less common definitions emphasize clinical reasoning as a complex cognitive process that synthesizes information obtained from a clinical situation.<sup>1</sup> A clinical reasoning framework that includes reflecting on a previous clinical situation or current patient encounter can also be applied to the practice of documentation. For example, a clinician may compile information about specific impairments in body functions and structure, activity limitations, and contextual factors to determine a hypothesis for the cause of an injurious fall. The clinician may use reflection and reasoning strategies combined with knowledge and experience to prioritize this data to create an individualized fall

prevention intervention plan. A similar clinical reasoning framework can be used when creating documentation. For example, a clinician may compile subjective information reported by a patient and objective data gathered during an encounter to indicate a response to the services provided and to devise a plan for a subsequent encounter. By using reflection and reasoning strategies to analyze relationships among these details, a clinician can create documentation that clearly relays the value and the skill required to deliver the services provided.

## WHAT IS THE GOAL OF DOCUMENTATION?

There are many consumers of a clinician's documentation. Among the first individuals to read a physical therapist's documentation are other members of a patient's interdisciplinary team. Physical therapist assistants, occupational therapists, speech language pathologists, nurses, physicians, and case managers may all be seeking slightly different information from the same documentation. Other users of documentation include physical therapy aides, students, managers, third-party payers, or external auditors. Clinicians mistakenly assume that the content of documentation is dependent upon who may read it. While it is true that there are many different consumers of the same documentation content, there is only one true goal of documentation; to ensure that clinical reasoning is included within clinical documentation. If a clinical reasoning process is present then whoever reads the health record will be able to extract the content needed to make a decision. Consider the following daily note:

The patient has no new complaints today. Reports fatigue.

See flow sheet.

The patient demonstrates poor activity tolerance.

Continue to work towards established goals.

Most would agree that there is little substance in this note that any user can consider when making decisions about the patient. In fact, the content in this note should generate several questions about how to interpret it:

- What were the patient's previous complaints?
- How is the patient's fatigue quantified?
- What activity elicits the fatigue?
- Is the fatigue improving or worsening?
- Were any of the activities listed in the flow sheet progressed or deferred?
- Were any new interventions added?
- Did the patient require any assistance or guidance?
- How was activity tolerance quantified?
- Were there any modifications to the plan of care due to the patient's performance?
- Is there a specific part of the plan of care that should be a current focus?
- Has there been any progress towards the established goals?
- Should the plan of care be progressed?

Perhaps a more useful note would resemble the following:

The patient indicates that he had to use his arms to push up to standing from his bed but was able to complete 4 of these stands consecutively before needing a seated rest.

See flow sheet for completed exercise. Added repeated sit-to-stands from 19-inch height surface per flow sheet.

Patient reported RPE = 16 after 5 sit-to-stands from 19-inch surface without upper extremities to assist due to shortness of breath. He was able to complete 3 sets of 5 with 2 minutes of recovery after each set. He required contact guard assistance during the third set due to decreasing eccentric control of quadriceps musculature during sitting phase.

Continue to practice sit-to-stands from lower surfaces as patient needs to be able to stand from seat height of 17 inches (height of commode in home).

This note is more useful because it relays a clinical reasoning process. This note is but one entry in a patient's health record, so there still may be a need for the note's reader to refer to additional content in the health record to obtain a more complete clinical picture of the patient for informed decision-making. However, this second note provides a clear and informative update. Most importantly, this note relays why skilled services were delivered and why they are still warranted. Thus, to infuse documentation with clinical reasoning means to ensure that every note indicates why skilled care was provided and if continued skilled care is necessary.

Medicare has published guidelines for creating "reasonable and medically necessary" documentation of therapy services.<sup>3</sup> These guidelines indicate that the physical therapy services delivered should be safe and effective, of appropriate duration and frequency, in accordance with the standard of practice for the patient's health condition, provided in the appropriate setting, delivered by a qualified provider, and appropriate to meet the patient's needs.<sup>3</sup> Medicare encourages, but does not require, narratives specifically justifying the medical necessity of services rendered be included in documentation to support why those services were delivered.<sup>4</sup> Medicare further indicates that a provider can include a support or justification statement in a patient's health record to assure that a reviewer "understands their reasoning for services" delivered.<sup>4(p179)</sup> It is not necessary to adjust the content of the note for a specific user such as a referring physician, a supervisor, a clinical instructor, or a third-party payer. Instead, it is appropriate to assume that if all documentation indicates why services were medically necessary, then anyone who uses the note to make decisions will be satisfied.

### HOW CAN CLINICAL REASONING BECOME A CONSISTENT PART OF DOCUMENTATION?

Regardless of the practice setting, every clinician who delivers

physical therapy services creates daily documentation for each patient. The SOAP note format is a commonly used framework for creating daily documentation. A clinician often records subjective (S) information that may include the patient's or caregiver's perception of the problem or self-reported signs and symptoms. Objective (O) data such as results of physical assessments or completed interventions may be collected and recorded. Following this subjective and objective information is an analysis or assessment (A) of the data. Lastly, a plan (P) based on the assessment is recorded. Omitted from the SOAP note is a framework that allows for a clinician to clearly relay a skilled decision-making process. An alternative note format or SIRP<sup>5</sup> may allow for improved organization of the details of a physical therapy encounter that emphasizes a clinician's clinical reasoning for relaying the medical necessity of the delivered services. The status (S) component of the note indicates how the patient has managed since the last encounter and could include information such as the patient's or caregiver's perception of current signs, symptoms, abilities, and limitations as compared to some previous point in time. The intervention (I) component of the note relays the actual content of the physical therapy encounter. This section could include a flow sheet that should be recorded such that it could be reproduced exactly as intended by its author. The details of the skilled interventions recorded in this section should reflect the content of the status portion of the note. The response (R) section of the note is the clinician's interpretation of how the patient responded to the events of the encounter. This section includes the result of what occurred in the session and how the patient's status changed or did not change as a result. The plan (P) section of the note relays what is left to accomplish in the established plan of care in a subsequent session.

Revisit the daily note indicated above and apply the SIRP<sup>5</sup> framework. The *status* section of this note relays detail that allows for further investigation into this patient's ability to stand. For example, the clinician may decide to alter the sit-to-stand surface height to determine changes in

the patient's sit-to-stand performance. Alternatively, the clinician may decide to further investigate the need for the seated rest and the exact circumstances that led this patient to require it. The *intervention* section of this note refers to a separate location of the note, the flow sheet, but also indicates in detail an added intervention. The additional information included in this section should directly relate the patient's performance of that intervention which is relayed in the response section of this note. In the *response* section of this note, the outcome of the added intervention is included as is the clinician's skilled interaction. Lastly, the *plan* section of this note demonstrates why the patient continues to require skilled physical therapy services.

Consistently applying clinical reasoning strategies to documentation requires reflection and continued practice in the same way that improving manual skills and movement pattern recognition requires reflection and continued practice. It may be valuable for a clinician to audit their own documentation to determine if they are using a clinical reasoning process when creating their notes. A reflection on one's documentation may include the following questions:

- Is the patient's status clearly indicated?
- Is there evidence that skilled interventions were delivered?
- Is the patient's response clearly relayed?

- Is there evidence that the clinician's input was skilled and necessary?
- Is there a clear plan for the subsequent session indicated?

Creating documentation infused with clinical reasoning will meet two primary goals of physical therapist practice: (1) patients will continue to receive the skilled services they need to fulfill the plan of care, and (2) third-party payers will pay for these skilled services. The shift in the current health care environment from volume-based care to value-based care will not occur successfully without input from clinicians. In other words, third-party payers will not recognize the value of skilled physical therapy care unless clinicians are skilled at relaying this message through their documentation. Therefore, it is incumbent upon physical therapists and physical therapist assistants to embrace documentation as a valuable adjunct to successful physical therapy practice. So, documentation helps clinicians help people.

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# Professionalism and the Electronic Medical Record: View from Home Health

*Kenneth L. Miller, PT, DPT, CEEAA; Elizabeth Budd, PT, DPT;  
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## BACKGROUND

In 2000, the House of Delegates of the American Physical Therapy Association (APTA) adopted Vision 2020 and a strategic plan to transition physical therapy to a doctoring profession. Professionalism is one of the 6 elements on the strategic plan and has been defined and described as what the graduate of a physical therapy program ought to demonstrate in their daily practice.<sup>1</sup> There were 7 core values of professionalism identified including accountability, altruism, compassion/caring, excellence, integrity, professional duty, and social responsibility.<sup>2</sup> The core value of accountability is defined as active acceptance of the responsibility for the diverse roles, obligations, and actions of the physical therapist including self-regulation and other behaviors that positively influence patient/client outcomes, the profession, and the health needs of society.<sup>2</sup> One indicator for accountability includes “adhering to code of ethics, standards of practice, and policies/procedures that govern the conduct of professional activities.”<sup>2</sup> It is critical for physical therapists working in home health to demonstrate self-regulation as part of their own accountability, follow the code of ethics, and use the companion

guide for professional conduct to assist in determining appropriate actions regarding the practice of physical therapy.<sup>3,4</sup> The companion guide is an interpretive guide to complement the code of ethics for physical therapists.<sup>4</sup> A second indicator for accountability includes “communicating accurately to others (payers, patients/clients, other health care providers) about professional actions.” It is this second indicator that will be the focus of this paper. Communication via documentation is paramount to professional practice in home health where face-to-face communication is more limited than in any other practice setting.<sup>2</sup>

## INTRODUCTION

Physical therapists, in order to practice professionalism must demonstrate accountability through self-regulation of behavior and actions in all dealings related to their practice. One key area of self-regulation is the effective use of the electronic medical record (EMR). Documenting accurate information at the appropriate time points following federal, state, local law, Center for Medicare and Medicaid Services (CMS) regulations, and agency policy is key to demonstrating accountability and ultimately professionalism in the

medical record.<sup>5</sup> The code of ethics and guide for professional conduct may be used as resources to clinicians when questions arise in their practice including documentation. All therapists are bound to the code of ethics as evidenced in the APTA Guide for Professional Conduct which states, “The Code and the Guide apply to all physical therapists.” As such, they have an obligation to follow the principles of the code that cultivates professionalism.

## CODE OF ETHICS

The APTA Code of Ethics for physical therapists that was revised in 2009 and became effective in 2010 contains 8 principles, 5 of which (3, 4, 5, 6 and 7) apply to documentation and conformance with the Medicare Prospective Payment System (PPS) final rule 2011 regulations for home health (Table 1).<sup>3,4</sup> Principle #3 states that physical therapists shall be accountable for making sound professional judgments that we believe should be reflected in the documentation provided in the EMR. An example of demonstrating professionalism and sound judgment is for physical therapists to document the required data elements in the medical record even when the EMR may be lacking some of the required data fields.

**Table 1.** Code of Ethics for Physical Therapists, APTA.<sup>3</sup>

<p><b>Principle #3:</b> Physical therapists shall be accountable for making sound professional judgments.</p> <p><b>Principle #4:</b> Physical therapists shall demonstrate integrity in their relationships with patients/clients, families, colleagues, students, research participants, other health care providers, employers, payers, and the public.</p> <p><b>Principle #5:</b> Physical therapists shall fulfill their legal and professional obligations. The Home Health Section believes that physical therapists are mandated to comply with CMS PPS 2011 requirements to follow their legal and professional obligation to practice physical therapy.</p> <p><b>Principle #6:</b> Physical Therapists shall enhance their expertise through lifelong acquisition and refinement of knowledge, skills, abilities, and professional behaviors.</p> <p><b>Principle #7:</b> Physical therapists shall promote organizational behaviors and business practices that benefit patients/clients and society.</p>
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An example of this could be seen if the EMR has a design weakness that does not prompt the physical therapist to document objective test results (which is a requirement found in the CMS PPS 2011 regulations).<sup>5</sup> The physical therapist demonstrates sound judgment and professionalism by being accountable to the regulation and puts the necessary data in the record.<sup>1,2,5</sup> It would be unethical for a physical therapist to state that he or she does not need to perform or document objective testing if the EMR did not have data fields to enter this required data.

In addition to objective testing, the PPS 2011 final rule mandates reassessment at defined time points. It is the professional and ethical responsibility of the physical therapist to assure compliance with this requirement regardless of whether the EMR prompts for this information. Electronic medical record vendors are accountable to the regulations as well, and when EMR vendors become aware that the EMR is lacking required data elements, professionalism on their part dictates the need for changes so that the EMR complies with federal regulations.

Federal requirements and CMS regulations change annually as new laws are passed and enacted including the Health Insurance Portability and Accountability Act (HIPAA), Health Information Technology for Economic and Clinical Health Act (HITECH), and the Patient Protection and Affordable Care Act that change.<sup>5-8</sup> All parties involved in the provision of home care have challenges in maintaining compliance with regulatory changes; however difficult, these challenges must be met with integrity. Principle #4 states that physical therapists shall demonstrate integrity in their relationships with patients/clients, families, colleagues, students, research participants, other health care providers, employers, payers, and the public. Furthermore, physical therapists shall provide truthful, accurate, and relevant information; shall not make misleading representations; shall discourage misconduct by health care professionals; and report illegal or unethical acts to the relevant authority, when appropriate.<sup>3</sup> The EMR should reflect truthful, accurate, and relevant information regarding the physical therapist's interactions with the patient.

This includes such things as start and end times of home visits, and accurate descriptions of the interventions provided. Lastly, integrity is defined in the APTA's Professionalism in Physical Therapy: Core Values document as "steadfast adherence to high ethical principles or professional standards; truthfulness, fairness, doing what you say you will do, and "speaking forth" about why you do what you do."<sup>2</sup> Maintaining integrity with all relationships and with documentation by demonstrating honesty, truthfulness, and accuracy is critical to maintain professionalism and ensure regulatory compliance.

While physical therapists are bound by the Code of Ethics, home health agencies and EMR designers/software vendors should conform to their mission/vision statements which often contain the word(s) "integrity" and/or "honesty" or complementary words as part of their values and beliefs. An example of an EMR vendor's mission statement that uses "integrity" states, "We value and believe in honesty & integrity, corporate social responsibility, innovation with purpose, reliable excellence, and a positive outlook. The only measure of our success is the success of our customers."<sup>9</sup>

Compliance and integrity go hand in hand with respect to error correction documentation in the electronic medical record. CMS has released a transmittal specifically addressing this topic. CMS transmittal 442 from Dec of 2012, effective Jan. 8, 2013 indicates that any changes to a medical record should indicate the original content as well as the changes, the clinician that made the changes and the date and time of those changes.<sup>10</sup> This transmittal makes the general statements that a medical record, "Clearly and permanently identify any amendment, correction or delayed entry as such, and clearly indicate the date and author of any amendment, correction or delay entry, and not delete but instead clearly identify all original content." It specifically states that an electronic health record (EHR) must "provide a reliable means to clearly identify the original content, the modified content, and the date and authorship of each modification of the record." If a required therapy reassessment is missed, it is unethical for physical therapists to re-create therapy reassessment documentation after the

fact. A record may be amended, after the fact, if an oversight or inadvertent omission occurred, however, the original entries should be maintained. Creating replacement notes and discarding original notes is incongruent with professionalism and is unethical.

## CASE SCENARIO

A physical therapist (PT) completed a therapy reassessment visit 2 weeks ago and upon review of the record the Therapy Director requests that the software vendor delete the visit and allow the clinician to "re-document" a better version of the reassessment with information that the therapist left out accidentally. Is this appropriate? No, medical records should not be deleted. The original documentation must be maintained according to recordkeeping principles found in the transmittal.<sup>10</sup> One way to maintain the original record is by archiving the note and writing an addendum note with the new information including an explanation of the transaction. Alternately, the clinician could add an addendum to the original note with the updated information. Transparency is the key to integrity and compliance with this regulation. It would be unethical for an EMR vendor or home health agency to delete entries or modify the documentation without explaining the modifications.

Home health agencies are encouraged to create policies on time frames for corrections to the EMR, specifying when a correction is allowed to be made and by whom so that field clinicians cannot make changes without administrator support/assistance/approval with compliance to CMS transmittal 442. Agencies should create policies on procedure for obtaining electronic signatures of clinicians and the patients. Conformance to agency policy where regulations are silent demonstrates integrity and professionalism.

Principle #5 has a broad definition and states that physical therapists shall fulfill their legal and professional obligations. Physical therapists are mandated to comply with CMS PPS 2011 requirements to follow their legal and professional obligation to practice physical therapy. These obligations relating to home health physical therapy provision are clearly defined in the Medicare Benefit Policy Manual

Chapter 7 which contains CMS' coverage requirements and regulations for home health services.<sup>5</sup> Section 40.2 pertains to the requirements for skilled therapy services. "As described in section 40.2.1(b), at defined points during a course of therapy, the qualified physical therapist (instead of an assistant) must perform the ordered therapy service visit, assess the patient's function using a method which allows for objective measurement of function and comparison of successive measurements, and document the results of the assessments, corresponding measurements, and effectiveness of the therapy in the patient's clinical record." The CMS requirement of including objective measurement of function and the repetition of the same objective measurements at specific time points during the episode of care was implemented in the PPS final rule in 2011 section 40.2.1.b.1.ii and 40.2.1.b.1.iii which states that a qualified therapist must determine the effectiveness of the Plan of Care (POC), or lack thereof.<sup>5</sup>

Physical therapists should understand and comply with CMS regulations directly, but federal laws such as HIPAA and HITECH have regulations that physical therapists, agencies, and vendors must follow as

well. The HITECH Act has regulations in federal law that relate specifically to EMR systems. The HITECH Act has 11 duties charged to the National Coordinator for Health Information Technology. See Table 2. The regulations are to ensure that patient health information is protected and secure which means that physical therapists, home health agencies, and EMR vendors put into place safeguards such as multiple passwords and encryption software to protect the data and for therapists to follow the policies and procedures created for protection of the medical records. Therapists should look to reduce health care costs by reducing medical errors, reducing inappropriate care or duplicative care, improving efficiency, and by providing all necessary data elements whenever documenting in the record. Therapists should provide appropriate information to help guide medical decisions. Therapists, home health agencies, and EMR vendors should look to use the EMR to improve the coordination of care and information among hospitals, laboratories, physician offices, and other entities through an effective infrastructure for the secure and authorized exchange of health care information.

According to principle #6 physical therapists shall enhance their

expertise through lifelong acquisition and refinement of knowledge, skills, abilities, and professional behaviors. Physical therapists have an obligation and responsibility to advance their skills to properly use whatever documentation the organization that employs them has in place. The organizations have a responsibility to adequately train their staff to the specifics of the EHR/EMR system that they use as well. Basic computer competencies for health care workers have been suggested by Technology Informatics Guiding Education Reform (TIGER) Initiative.<sup>12</sup> The competencies include basic computer skills, information literacy, and information management. Without these skills, a physical therapist is at a significant disadvantage in his or her ability to provide proper documentation on the EMR including formation of the assessment and plan of care. Physical therapists would also be limited in their ability to gather and interpret other professionals' documentation which may be imperative for appropriate treatment planning and provision of services. It is the physical therapist's professional responsibility to understand documentation requirements for their discipline and be able to integrate that knowledge into practice. A home health agency that provides training in use

**Table 2.** HITECH ACT. National Coordinator for Health Information Technology Duties.<sup>7</sup>

<p>Development of a nationwide health information technology infrastructure that allows for the electronic use and exchange of information and that—</p> <ol style="list-style-type: none"> <li>(1) ensures that each patient's health information is secure and protected, in accordance with applicable law;</li> <li>(2) improves health care quality, reduces medical errors, reduces health disparities, and advances the delivery of patient-centered medical care;</li> <li>(3) reduces health care costs resulting from inefficiency, medical errors, inappropriate care, duplicative care, and incomplete information;</li> <li>(4) provides appropriate information to help guide medical decisions at the time and place of care;</li> <li>(5) ensures the inclusion of meaningful public input in such development of such infrastructure;</li> <li>(6) improves the coordination of care and information among hospitals, laboratories, physician offices, and other entities through an effective infrastructure for the secure and authorized exchange of health care information;</li> <li>(7) improves public health activities and facilitates the early identification and rapid response to public health threats and emergencies, including bioterror events and infectious disease outbreaks;</li> <li>(8) facilitates health and clinical research and health care quality;</li> <li>(9) promotes early detection, prevention, and management of chronic diseases;</li> <li>(10) promotes a more effective marketplace, greater competition, greater systems analysis, increased consumer choice, and improved outcomes in health care services;</li> <li>(11) improves efforts to reduce health disparities.</li> </ol>
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of new EMR systems and establishes competencies to assure itself of properly trained clinicians is providing a culture that supports professionalism.

Physical therapists should work together with home health agencies, EMR designers/software vendors, and other organizations involved in the home health industry for the purpose of promoting practices that benefit patients/clients and society. Physical therapists should be active participants in facilitating and advocating for organizational behaviors and business practices that focus on the best care of patients/clients and society as a whole is congruent with and mandated by principle #7. Being an advocate for the patients, through organizational behavior, demonstrates the core values of professionalism as defined by the APTA.<sup>2</sup>

Physical therapists have the ethical obligation to be knowledgeable of federal, state, local laws, and CMS regulations that collectively includes standardized assessments, documentation requirements, billing requirements, coverage, and eligibility requirements. In the home health setting, the mandated assessment tool for use with patients having Medicare and Medicaid insurance is the Outcome and Assessment Information Set (OASIS). It is the professional responsibility of physical therapists practicing in home health to become competent in administering and documenting the OASIS assessment in the EMR, thus adhering to principle #6, "physical therapists shall achieve and maintain professional competence."

Competence in performing the OASIS assessment relies on an understanding of its purpose as a framework for a comprehensive assessment of an adult home care patient and the basis for measuring patient outcomes for purposes of outcome-based quality improvement (OBQI).<sup>12</sup> The OASIS data are collected at specific time points in the episode following the CMS regulations for OASIS data collection. Overall, the OASIS items have utility for outcome monitoring, clinical assessment, care planning, and measuring compliance using process measures. An example of a process measure is the performance of a falls risk screen by the physical therapist doing a

start of care visit.<sup>14</sup> The results of the falls risk screen should prompt the clinician in determining an appropriate plan of care. Electronic medical record vendors must include the OASIS items as part of the assessment templates. As with other parts of the assessment, the OASIS data must be collected with integrity and any changes or error correction must be clearly documented conforming to the CMS regulations provided in Transmittal 442.<sup>10</sup>

The scenarios below illustrate situations in which integrity and transparency in the context of federally mandated data collection may be challenged.

### CASE SCENARIO

The clinician performing the comprehensive assessment for the start of care (SOC) completes his or her documentation of the OASIS items and synchronizes the visit as completed. Upon review by the quality assurance department, two answers are changed without discussing these changes with the clinician who performed the SOC assessment. Is this appropriate? No. Only one person may complete OASIS data collection. Some items allow collaboration between clinicians. In the case of OASIS reviews for accuracy, changes that are made must be discussed and approved by the assessing clinician. Record of the changes and original documentation must be maintained.<sup>13</sup> A home health agency is demonstrating integrity when OASIS reviewers contact the SOC clinicians before making any changes to the EMR. Additionally, the original entry will remain part of the record along with an addendum to reflect the reason for the change. Electronic medical record vendors demonstrate integrity and professionalism when designing software systems that restrict changes to the EMR that follow CMS Transmittal 442.

### CONCLUSION

Physical therapists, home health agencies, and EMR vendors are mandated to follow governmental regulations and are accountable for their actions in all dealings related to their practice. Professionalism dictates an obligation to demonstrating integrity and transparency in the EMR. Physical therapy, as a doctoring profession, should

strive to maximize professionalism and demonstrate accountability through self-regulation and actions in all dealings related to their practice using the code of ethics as a guide. Conforming to federal, state, local law, CMS regulations, and agency policy is key to demonstrating accountability and professionalism in the EMR. Physical therapists have an ongoing obligation to maintain knowledge of current regulations and application to practice as these will continue to evolve with annual changes to PPS, OASIS guidelines, and payment models.

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## Glossary

**Electronic Health Record (EHR):** The aggregate electronic record of health-related information on an individual that is created and gathered cumulatively across more than one healthcare organization and is managed and consulted by licensed clinicians and staff involved in the individual's health and care. (National Alliance for Health Information Technology and National coordinator of Health IT [ONC])

**Electronic Medical Record (EMR):** The electronic record of health-related information on an individual that is created, gathered, managed, and consulted by licensed clinicians and staff from a single organization who are involved in the individual's health and care. (National Alliance for Health Information Technology and National coordinator of Health IT [ONC])

**Health Information Technology for Economic and Clinical Health Act (HITECH Act) of 2009:** The HITECH Act of 2009 provided for further promotion of the use of electronic medical record documentation with the establishment of incentive programs and included standardization of the EMR and the players involved in the process. Legislature enacted "to promote the adoption and meaningful use of health information technology. The HITECH Act further clarifies the protection of health information that is addressed in the HIPAA Act. The Act defined the term, "Health Information Technology" which means hardware, software, integrated technologies or related licenses, intellectual property, upgrades, or packaged solutions sold as services that are designed for or support the use by health care entities or patients for the electronic creation, maintenance, access, or exchange of health information.

**Health Insurance Portability and Accountability Act (HIPAA Act) of 1996:** The Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) called for the establishment of standards and requirements for transmitting certain health information to improve the efficiency and effectiveness of the health care system while protecting patient privacy.<sup>4</sup> HIPAA requirements initiated movement towards establishment and standardization of an electronic medical health record and electronic transactions related to billing.

**Missed Visit:** A visit that cannot be performed on the day it is scheduled and cannot be rescheduled before a new Medicare week starts.

**Outcome and Assessment Information Set (OASIS):** A CMS mandated assessment used in home health containing a group of standard data elements for Medicare and Medicaid patients.

**Start of Care (SOC):** The initial collection of data for patients beginning service with an agency.

**Synchronization (sync):** The two-way process of transferring data between a mobile device and the electronic medical record platform.

**Technology Informatics Guiding Education Reform Initiative (TIGER):** formed in 2004 to bring together nursing stakeholders to develop a shared vision, strategies, and specific actions for improving nursing practice, education, and the delivery of patient care through the use of health information technology (IT).

**Verified /Completed Visit:** A visit that has been performed, properly documented, electronically signed and synchronized.

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programs Progressive Therapy Education since 2014 teaching courses on strength training, home care, exercise program design, balance, falls and documentation. Her career as a PT has included work in acute care, rehab, outpatient, wellness and home care. She is a consultant for Rodan and Fields. Vicki received her bachelors in Health Science-Physical Therapy from University of Missouri in 1993 and her DPT from Boston University in 2007. She may be reached at [vdlanders@gmail.com](mailto:vdlanders@gmail.com).



Bud Langham has been a physical therapist for 18 years and has held leadership roles in a variety of acute and post-acute care settings. He currently serves as Chief Clinical Officer of Encompass Home Health and Hospice and is based out of Dallas, TX. He leads the company's efforts to promote evidence-based practice, patient-centered care, and innovative care practices with the goal of achieving the highest level of quality and patient satisfaction. Bud has been with Encompass for 9 years. He obtained his PT degree and MBA from the University of Oklahoma.

*Each year, 3 million older people are treated in emergency departments for fall injuries according to the CDC.<sup>1</sup>*

## September is Fall Awareness and Prevention Month

Plan now to volunteer at or organize a community event to help prevent falls.

**Ideas and resources available at**

<https://www.cdc.gov/homeandrecreationalafety/falls/adultfalls.html>

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# Reframing Aging: A Synopsis of the FrameWorks Institute's Publications on Aging

Cathy Ciolek, PT, DPT, FAPTA

“To reap the longevity dividend, America needs an aging attitude adjustment.”<sup>1</sup>

## REFRAMING AGING PROJECT

“When would you say a person is old?” and “What is it like to be an older person in America?” These are some of the questions that the FrameWorks Institute started asking the public to determine the cultural beliefs that Americans hold about aging. They worked as the research partner for the Reframing Aging Project (see Box) that led to the publication of several reports on Aging in America. The goal of this project was to use communications research and outreach efforts to create more informed conversations about aging and how an aging population will impact communities in the future.

### Box. Reframing Aging Project Initiative Organizations

Partnership Organizations: AARP, American Federation for Aging Research, American Geriatrics Society, American Society on Aging, Gerontological Society of America, Grantmakers in Aging, National Council on Aging, National Hispanic Council on Aging  
Funding Organizations: AARP, Archstone Foundation, The Atlantic Philanthropies, Endowment for Health, Fan Fox and Leslie R. Samuels Foundation, The John A. Hartford Foundation, The Retirement Research Foundation, Rose Community Foundation, and The SCAN Foundation

## FRAMEWORKS INSTITUTE<sup>2</sup>

An independent nonprofit organization founded in 1999, FrameWorks has become known for its development of Strategic Frame Analysis™, which roots communications

practice in the cognitive and social sciences. FrameWorks designs, conducts, and publishes multi-method, multi-disciplinary communications research to empirically identify the most effective ways of reframing social and scientific topics. The Institute also offers strategic guidance and a variety of professional learning opportunities for advocates, scientists, policymakers, and nonprofit leaders. Through this applied communications research and knowledge translation process, FrameWorks prepares nonprofit organizations to expand their constituency base, to build public will, and to further public understanding of specific social issues. The stated mission of the FrameWorks Institute is: To advance the nonprofit sector's communications capacity by identifying, translating, and modeling relevant scholarly research to frame the public discourse on social problems.

## POPULAR MISCONCEPTIONS WITHIN THE UNITED STATES

In 2015 one of the first reports focused on misconceptions held by the general public about aging. This report mapped the gap between the views of professionals working with an aging population and what they define as 6 implicit understandings and assumptions held by the American population at large.<sup>2</sup>

### “Ideal Vs. Real”<sup>3</sup>

Americans like to think that the aspirational ideals of being active and engaged exist and that their personal future health will not be an issue. However, the population surveyed hold negative understandings of the aging process and often feel a sense that aging is something to be fought (ie, entire lines of anti-aging beauty products). They dread aging and prefer to not think about it happening to them.

### “Us vs Them”<sup>3</sup>

This can be viewed as “othering.” The “elderly” are compartmentalized as a separate group from the rest of society. Any initiatives to assist older adults will come at the expense of another group in society and so it is a view of limited resources for all.

### “Inefficient Government”<sup>3</sup>

Here the report describes that Americans feel their government cannot manage the collective resources to meet the needs of everyone. This leads many people to anticipate that Social Security and Medicare cannot be fixed and will not be available for “us” in the future.

### “Fatalism”<sup>3</sup>

There is a view that little can be done to improve the future. Demographics that appear overwhelming created terms like “Silver Tsunami” as an unstoppable force that will destroy everyone in its path. These fatalistic views cause people to think nothing can be done, so why bother to prepare.

### “Cognitive Holes”<sup>3</sup>

Cognitive holes refer to areas that the public really has no idea or thoughts about within an issue; these are issues that are just not in the public consciousness. Several specific areas of cognitive holes are described including how social determinants of health impact well-being in aging and how ageism negatively impacts aging. The take home message of this report: Aging is misunderstood. This misunderstanding is an impediment to policy and practice changes.

## FRAMES THAT WORK

The Reframing Aging Project identified a great deal of work to do! Even more importantly they field tested messaging for individuals and organization to use to see if the

messaging positively or negatively impacted the recipient. FrameWorks Institute identified two narrative themes that can elevate discussion: Confronting Injustice and Embracing the Dynamic.<sup>4</sup>

### “Confronting Injustice”

The United States does not treat older people as equals and too often marginalizes their activities and contributions. To improve as a society, we must address ageism as an injustice against older people. For example; how many of our colleagues have an implicit bias in goal setting for older adults? If older persons are accepted as *equal* members of society, then the expectations of the physical therapist for older people’s participation in society should be based on what is important for that person’s well-being irrespective of their chronological age. Physical therapy goals should be set accordingly.

Specifically, in addressing issues of ageism, the research findings of the Reframing Aging Project conclude that sharing a definition of ageism is key. Most people do not understand the term and are influenced by a culturally implicit bias. Use of concrete examples of this bias are found to be essential to sharing a definition of ageism.

### “Embracing the Dynamic”

The “Embracing the Dynamic” narrative demonstrated greater efficacy for policy reform. This focuses on the concept of American ingenuity: we are problem solvers who can do things better and smarter if we try. Older people have a wealth of accumulated

experience and wisdom that can drive society to change in new ways. Society will grow when we form partnerships to meet all of our future needs.

Embrace the dynamic future and build momentum by looking at all the possibilities for a more engaged future self and what *you (we)* need to do to get there. Physical activity, for example, is beneficial to health and well-being. Know what resources and access to exercise programs exist for your patients after discharge, for example, those that impact balance. The process to identify the barriers must begin to encourage us (collectively and individually) to try an innovative approach to modify social determinants of population health, even one person at a time.

### COMMUNICATION TIPS

One of the key elements is for professionals in all sectors of aging services to try to use this framework to reinforce the same message as opposed to having competing narratives and messages. The American Geriatrics Society (AGS) switched to AMA (American Medical Association) formatting with additions for the *Journal of the American Geriatrics Society* to embrace AMA standards around aging and using people first language.<sup>5</sup> Words matter. Additionally, the AGS is developing resources for authors and readers to promote the “Embracing the Dynamic” narrative. The APTA and its components should consider adopting similar guidelines.

The FrameWorks Institute website has multiple learning opportunities including the interactive Toolkit,<sup>6</sup>

research publications, and a webinar. The data is fascinating. It will make you reconsider terms and thoughts on how you speak in presentations and personal interactions. There are also some simple step by step guides on how to review messaging before posting to Twitter, Facebook, and blogs. Most importantly, they describe some concepts that showed a worsening of view points when some narratives were used. Unfortunately, these are often the narratives we see in major news publications and stories. Learn to recognize poor word choices and substitute the new narrative; examples are provided in Table 1.

### CONCLUSION

Each physical therapist and physical therapist assistant who works with older people can take some simple steps to improve their own word choice and strategies when they discuss issues associated with aging. Share the communications toolkit with your organizations’ public relations department who may be putting together articles for a newsletter or webpage. When you have the opportunity to work with students, have them start thinking about their future selves. Each of us can help build momentum for a just society that treats older people as we hope to be treated.

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**Table 1.** Words Are Important!

Avoid	Try to use instead	Why
They, them	Us, we	Aging is not something that happens to someone else. It is (hopefully) in all our futures!
Senior, Elderly	Older Person or Older Adult	Testing showed Older Adult as preferred word choice but an association with 54 years old. Older Person was very close and reflected a 64 years old and is more in target range for policy.
Silver Tsunami or Gray Wave	As more Americans age, we need to adjust...	Demographics are clear, but use of these terms creates a fear message that discourages long-term engagement (fatalism).
Super Senior Narrative	Use stories that show how social contexts and environments matter as we age	Super senior reinforces an individualism belief that rely solely on personal choices for outcome and ignore social determinants of health.
Term Ageism Without Explanation	Define ageism and show how this is an implicit bias in society	Most Americans are unfamiliar with ageism and comparing it to other civil rights issues makes people think it couldn’t possibly be as bad as other “isms.”

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# Communicating with Persons with Cognitive Impairment: Improving Physical Therapy Students' Effectiveness through a Blinded Role-play Experience

*Jen Mullen, DPT, BSW, MPA; Brad W. Willis, MPT, GCS; Evan Prost, DPT, CEEAA*

## INTRODUCTION

Inappropriate communication from health professionals can increase resistance to care<sup>1</sup> as well as elevate levels of anxiety and depression<sup>2</sup> in persons living with dementia. The University of Missouri Doctorate of Physical Therapy (DPT) program received feedback from clinical instructors that DPT students needed more training in communication with patients living with dementia. A quality improvement initiative laboratory simulation was designed to address the deficit by specifically focusing on using fewer words when giving instructions. It was hypothesized that a blinded role-play laboratory simulation with verbiage transcription, word counting, and editing would reduce the word count from the initial levels.

## BACKGROUND

Physical therapy (PT) students and physical therapist assistant students can expect to work with older adults upon graduation. In 2030, nearly 1 in 5 US residents will be age 65 or older. By 2050, that age cohort is projected to be more than double the 2010 population for the same group.<sup>3</sup> Dementia measured on a global scale makes up approximately 5% to 7% percent of adults over age 60.<sup>4</sup> The percent of long-term care service users in nursing homes diagnosed with Alzheimer's disease or other dementias is 50%, while this rate in residential care community residents and home health agency patients is reported at 37% and 31%, respectively.<sup>5</sup>

Unfortunately, such cognitive impairments can manifest with communication difficulties, which can lead to social isolation and a tendency for the person to be treated as an object instead of as a person, further negatively impacting the quality of life.<sup>2</sup> Specifically, the deterioration of communication skills

may lead to behavioral changes that create a vicious cycle of increased isolation, as it has been shown that care staff/partners interact the least with people who have communication difficulties.<sup>2</sup> Notably, it has been reported that persons with Alzheimer's disease or vascular dementia exhibit rates of depression as high as 87%.<sup>5</sup>

Fortunately, the training of caregivers has been shown to improve outcomes for both those living with dementia and the people responsible for their care.<sup>6</sup> A person-centered communication strategy uses the family and other resources to better know the patient, ensuring that caregivers talk to the patient rather than about the patient.<sup>2</sup> This strategy is built around the cornerstone of involving the client in the decisions made around his or her care, which is aimed at reducing potential social isolation.<sup>2</sup>

As dementia progresses, the person experiences a decline in receptive and expressive communication as well as memory loss.<sup>2</sup> This decline requires caregivers to be especially cognizant of their own communication behavior. Speaking more slowly allows the person living with dementia greater time to process the message, although it is important to maintain the same tone of voice as one would use in typical speech.<sup>7</sup> In addition, providing context and using simple sentence structure can enhance communication, eg, by avoiding pronouns and not using more than one verb in a sentence.<sup>7</sup> Although the use of repetition and yes/no questions may garner better understanding than more complex open-ended questions, the caregiver should ensure the message is understood before assuming that "yes" equates to patient comprehension and consent.<sup>7</sup>

The University of Missouri DPT program solicits open-ended feedback

from clinical instructors about the performance of DPT students during their clinical rotations. As a result, clinical instructors identified students' need for more training in how to communicate effectively with patients living with dementia.

During the fall of their third and final academic year, DPT students complete the course "Geriatrics and Orthopedics." This investigation specifically examined third-year student cohorts in the fall of 2014 and 2015, following feedback from clinical instructors about perceived areas for improvement. During this time, students attended a lecture and received a handout focused on methods to improve communication when working with persons living with cognitive impairment. One key recommendation was to use fewer words when giving instructions. In a subsequent laboratory experience, students completed a blinded role-play activity. This was intended to raise their self-awareness about how many words they used when giving instructions on how to perform the Timed Up and Go (TUG), a functional performance test commonly used with older adults.

## METHOD

In 26 teams of three, 78 participants (DPT students) were given the role as either therapist, patient with dementia, or recorder. Subjects completed a pre-word-count activity, intervention, and post-word-count but were initially blinded to the intervention and post-word-count activities. The pre-word-count activity was an audio recording of the student who was role-playing the physical therapist, explaining how to perform the TUG to the student who was role-playing a patient with cognitive impairment. For the intervention,

subjects listened to the recording, transcribed the therapist's instructions, and counted the number of words (except the social introduction). For the post-word-count activity, teams reviewed past lecture notes and handouts for tips about how to improve communication with persons with dementia, eg, simplify and use fewer words.<sup>6,8</sup> Teams rewrote their initial verbal instructions and counted the words. Comparison of pre- and post-word-count was calculated using the Wilcoxon Signed-Rank Test using IBM SPSS v.23.

## RESULTS

The number of words was significantly reduced from pre- to post-word-count ( $p < .001$ ). The average word reduction was 50.1% ( $\pm 23.0$ ). The pre-word-count average was 57.0 ( $\pm 25.8$ ), with a range of 20-149 (Figure 1). The post-word-count average was 25.6 ( $\pm 10.8$ ), with a range of 10-58 (Figure 2).

## CONCLUSION

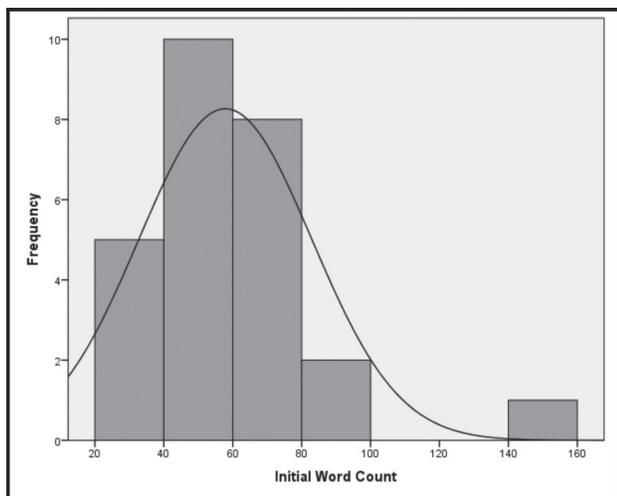
The sole use of lecture and handout materials, with tips aimed at improving communication with older adults suffering from cognitive impairment, did not translate into the delivery of simple, concise instructions during a clinical scenario role-play. Later transcription and editing of verbiage was an effective method for subjects to practice developing simple, concise instructions to communicate with older adults living with cognitive impairment.

## CLINICAL RELEVANCE

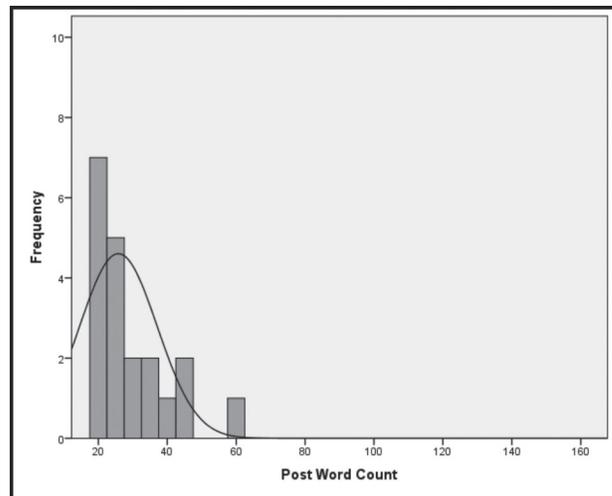
Before graduating from a DPT program, students may have had minimal clinical experience working with patients living with dementia, and students may lack self-awareness of their habitual language patterns in the clinic. A blinded role-play laboratory simulation with a clinical scenario, including either a standardized patient or another student role-playing a patient with dementia, can help translate didactic communication tips into improved clinical communication behavior and facilitate the delivery of simple, concise instructions. Specifically, the use of verbiage transcription appears to be an effective teaching tool for practitioners. If appropriately implemented, enhanced communication skills by health care providers may further improve interactive behavior<sup>9</sup> as well as quality of life and well-being<sup>6</sup> for persons living with dementia.

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**Figure 1.** Initial word count of instructions to perform the TUG.



**Figure 2.** Word count, after editing the transcribed audio recording of instructions to perform the TUG.



Jen Mullen is a 2018 graduate of the doctor of physical therapy program at the University of Missouri in Columbia, Missouri. She obtained a Baccalaureate of Social Work in 1999 and a Masters of Public Affairs in 2006. She spent 15 years as a social worker and manager focused primarily on advocacy and care of children and also adults with developmental disabilities before returning to school in 2014 to pursue a doctor of physical therapy degree.



Brad W. Willis is a board-certified geriatric clinical specialist who received a Master of Physical Therapy in 2008 and is currently working on a PhD in Educational Leadership and Policy Analysis from the University of Missouri. His research interests include the use of markerless motion capture during functional movement tasks, the exercise habits of older adults, and the development of critical thinking and clinical reasoning skills in DPT students.



Evan Prost received a BS in Elementary Education in 1978, a BSEd in Physical Therapy in 1988, and a Doctorate of Physical Therapy in 2010. He is a member of the Show Me Falls Free Coalition and has organized and participated in numerous fall risk screening events for community-dwelling, older adults. His primary research interest is exploring the potential benefit of using walking poles for older adults, particularly those with chronic lower back pain.

## Celebrate Active Aging Week

*Lori Schrodt, PT, MS, PhD*

### ACTIVE AGING WEEK 2018: INSPIRING WELLNESS September 23 – September 29, 2018

It is time to start planning for Active Aging Week!® (AAW) Sponsored by the International Council on Active Aging (ICAA), this week is dedicated to celebrating and promoting active aging. The week offers physical therapists and physical therapists assistants a terrific opportunity to help promote wellness activities in local communities.

Active Aging Week is an international celebration of positive, active aging. This year's AAW *Inspiring Wellness* theme encourages adults 50 years and older to experience a variety of wellness activities and live a more healthy lifestyle. During AAW individuals have the opportunity to experience exercise and other healthy aging activities throughout their communities. Anyone can get involved and offer one or more programs during AAW. Traditionally senior centers, retirement communities, area agencies on aging, health care, and other aging and wellness partners celebrate AAW by offering a variety of free (and fun!) programs.

Consider partnering with other agencies to expand your reach. Typical programs include group exercise classes, health fairs, educational events, group walks, dances, and arts and craft classes. This year's special themes include AquaDance, fall prevention, and WALK! with Aegis Therapies. Last year over 3000 organizations across 5 countries, including the United States, participated in AAW. Let's get out there and increase the role of physical therapy in promoting active aging and wellness! Start a new program yourself or check with your partners and agencies to find out more about AAW programs in your area.

ICAA offers support to organizations and participants through a dedicated AAW website ([www.activeagingweek.com](http://www.activeagingweek.com)). The website includes success stories and samples of previous programs, a toolkit for planning and promoting events, and other health and activity materials. If you have not joined in AAW in the past, consider doing so this year.

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

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

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