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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/Memoriam Fund is a wonderful expressive memorial.
We need to own our role. What I am referring to: assuring that we are practicing to the fullest extent of our education and training within the boundaries of our jurisdictional law as physical therapists (PTs) and physical therapist assistants (PTAs). In other words, are we ‘practicing at the top of our license?’ Physical therapists and PTAs have education and training in providing skilled health care to our patients and clients. The term ‘skilled,’ when used in this context frequently leads one down the thought train towards only those services which are (currently) billable – eg, ‘therapeutic exercise’ or ‘gait training.’ When we provide these services, how skilled are they? That is not a question about the code, it is a question about the provider and it begs honest self-reflection. Are we guilty of under-dosing exercise in our aging patients? Are we ‘ambulating’ instead of gait training? Are we challenging balance enough, or providing training in the context in which our patients will live and function? Did we check vital signs to know how our patients’ cardiovascular-pulmonary systems responded to our interventions? Were their vitals normal even before we began our interventions? These are questions we must ask with every patient, on every visit.

Beyond the skilled, billable interventions we provide, we have an important role in patient management. In most settings, PTs and PTAs interact with patients more often than any other provider. We have an obligation to manage the patient and not simply treat the patient. We should be screening every patient over the age of 60 for falls, regardless of the reason for referral. We should be asking questions about the patient’s social determinants of health like: his or her education level, the structure and adequacy of the home, nutrition, immunizations, and substance abuse. We should recognize red and yellow flags for disease (including mental illness) and disability. When we fail to truly ‘manage’ the patient or client, we fail them. We also fail society and, importantly, we fail our profession.

Physical therapists and PTAs must work collaboratively with other professionals and caregivers to produce the best outcomes for the patient. Sometimes, that means managing components of care that are not directly attached to a CPT code. New payment models are about to drastically change the way we work in the skilled nursing facility (SNF) and home health (HH) settings. The SNF prospective payment system changes dramatically in October 2019 to the Patient Driven Payment Model (PDPM). The HH prospective payment system follows right after in January 2020 with the implementation of the Patient Driven Groupings Model (PDGM) (See: Strunk E. Policy Talk: Post-acute care payment is changing. GeriNotes. 2019;25(1):5-8). These new models of payment are a big shift towards true value-based payment. Financial success in these models will depend much less on utilization of therapy services and far more on patient outcomes. That means PTs and PTAs can and should be involved in holistic management of the patient’s condition. Stepping up to the plate and practicing at the top of our licenses will be critical to patient success, organizational success, and personal success. We can no longer tolerate substandard care, questionable ‘skill,’ or under/overutilization. In fact, if we continue to allow this (I would argue that we have allowed it), it will be the death of our profession. Complacency will kill us.

Am I overstating and hyperbolizing this problem? Personally, I do not think so. We have all seen poor patient management, under-dosing, non-skilled care, or under/overutilization. Why have we tolerated it? Why have we not called it out? We need to take a long, hard look at ourselves, as a profession. As much as we do not like to say that payment drives behavior, it does. Patient driven payment model and PDGM provide us with an opportunity to truly reflect on our past behavior and change what is necessary to succeed in a drastically new world. This is not a bad thing. It is an opportunity for PTs and PTAs to shine. And most importantly, it is an opportunity for our patients to get high quality, skilled, necessary, comprehensive care.

Patient driven payment model and PDGM will not be the last significant payment change we see. In fact, they are the first step towards an even broader value-based purchasing model. If our profession can shine in these new models, our services become essential in any model. But if we fail to step up, if we fail to elevate care, if we fail to practice at the top of our licenses, we fail our patients, ourselves, and our profession. While I may be preaching to the choir, we have an obligation to help all of our colleagues elevate their practice. This is not a problem for every PT or PTA; it is a problem for our profession as a whole.

The AGPT has invested a tremendous amount of resources to help you learn more about both PDPM and PDGM. Watch for webinars, podcasts, courses, and more. Keep an eye on our website for frequent updates, resources, and reach out to your Board of Directors or Committees for more information. We can use this opportunity to reflect on our practice individually and collectively to foster change. It is time.
Editor's Note

Michele Stanley, PT, DPT

Employment of physical therapists is projected to grow 28 percent from 2016 to 2026. It further delineates: “Job opportunities are expected to be good for licensed physical therapists in all settings. Job prospects should be particularly good in acute-care hospitals, skilled-nursing facilities, and orthopedic settings, where the elderly are most often treated. Job prospects should be especially favorable in rural areas because many physical therapists live in highly populated urban and suburban areas.”1 This may be reassuring news to highly populated urban and suburban therapists. Am I predicting similar dire circumstances as a PowerBallTM winner or stock market superstar? There will be changes, however, and there will be people on both sides of the management aisle who are not well adapted to change. You don’t need to be one of them. Many therapists have already adapted to fickle market shares and changing insurer requirements to develop niche practices or additional therapy-related income streams as a hedge against changes. In one of the next issues, we will be featuring the practices and stories of some of these colleagues—and we would like to feature YOU as well if you work in an “alternative” setting as you treat older adults: fitness centers? wellness coach? home modification or housing placement consultant? Let’s talk. In the interim, read the insights of one of our geriatric residents on his unique perspective as a former financial planner on the likely impact of PDPM on skilled nursing facilities.

Combined Sections Meeting 2019 is over, read all about what the Academy is up to and congratulate our award winners. Especially exciting is the creation of a new Award, named in honor of our very own columnist and geriatrician: Carole Lewis. GET LIT, the regular GeriNotes column by Carole and new co-author Linda McAllister returns with 13 evidence-based core exercises that you will want to try with your patients. Also in this issue, we continue trying to highlight something of special interest to PTAs, like Linda Eberly’s study. A new mini-series starts relating to yoga practices geared toward an older clientele for fall risk reduction with an exciting first for GeriNotes: an embedded QR code to demonstrate videos and supplemental online only content. Anyone with a similar Tai Chi practice that you would like to share?

We all get pitches for financial support: research award fellowship winner, Rebecca Klatt shares the personal impact of your professional and personal generosity in advancing our profession. “Research” need not be as high-powered and impressive as Dr. Klatt’s work to generate our interest and provide a stepping stone for further inquiry. Please be generous in sharing your own case reports.

Is there a product that you heard about and tried (with success or failure) with a special patient problem? Did you find a way to improvise a solution or a systematic education approach that solved a client or family hurdle? Have you found a way to make your clinic environment more LGBQT friendly? What kind of nutrition information do you include in your practice? We all need ideas to achieve functional outcomes for some of our own special clients. A reminder: a great way to problem-solve and get collective ideas is to post in our moderated Spam-free listserv. Go to https://groups.yahoo.com/neo/groups/geriatricspt/info.

Are you going to NEXT? Join over 2,000 of your peers in Chicago June 12-15 for some great programming and networking. If you would like to ask questions about the Academy of Geriatric Physical Therapy (AGPT), there will be a Board member at the AGPT booth in the exhibit hall during all of the unopposed times [Wednesday 6/12: 4:00 -6:30 p.m.; Thursday and Friday 6/13-14: 11:00 a.m.- 2:00 p.m.]. I will be there on Thursday and Friday during those times as well and would love to hear your ideas for a story pitched. YOU can also sign up to volunteer at the AGPT booth (https://geriatricspt.org/next/). This is a fun way to meet new people.

REFERENCE

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REFERENCE
Academy of Geriatric Physical Therapy Awards Ceremony and Member Meeting Recap

Karen Curran, AGPT Executive

Thanks to everyone who attended the Breakfast of Champions at CSM 2019 in Washington, DC last January. It was wonderful to see so many members at our inaugural event that included the GCS Breakfast, the AGPT Awards Celebration and our very first named lecture. Congratulations to all the 2019 award and recognition winners!

CAROLE B. LEWIS LECTURE AWARD

We were honored to have Dr. Carole B. Lewis deliver the lecture and excited to announce that the Academy of Geriatric Physical Therapy has created the Carole B. Lewis Lecture Award to promote discussion of challenging issues, advocacy, and leadership in geriatric physical therapy. The lecture will be an annual event during the Combined Sections Meeting of the APTA. Dale Avers, PT, DPT, PhD, FAPTA, was announced as our guest lecturer for CSM 2020.

JOAN M. MILLS AWARD

We especially thank all of the charter members, and Joan Mills winners, and past presidents in attendance and congratulated our latest Joan M. Mills Award winner, Ann Medley, PT, PhD. The Joan M. Mills Award is the most significant recognition that the Academy can give to one of its members. This prestigious award was initiated in 1980 to honor individuals who have generously, unselfishly, and creatively given of their time and gifts in service to the Academy. These wonderful attributes are those that typify Joan M. Mills, the founder of the Academy.

Ann is a Professor and Director, School of Physical Therapy, Texas Woman’s University where her research interests include functional assessments for older patients and patients following stroke. Ann currently serves on the Academy’s Board of Directors as our very capable Secretary where she was just re-elected for her second term. Ann is also the Board Liaison for the Communications Committee. In that role she oversees many parts of our new strategic plan including encouraging the use of social media and email communication, as well as printed materials to communicate with the membership.

She previously served on the AGPT PR Committee and as the AGPT Alternate Delegate. Ann chaired the AGPT Bylaws Task Force in 2015. She was heavily involved in the process of changing the Section on Geriatrics to the Academy. Ann is an Associate Editor for the Journal of Geriatric Physical Therapy and is certified as an Exercise Expert for the Aging Adult.

Ann has a wonderful ability to interact with other physical therapists who also share a love for treating older people. She has strong organizational skills, clear communication, and the ability to work with multiple individuals simultaneously, which serves her well in her roles as Secretary and Communications Committee liaison. She serves as a mentor to members, students, and clinicians and possesses outstanding leadership and organizational skills.

PRESIDENT’S AWARDS

Also recognized for their outstanding service were Beth Black, PT, and Heidi Moyer, PT, DPT, who received President's Awards. Beth and Heidi have been instrumental in growing our state advocate program by leaps and bounds! Almost all states now have an advocate and many have co-advocates to share the workload. Beth is the Western Regional Co-Coordinator and Heidi is the Eastern Regional Co-Coordinator.
OUTSTANDING PTA STUDENT AWARD

Congratulations to Jeremy Darnell, who received the 2019 Outstanding PTA Student Award.

Jeremy is from Somerset Community College where he is a very active member of the APTA. He holds membership in 4 sections, including AGPT, and has led fundraising efforts for the 2018 Mercer-Marquette Challenge. Jeremy has co-authored brochures for the AGPT Educational Brochure design competition. At the Kentucky Student Conclave, he was named to the 2018 KPTA All-Academic Team. Mentorship is a strength for Jeremy as he serves as a peer mentor and has presented to touring high school students about physical therapy. Within Somerset Community College PTA program, Jeremy excels in his coursework and is president of his class. In addition to his studies and all of his APTA involvement, he has volunteered for numerous local community service events.

OUTSTANDING PT STUDENT AWARD

The Outstanding PT Student Award was given to Noelle Alicea from Thomas Jefferson University. Noelle’s compassionate heart and passion for geriatric physical therapy was evident throughout her nomination and support letters from faculty and students. As a student, she has dedicated her time through service, leadership, and research activities to advance her knowledge and to elevate the performance of her peers.

Noelle traveled to Guatemala for a service-learning trip to provide physical therapy through the Hearts in Motion organization. She was described as a leader on this trip and her affinity for working with older adults was clear during the treatment sessions. Noelle was also involved in forming the Geriatric subcommittee of the Thomas Jefferson University PT Society. Noelle is active within the APTA and has attended the PPTA conference and CSM.

VOLUNTEERS IN ACTION AWARD

The Volunteers in Action Award recognizes the exceptional contribution of a physical therapist or physical therapist assistant in community service that benefits older adults. The 2019 award was given to Phyllis Kitchens for her volunteer work for the Alzheimer’s Association, Emory Alzheimer’s Disease Research Center at Lou Walker Senior Center in DeKalb County, Georgia. She serves on the DeKalb for Seniors Board at the Lou Walker Center. As a home health therapist, Phyllis has always been a servant community leader; working with these organizations has allowed her to be part of programming and implementation of programs directly affecting the older adults in her community.

CLINICAL EDUCATOR AWARD

The Clinical Educator award recognizes a physical therapist or physical therapist assistant for outstanding work as a clinical educator in the geriatric health care setting. Dr. Tara Granada, winner of the Clinical Educator Award, has had a passion for clinical education throughout her physical therapy career. Her nomination packet emphasized Tara’s commitment to her patients and her students in the clinic. One of her former students stated that Tara “used every patient interaction as an opportunity to teach me something new.” It is clear that she prioritizes her student’s goals as well as making sure that her patients receive optimal care. The students that wrote support letters emphasized Tara’s commitment to using evidence-based evaluation strategies and interventions that are specific to each patient. They also described her teaching ability and passion for geriatric physical therapy. Tara advocates for her patients and creates opportunities for her students. Tara strives to be the best geriatric therapist she can be so she can pass this onto her patients and her students.

CLINICAL EXCELLENCE AWARD

This award for outstanding clinical practice in geriatric health care settings was given to Dr. James Ballard, a faculty member at the University of Utah Department of Physical Therapy and Athletic Training. Dr. Ballard actively advocates for older adults in the many positions he holds. He is a role model for excellence in physical therapy practice.

He demonstrates leadership by teaching within the Vestibular Rehabilitation: A Competency Based Course, by being a Stepping On instructor, by being a member of the multidisciplinary Deep Brain Stimulator (DBS) team assessing appropriateness of DBS for people with Parkinson’s Disease and tremors, and by teaching entry-level DPT students. He demonstrates clinical excellence by applying the knowledge, skill, and techniques used in these exposures and using them with his own patients. Dr. Ballard sees a variety of older adults in his practice. His patients have been diagnosed with anything from pelvic floor dysfunction, to dizziness, to decreased balance, to Parkinson’s Disease. He approaches each patient with respect, empathy, and compassion and his dedication to help them is admirable. His passion influences other providers within the clinic and the students who are lucky enough to have him in in the classroom and lucky enough to see him interact with patients. All of his letters of recommendation describe his awesome sense of humor, quick wit, and kind and caring personality.

OUTSTANDING PTA AWARD

The Outstanding PTA award recognizes a physical therapist assistant for...
outstanding practice in a geriatric health care setting.

Jeremy Foster, winner of the Outstanding PTA Award, was described as an extremely hard worker that is energetic and dedicated to his patients. He earned the Advanced Proficiency Certification for the PTA in Geriatrics in 2010 and holds Advanced Proficiency Certifications in Acute Care (2012) and Integumentary System (2005). Being an active member of our professional organization is also important to him. He has been a member of the APTA since 1999 and he has represented Mississippi as the PTA Caucus Representative since 2015. He was voted the Mississippi PTA of the year in 2017. This year, Jeremy used his own funds to create and mail postcards to all 1240 licensed PTAs in Mississippi. He thanked them for their service and also informed them of the 15% decrease in reimbursement for PTA treatment of Part B Medicare patients. He encouraged all to contact him, join the APTA, and lobby for change. Finally, Jeremy was chair of the task force that created the document, “Core Competencies for the Entry-Level PTA in the Acute Care Setting” (2017).

EXCELLENCE IN GERIATRIC RESEARCH AWARD


Fellowship for Geriatric Research

Brook Klatt, DPT, PhD, post-doctoral research at John Hopkins University; research focus: relation of vestibular function and cognition; visuospatial ability particularly related in older adults and persons with Alzheimer Disease.

STUDENT RESEARCH AWARD

Ashleigh Trapuzzano, DPT, student at the University of Central Florida; current research involvement in predictors of comfortable and fast gait speed in older adults and the interplay of physical performance and cognition with comfortable and fast gait speed in older adults.

The Awards and Research Committees would like the thank all of the nominees and their supporters for their nominations for 2019. Please consider honoring someone who is doing extraordinary work in geriatric physical therapy by nominating him or her for a 2020 award. Please see the AGPT website at https://geriatricspt.org/awards/ for a description of AGPT awards and the nomination process.

DISTINGUISHED EDUCATOR AWARD

Dr. Stephen Carp is this year’s winner of the Distinguished Educator Award, recognizing excellence in teaching. At DeSales University, Dr. Carp instructs the geriatrics class and the geriatrics pro-bono clinic. His nomination packet described his passion for geriatrics that is supported by his numerous publications, textbook authorship, service to the Journal of Geriatrics Physical Therapy, and service and compassion to older adults in the community. His colleagues and students report that he uses innovative teaching methods to motivate and facilitate learning. Dr. Carp has developed a dynamic Geriatrics-focused curriculum that accommodates several different learning styles through the continued use of student feedback to ensure the success of those he teaches. He uses an array of resources such as evidence-based research, podcasts, videos, and clinical case studies, including an incredible amount from his own clinical experience. His teaching extends even beyond the classroom, as he continues to prepare and send case studies to alumni. These teaching opportunities not only provide clinically objective cases, but life lessons on developing trusting therapeutic relationships and interpersonal skills. One of the student support letters said, “Dr. Carp is producing future clinicians who share his compassion, ability to provide excellent care that is patient-centered, and to make everyone feel cared for.”

ADOPT-A-DOC AWARDS

Pamela Dunlap, DPT, NCS, doctoral student at the University of Pittsburgh; major field of study: vestibular rehabilitation, balance, and falls.

Talina Corvus, DPT, doctoral student at Pacific University; major field of study: education and leadership; aging, physical activity as relates to cultural minorities.
Saying Thank You to Our Outgoing Leaders

Myles Quiben—Outgoing Director of Education
Richard Bohannon—Outgoing Editor-in-Chief of the *Journal of Geriatric Physical Therapy*
Mariana Wingood—Outgoing Balance & Falls SIG Chair and Program Committee Co-Chair
Lise McCarthy—Outgoing Cognitive & Mental Health SIG Chair
Lisa Dehner—Outgoing Global Health for Aging Adults SIG Chair
Lori Schrodt—Outgoing Health Promotion & Wellness SIG Chair
Lee Ann Eagler—Outgoing Awards Committee Chair
Ron Meade—Outgoing Membership Committee Chair
Anne Coffman—Outgoing Nominating Committee Chair
Sarah Ross—Outgoing Program Committee Co-Chair
Rania Karim—Outgoing GCS/APP Subcommittee Chair (Practice)
Ken Miller—Outgoing Evidence Dissemination Subcommittee Chair (Practice)

Jane Jackson—Outgoing PTA Advocate
Ryan Murphy—Washington State Advocate
Cathy Renkiewicz—Virginia State Advocate

Congratulations to our new Officers and Chairs

Kate Brewer—AGPT Treasurer
Ken Miller—AGPT Director
Sue Wenker—AGPT Director

Lucy Jones—AGPT Nominating Committee
Jennifer Vincenzo—Balance & Falls SIG Chair
Shweta Subramani—Balance & Falls SIG Vice Chair
Heidi Moyer—Balance & Falls SIG Secretary
Sherri Betz—Bone Health SIG Chair
Andi Morgenthaler—Bone Health SIG Vice Chair
Virginia Renegar—Bone Health SIG Secretary
Amy Wagner—Bone Health SIG Nominating Committee
Christine Childers—Cognitive & Mental Health SIG Chair
Jennifer Howanitz—Global Health for Aging Adults SIG Interim Chair
Gina Pariser—Health Promotion & Wellness SIG Chair

Also, at the Members Meeting, the Academy’s new Mission, Vision, and Strategic Plan were unanimously approved and already your Board of Directors is working hard on many of the new and exciting initiatives!

**Academy of Geriatric Physical Therapy**  
**2019 – 2020 Strategic Plan**

**Vision Statement:**
Embracing aging and empowering adults to move, engage, and live well.

**Mission Statement:**
Building a community that advances the profession of physical therapy to optimize the experience of aging.

**Goals:**
Goal 1: AGPT provides education that enhances practice by producing value, empowering advocates, and promoting the use of evidence informed practice.
Goal 2: AGPT attracts, engages, and mobilizes physical therapists, physical therapist assistants, and students serving aging adults.
Goal 3: AGPT builds relationships to expand its influence and the reach of physical therapy.
Goosebumps

Carole B. Lewis, PT, DPT

The word Goosebumps reminds me of the books my children used to read. Today, the word best describes the visceral reaction I experienced upon learning that the Academy had named a distinguished lecture series in my honor. Even now, as I think about it, my body responds unbidden with the same intense reaction.

As a founding member of the Academy, my early contribution was membership recruitment. My most successful strategy was to offer continuing education courses at a discount to recruit members. After that I served as a member of the Board of Directors, as Vice President, then as President. I have never strayed too far from this group. Given that my passion is geriatrics, what could be more fulfilling than to share time with like-minded people?

I am humbled by this honor and grateful to the Academy. But the true significance of the lecture series is the recognition of the many outstanding clinicians and researchers working in the area of geriatrics. We strive continually to improve the quality of life of older adults and this lecture series is an important platform we can use to highlight our successes, inspire others, and promote our role in optimal aging.

I enthusiastically support the creativity and new directions the Academy is taking under the leadership of Greg Hartley, and I cannot thank the Board and the Academy enough for bestowing this distinction on me. At some point, I might stop getting goosebumps when I think or talk about it, but maybe not.

A heartfelt thank you to all of you!

Carole B. Lewis

Policy Talk: Frequently Asked Questions

Ellen R. Strunk, PT, MS

How are you preparing for the new payment models hitting the post-acute care space in the next 12 months? The Skilled Nursing Facility (SNF) Patient Driven Payment Model (PDPM) and the Home Health (HH) Patient Driven Groupings Model (PDGM) will bring landmark changes to these two practice settings. This may be the first-time therapists in these practice find themselves in a ‘value-based’ payment model, eg, where the volume of the services they deliver will have no bearing whatsoever on the amount the facility/agency is paid.

Providers are barraged with an abundance of webinars, articles, podcasts, and conferences that discuss the new models of care and seek to provide projections about the impact the models may or may not have on patient care and on the therapy world itself. The truth is the models have never been trialed before, so no one really knows what the outcome will be. What is true, however, is that patients’ clinical conditions, impairments, and illnesses will still require physical therapy services, and these patients will still exist on October 1, 2019, and January 1, 2020.

The Academy of Geriatric Physical Therapy (AGPT), the Health Policy and Administration (HPA) – The Catalyst Section, and the Home Health Sections (HHS) in collaboration with the APTA are working to develop tools and resources for clinicians in these areas. They can be found here: https://geriatricspt.org/practice/payment-policy-and-advocacy.cfm? and http://www.apta.org/PostacuteCareReform/.

Recently these groups recorded webinars on the PDPM and PDGM models and hosted live Q&A sessions following them. Here is a sample of the most frequently asked questions. For more information and additional Q&A, visit the webpages above and register for the free recordings.

SKILLED NURSING FACILITY’S PATIENT DRIVEN PAYMENT MODEL (PDPM)

PDPM Q1. Will restorative nursing replace therapy services?

Maintaining independence with activities of daily living is critical, and restorative nursing is an important part of a program to maintain functional skills. A resident may be started on restorative nursing who may not be a candidate for therapy or in conjunction with therapy. Restorative nursing will not replace therapy services. There are opportunities for skilled therapy and restorative nursing to work together. The PDPM provides therapists an opportunity to look at how restorative nursing and therapy services may be coordinated in an effort to improve patient outcomes and increase satisfaction.
PDPM Q2. Under PDPM, RUG minutes go away. So who decides how many minutes the patient gets/needs with the change in reimbursement?

The determination of the level of therapy does not change just because the payment model is changing. The basic criteria for a patient qualifying for a SNF Part A benefit has not changed. A resident must require skilled nursing 7 days/week and/or skilled therapy services 5 to 7 days/week. Therapists must learn to think about clinical approaches separately from this new payment methodology rather than equate the two. This is a patient-driven payment model. The patient will be the same person on September 30 as they are on October 1. How much therapy a patient needs/receives should always be determined by health care professionals, with input by the patient.

Now that rehabilitation is not necessarily the driver of payment, unfortunately there may be some knee jerk reactions by some SNF providers. As advocates for appropriate clinical decision-making, you should start talking with your colleagues, peers, and administrators about what volume and dosage of therapy is appropriate. The amount of therapy a patient requires should be based on physical presentation and his or her needs.

PDPM Q3. Are there any changes with students and reimbursement under PDPM?

Patient driven payment model makes no changes to the rules as it relates to students. The MDS RAI Manual provides the following guidance related to the use of therapy students:

**Individual Therapy:** The treatment of one resident at a time. The resident is receiving the therapist’s or the assistant’s full attention. Treatment of a resident individually at intermittent times during the day is individual treatment, and the minutes of individual treatment are added for the daily count… When a therapy student is involved with the treatment of a resident, the minutes may be coded as group therapy: the therapy student is providing the group treatment and the supervising therapist/assistant is not treating any residents and is not supervising other individuals (students or residents); or the supervising therapist/assistant is providing the group treatment and the therapy student is not providing treatment to any resident. In this case, the student is simply assisting the supervising therapist.

**PDPM Q4.** Under PDPM, up to 25% of therapy services can be delivered as group or concurrent. If my SNF has been delivering primarily individual therapy, and we begin to deliver 25%, will my SNF be flagged for audit? With this new limit on group and concurrent, how can my SNF stay fiscally responsible under PDPM?

Centers for Medicare and Medicaid Services (CMS) expects a significant portion of therapy delivered to the patient will be individual (no less than 75%). The decision to use group and concurrent therapy should be based on patients’ needs and clinical presentation. Although CMS expects to see an increase in group and concurrent therapy delivered to Medicare beneficiaries, if a patient went from 1% of group or concurrent to 25% overnight, that likely would be a red flag to CMS. Medicare will monitor group and concurrent therapy utilization and expects utilization to be appropriate, reasonable, and necessary. They will also be monitoring other important measures of clinical care appropriateness such as the quality measures and rehospitalization rates.

**PDPM Q5.** Currently, a therapist fills out Section GG in our SNF. Will a therapist continue to do so?

A clinician should be determining the final score for Section GG. Now that Section GG directly relates to payment for PT, OT, SLT, and Nursing components, there will be more attention to what is included in Section GG. If the scores chosen do not reflect the documentation, that could be a problem for providers. Begin to think about how those scores can be chosen.

Additionally, while therapists may be better suited to answering some GG items, others may be more appropriately answered by nursing. So there should be collaboration between providers. If you are currently completing Section GG as part of an outcome module or as part of the evaluation, you may continue to do so, but it may not be the same numbers that end up on the MDS.

**HOME HEALTH AGENCY’S PATIENT DRIVEN GROUPINGS MODEL (PDGM)**

**PDGM Q1.** I have a lot of concern around populations of patients that need therapy services but may not fall exclusively in that musculoskeletal or neurological group like cardiopulmonary patients. Is it a strategy to code those more in those groups?

It is not a strategy. You must code appropriately. Under PDGM,
just because someone is not in the musculoskeletal rehabilitation or neurological rehabilitation clinical groupings, does not mean they are not eligible to receive rehabilitation. If patients in MMTA, complex nursing, behavioral health, and wounds have rehabilitation needs, then agencies and their therapy professionals must satisfy those needs. Rehabilitation services are not confined to the neurological rehabilitation and musculoskeletal rehabilitation groupings. There will be many agencies that do not understand this. Therapy professionals must stand up and inform the agencies about the right way to do things.

As far as strategy, the strategy is for rehabilitation professionals to understand how to accurately code patients for the episodes of care that PTs and PTAs are involved in. Accuracy must be what we strive for. Patients who fall into the musculoskeletal rehabilitation or neurological rehabilitation clinical groupings need rehabilitation services. There is a myth that the patient in 1 of the other 4 clinical groupings will not need rehabilitation. However, rehabilitation needs are not driven by clinical grouping. There are many types of patients who may need rehabilitation services; we should not allow anyone to exclude access to rehabilitation just because of the clinical grouping.

Centers for Medicare and Medicaid Services reiterated this same sentiment during a February 12, 2019 PDGM webinar,² stating: “While there are Clinical Groups where the primary reason for Home Health services is for therapy, and others where the primary reason for Home Health is for nursing, these groups reflect the primary reason for Home Health services during the period of care - but not the only reason. Home Health remains a multi-disciplinary benefit, and payment is bundled to cover all necessary services identified on the individualized Home Health plan of care. So, for example, if a period of care is grouped under the complex nursing interventions group because the primary reason the patient needs Home Health services is for nursing care, therapy services could also be provided if those therapy services are reasonable and necessary and ordered on a Home Health plan of care.”

PDGM Q2. Productivity has been such a major driver of therapy behaviors and measure of financial success. Do you see the focus of this measure changing in the future and if so, what might therapists expect?

Productivity as an operational metric for all staff will not change. Ensuring agencies have a productive, efficient, and effective workforce is vital to the agency remaining in business and extending services to the patients who need them. Measuring specific productivity of therapy as a financial measure may change because there is no incremental revenue from it. That is for the better. There is need for a reimbursement system focused on clinical characteristics of the patient’s specific issues, not striving to achieve a certain level of reimbursement under the system. Rehabilitation professionals should take a proactive approach to ensuring agencies have a focus on the right metrics as we move forward under PDGM.

PDGM Q3. What does PDGM expect of rehabilitation professionals?

It is expecting that rehabilitation professionals will continue to deliver high quality therapy services that are reasonable and necessary. It is expecting such professionals will continue to drive value, which requires rehabilitation professionals to keep asking the question – how are we doing this? What do we need to do differently? What do we need to do better to drive value for our patient population?

People need to continue to ask questions about technical aspects of the rule change and how it will impact agencies operationally. These questions should include a workflow perspective, a documentation perspective, ensuring the EMR is ready to accommodate the changes, and how it will impact patient care. If a rehabilitation professional has concerns, he or she should not drive patients to outpatient therapy. The PDGM is a payment structure; it is not a benefit. The benefit is not changing. The benefit says: as long as a patient is homebound, he or she should receive home health services. The PDGM should not change how you are thinking of your patient from a homebound to a non-homebound patient. In other words, either the patient is eligible for the home health benefits or he or she is not.

PDGM Q4. I have concerns the PDGM may reduce the impact that therapy may have in home health due to concerns that therapy wouldn’t be “driving” the reimbursement anymore compared to now.

Many therapists are feeling this way. There are big changes happening in home health as well as skilled nursing facilities. Minutes will no longer drive reimbursement for SNFs. Care may look different. It is still is important to make sure that you get out there in front of your agencies, customers, and colleagues. Remind them of the value you bring to a patient’s quality of life, quality metrics, and be able to verbalize your impact on the patient.

If the only impact of therapy is as a revenue center, then we have not been doing it right. Under PDGM, rehabilitation professionals have an opportunity to demonstrate the significant value of rehabilitation services in this new model. Agencies are looking for high value therapy professionals. High value therapy professionals, committed to the organization, to the culture, to the patients, and who are driving value – driving patient satisfaction, are lifelong learners, who are committed to an innovative culture, etc.

PDGM Q5. Do you see these changes driving referrals toward home Medicare Part B visits as it relates to Physical Therapy?

This is one of those behavior versus benefit questions. The PDGM changes should not drive patients to outpatient therapy. The PDGM is a payment structure; it is not a benefit. The benefit is not changing. The benefit says: as long as a patient is homebound, he or she should receive home health services. The PDGM should not change how you are thinking of your patient from a homebound to a non-homebound patient. In other words, either the patient is eligible for the home health benefits or he or she is not.

REFERENCES
Improving Balance and Navigation for Older Adults, and for an Almost Middle-Aged Adult Too!

*What receiving the 2019 AGPT Geriatric Fellowship Award means to me professionally and personally*

Brooke N. Klatt, PT, DPT, PhD

Receiving the 2019 AGPT Geriatric Research Fellowship Award is a great honor. I extend my gratitude to the AGPT Research Committee for the award and for the opportunity to reflect on its professional and personal impact. Professionally, the award will support my research aims to investigate the association between vestibular and cognitive function. Personally, the honor represents a celebration of teamwork and an appreciation for sacrifices that have been made to get me to this stage of my research career. Currently, my research aims and my personal life goals are the same – to improve balance and navigation.

**PROFESSIONAL IMPACT**

Vestibular physical therapy (VPT) is effective in improving balance and reducing fall risk in cognitively-intact persons with vestibular impairment.1 It is well documented that people with Alzheimer’s Disease (AD) have increased falls;2 and recent evidence indicates that about half of individuals with mild-moderate AD have vestibular loss.3 However, VPT is not typically offered to patients with AD – despite the success other rehabilitation programs have shown is possible for people with AD and dementia.4,5 Our team has proposed a theoretical guide for applying VPT in individuals with cognitive impairment that integrates a Strength-based Approach to optimize motor learning by using the individual’s abilities and communication strategies to promote a therapeutic alliance.6 We are currently using this guide to investigate the benefits of VPT for individuals with AD.

During my fellowship, I am also exploring how visuospatial ability and navigation, both known to be impaired in people with AD7 and people with vestibular disorders,8,9 might be enhanced with rehabilitation. The AGPT Geriatric Fellowship Award funds will be used to complete coursework that will enable me to conduct research with continued focus on optimizing balance and navigation for older adults. By improving balance and navigation, we hope to increase activity and participation, and ultimately optimize quality of life for older adults with and without cognitive impairment.

**PERSONAL IMPACT**

Celebration of Teamwork

The recognition for this award belongs to a team of people. First, the ideas being investigated during my fellowship are generated from a team of people, mainly Dr. Yuri Agrawal, MD, MPH, FACS, at Johns Hopkins University, who has made significant contributions to the field of vestibular cognition. It is humbling to work in her lab and I am excited for all the future discoveries that will be unveiled. Furthermore, I would never be here without the support, mentorship, encouragement, and love from the other teams to which I belong. I am extremely proud to have received my scientific research training from the University of Pittsburgh in Rehabilitation Sciences with mentorship from vestibular experts: Joseph M. Furman, MD, PhD; Patrick J. Sarto, PT, PhD; and Susan L. Whitney, PT, DPT, PhD, ATC, FAPTA. I am eternally grateful for the scientific opportunities they have provided, and even more for their collegiality and friendship. During my PhD studies at the University of Pittsburgh, I was fortunate to receive mentorship from many other visionaries and I am forever grateful for their insight and guidance.

Clinically, I have the privilege of being a part of the University of Pittsburgh Medical Center – Centers for Rehab Services Neuro and Vestibular Outpatient team that consists of the most caring, devoted, and talented group of individuals I could imagine. This team also includes the people we have the opportunity to serve who give me purpose and inspiration. Lastly, my friends and family who have supported and loved me unconditionally, as I ventured into the world of research. If I have done anything right in my professional and personal life, it has been surrounding myself with greatness.

**Appreciation of Sacrifices Made**

I am proud of the sacrifices I have made over the past 6 years of my young investigator career, and I am grateful for the sacrifices others have made for me. I recognize that my mentors have sacrificed much time and effort on my behalf, and I am forever indebted to them for their investment and faith in me. My family has also made many sacrifices to allow me to pursue my scientific research endeavors, especially my husband who is the superman at work and at home. While my kids might not realize it yet, they too have sacrificed on my behalf. I hope that they each will someday appreciate that sacrifice and hard work is part of following your dream. At the young ages of 6, 4, and 1, they have inspired me to be my best for them.

Some days, “my best” doesn’t always seem particularly good in any aspect of life, but I continuously strive to be present during the time I am devoting to the things that are important to me – my career, faith, family, friends, health, hobbies, and service. I also appreciate that especially in this stage of my life, I
might need to "reweight" how I prioritize my time. While I am confident that I am on the right path, I recognize that I am a far distance away from being an independent investigator. I know that to successfully navigate my way through the early investigator stage of research, I will need continued guidance and mentorship. Just like Albert Einstein said, “Life is like riding a bicycle. To keep your balance, you must keep moving.” Smart words for older adults, an almost middle-aged adult who is pursuing a research career, and actually everyone, to live by.

REFERENCES

Brooke Klatt, PT, DPT, PhD, NCS, is a postdoctoral research fellow in the Department of Otolaryngology – Head and Neck Surgery at Johns Hopkins University School of Medicine where she is exploring the associations between vestibular and cognitive function in the laboratory of Dr. Yuri Agrawal. Dr. Klatt is a board-certified Neurologic Clinical Specialist and works clinically at the University of Pittsburgh Medical Center – Centers for Rehab Services. She received a PhD in Rehabilitation Sciences at the University of Pittsburgh, her DPT at New York University, and a BS in Kinesiology from Penn State University.

CSM 2019 Update
Kathleen Walworth and Tiffany Adams, Programming Co-Chairs

With a strong turn-out of over 16,700 PTs, PTAs, and students combined with exceptional programming and engagement, CSM 2019 in Washington, DC was certainly the place to be! The AGPT programming commenced with 3 pre-conference courses and continued with 17 educational sessions and 14 co-sponsored sessions. Topics for the educational sessions ranged from Interprofessional Pain Management in Older Adults with Cognitive Impairment to Aerobic Exercise in Aging and Chronic Stroke to Geriatric Concussion. Thank you to all of our speakers for sharing your expertise! At the Members Meeting, AGPT members unanimously endorsed the new strategic plan for 2019-2020. The first ever Breakfast with Champions was a great success and included the inaugural Carole B. Lewis Distinguished Lecture. Carole presented an extraordinary message titled “Getting to Great in Geriatrics: Overcome Our Fear of Greatness by Piercing the Seduction of Certainty and Welcoming the Future.” Dale Avers has been selected to present this lecture for CSM 2020 and we can’t wait! The deadline for CSM 2020 educational session proposals was March 20th and the deadline for poster and platform presentation submissions is July 12th.
Membership in the APTA has always been a priority for me, but it is fair to say my dues and my commitment to the profession were my only contributions for too many years. In 2016 I took a slightly more active role in the Academy of Geriatric Physical Therapy (AGPT) when I was asked to be a clinical liaison for the Cognitive and Mental Health Special Interest Group (CMHSIG). Around that same time I participated in a preconference course at the Combined Sections Meeting in San Antonio. After a few exhilarating days surrounded by so many dedicated professionals I impulsively volunteered to be the AGPT state advocate for Connecticut.

State advocates are encouraged to set two goals for the year, and one of mine was to start a CMHSIG in Connecticut. My passive participation up to that point had extended to my state chapter as well, but I suddenly realized I had better find out what I was been missing. A quick tour of the Connecticut Physical Therapy Association (CTAPTA) website showed me who was doing all the heavy lifting—outpatient, orthopaedic, and pediatric clinicians and educators were very visible. I was surprised to learn Connecticut was doing all the heavy lifting—outpatient, orthopaedic, and pediatric clinicians and educators were very visible. I was surprised to learn Connecticut did not have a Geriatric Special Interest Group (Geri SIG). For me nothing compares with home care and the joy of working with older adults, so my original plan to initiate a CMHSIG was postponed and instead I hesitantly reached out to see if there might be interest in starting a Geri SIG.

I had never attended a single meeting of the state chapter, but I found what I needed in the contact information on the CTAPTA website and fired off some emails to current office holders. An appropriate response from these hardworking leaders might have been something along the lines of “Who are you, and where have you been for the last few decades??” Fortunately for me, that did not happen. They demonstrated encouragement and support from the very beginning and followed up with clear explanations of the necessary steps to start a new SIG.

THE PETITION

In Connecticut, the first requirement is a petition signed by 10 members of the state chapter. I requested and received (from Karen Curran at the offices of the AGPT) a list of email addresses for all members of the AGPT who reside in Connecticut. I reasoned that therapists who were already demonstrating a commitment to geriatrics might be interested in this project and once again I was fortunate to get a favorable response to my exploratory email. A central location was secured for our first meeting in mid-May 2018. That organizational meeting was an opportunity to brainstorm our vision for the SIG and get the necessary signatures on a petition that stated simply “We the undersigned propose to form a Geriatric Special Interest Group.” The petition was presented in late May at the quarterly meeting of the CTAPTA Board of Directors and our request was graciously approved. This allowed us to begin working on the creation of Geri SIG bylaws.

THE BYLAWS

The CTAPTA board provided a template that outlined the required components for SIGs in Connecticut and Massachusetts, as well as samples of the bylaws that had been created by some SIGs already in existence in those two states. Colleagues at the APTA CMHSIG kindly shared the Rules of Order for the Geri SIG they had previously started. These resources were an integral guide for the language and direction we needed to create our bylaws.

Email communication allowed us to easily disseminate this information to all interested parties and soon we chose a date and central location to meet again. Most public libraries in Connecticut allow free use of meeting rooms via online reservation, which proved to be a convenient way to get together. Institutions with DPT programs are also great locations to meet. Our second meeting, lasting approximately 90 minutes, resulted in a first draft of the bylaws and a great deal of comradery. The document was later shared via email to elicit suggestions and corrections from those who had not been able to attend in person. Those of you in larger states may wish to do more of the work online to avoid long travel distances, but in a small state it was beneficial to meet twice in person.

OBJECTIVES

Bylaws must include the purpose and goals of the group. Based on our shared interest in geriatrics, we found we had a clear vision of the purpose of the SIG and how it should function. The templates were a big help in guiding our decisions about matters related to the structure of the executive committee, frequency of meetings, filling of vacant positions, and other specific requirements that may vary from one state to another.

Simplicity was our byword throughout the process. For example, we plainly said the purpose of the Geri SIG would be to “provide a forum for chapter members who have a common interest in geriatrics.” In terms of objectives, we identified an aim to meet the needs of persons interested in geriatrics, those providing care for the geriatric population, and to provide a mechanism for the exchange of information among physical therapy educators, researchers, practitioners, and other persons interested in geriatric practice. A primary goal that emerged was to foster utilization of standards of competency for practice, research, and education in geriatric practice, with special attention to the promotion of evidence-based physical therapy practice. We committed to sponsoring a
minimum of one educational session per year related to geriatric practice.

The CTAPTA Executive Board approved the bylaws in September 2018 giving Connecticut a Geriatric Special Interest Group, just 4 months after beginning the process! A Geri SIG booth at the annual state conference in November 2018 introduced the SIG to the general membership. Email communications helped boost attendance at our first official meeting in December 2018 for the purpose of designating an executive committee. The SIG will sponsor a spring lecture “Pharmacology Implications Working with Older Adults” and plans are underway for a geriatric presentation at this year’s annual conference in the fall. We have begun a resource guide project to collect pertinent information about SIG members (eg, clinical interests, certifications, areas of specialization) that will foster statewide networking opportunities.

My experience illustrates how easy it is to become involved at all levels of the APTA. All of us in the Connecticut Geri SIG encourage every state without one to take the first step. The Geri SIG of Connecticut sincerely appreciates the assistance received from leadership at the state and national level. We extend grateful thanks to the AGPT especially the Co-chairs of the state advocates committee and all the members of the Cognitive and Mental Health SIG for their shared wisdom.

Jean Miles, PT, DPT, has been a home care clinician for 20 years with previous experience in outpatient and acute care and is currently employed at McLean Health Center in Simsbury, CT. She is a member of a multidisciplinary Quality Assurance Performance Improvement team at McLean; her focus is on innovative methods to foster person-centered care. She is an Adjunct Professor in the Department of Rehabilitation Sciences at the University of Hartford. Jean can be contacted at 1977miles@gmail.com or 860-214-3157.

Academy of Geriatric Physical Therapy Balance and Falls Special Interest Group: 2018-2019 Update

Jennifer Vincenzo, PT, MPH, PhD; Mariana Wingood, PT, DPT; Heidi Moyer, PT, DPT

“The primary purpose of the Balance and Falls SIG is to provide a forum for the increase of knowledge and quality of practice for physical therapists in relation to older persons with balance problems and an increased risk for falling. The SIG uses various means to foster discussion and communication among its members. These include programs at CSM, articles in GeriNotes or other publications, and newsletters to members. Interested Academy of Geriatrics members are encouraged to provide email addresses for communication.”

The Balance and Falls Special Interest Group (BFSIG) took 2018 as an opportunity for growth and development to cultivate efforts to better serve our patients, clients, and great community in managing balance and falls issues. We first would like to introduce our new and current officers and liaisons who are graciously volunteering their time:

1. Jennifer Vincenzo, PT, MPH, PhD (Chair) - Assistant Professor, Department of Physical Therapy, University of Arkansas for Medical Sciences, Fayetteville Arkansas
2. Mariana Wingood, DPT, PT (Past Chair) - Physical Therapist, Instructor, University of Vermont, Burlington, Vermont
3. Shweta Subramani, PT, MHS (Vice Chair) - Physical Therapist, Alta Therapies, Skilled Nursing and Long-term Care; Precision Health Services, Outpatient Pulmonary Rehabilitation, Salt Lake City, Utah
4. Heidi Moyer, PT, DPT (Secretary) - Physical Therapist, Lexington Health Network, Home Health; Chicago, Illinois
5. Anne Reilley, PT, DPT (Nominating Committee Chair)
6. Elizabeth Wang-Hsu, PT, PhD (Research Liaison) - Level IV Clinician & Fall committee member, Penn Medicine, Chair, Geriatric Special Interest Group, Penn Medicine Homecare Entity, Bryn Mawr, Pennsylvania
7. Haim D. Nesser, PT, DPT, CEEAA, CI (Clinical Liaison) - Physical Therapist, Propel Rehabilitation & Wellness, Monmouth County, New Jersey
8. David Taylor, PT, DPT (Community Outreach Liaison) - Clinical Assistant Professor and Director of Clinical Education; Department of Physical Therapy, College of Health Professions, Mercer University, Atlanta, Georgia
9. Angela Onyekanne, PT, DPT (Public Relations Liaison)
10. Brenda Holman, PTA (PTA Liaison)
11. Holly Bennett, BS, SPT (Student Liaison), University of Arkansas for Medical Sciences, Fayetteville, Arkansas
Stay tuned for details! We would like to recognize members of this task force for all of their hard work and efforts in this 2-year journey: (1) Carmen Abbott, PT, PhD; (2) Susan Sullivan Glenney, PT, DPT; (3) Paula Graul, PT, MS; (4) Haim D. Nesser, PT, DPT; and (5) Mariana Wingood, DPT, PT.

National Falls Prevention Awareness Day Toolkit Task Force

A National Falls Prevention Awareness Day (NFPAD) toolkit is in the works as well. David Taylor, our incoming Community Outreach Liaison, graciously allowed the SIG access to the materials he developed and used for a razingly successful NFPAD event across Georgia (facilitating screening of over 1,000 older adults) to be reworked for applicability to all settings and types of events. Haim Nesser (Clinical Liaison and Task Force leader) spearheaded revamping and revising materials for the toolkit. The toolkit will include improved marketing materials (State Advocates, other disciplines, advertisements, consent for photo releases), ideas for events, and PowerPoint presentations for community-based education. We would like to thank the other members who have been hard at work on the FPAD Toolkit: (1) Deborah Constantine, PT, DPT; (2) Paula Graul, PT, MS; and (3) Jennifer Vincenzo, PT, MPH, PhD, BFSIG Chair. Haim and Jennifer will be finalizing materials and submitting for board approval in April/May to have materials prepared for NFPAD 2019 in September!

Building Relationships

The AGPT recently created a formal Task Force to partner with the National Coalition on Aging (NCOA). The BFSIG was pivotal in initiating this collaboration and is excited to see it continue on a more formal and official level. Jennifer Vincenzo, the current BFSIG Chair will serve as our representation on this Task Force.

The BFSIG also began communications with the Foot and Ankle SIG of the Academy of Orthopaedics to initiate efforts to produce relevant and evidence-based materials important to fall risk management related to orthopedic conditions of the lower extremity. Mariana Wingood will continue this collaboration on behalf of the SIG.

Our chair is currently working with a tri-alliance with the Balance and Falls SIGs of the Oncology and Neurology academies to submit programming to CSM 2020 on balance and falls screening across settings with the goal of promoting highest level of practice for at risk populations through inter-SIG collaboration.

Upcoming Webinars Featuring Guest Speakers from the Centers for Disease Control and Prevention

The Executive Committee is hard at work on projects to continue to serve the needs of the BFSIG members. One such project has been spearheaded by our community outreach liaison, David Taylor. David is facilitating the Centers for Disease Control and Prevention (CDC) to provide two webinars to our membership and AGPT. These are anticipated to occur late summer of 2019 and will be hosted by AGPT. They will cover the topics of the new “My Mobility Plan” tool that the CDC recently produced as well as defining and expanding the role of the physical therapist in the use of STEADI for fall risk screening. My Mobility Plan is a method to promote a healthy aging perspective through positive changes by changing the way we approach balance and falls management through our language. By encouraging initiation of an action plan to stay independent longer versus the negative phrasing of “don’t fall,” it is encouraging older adults to think of solutions to their mobility problems to maintain mobility instead of focusing on what they can or should no longer do to avoid falls. You can find more information on this topic at https://www.cdc.gov/motorvehiclesafety/older_adult_drivers/mymobility/index.html. Other ideas for webinars include aging in place and falls prevention in long-term care. If you have suggestions, please email us at agptbalanceandfallsig@gmail.com.

Monthly Challenge

The Monthly Challenge is now in the third year and has over 100 subscribers! Topics in 2018 highlighted evidence and interventions on fear of falling, medication management, and educating our medical contemporaries on fall-related issues. In 2019, Haim will be building on those reviewed in 2019 and also include education on revamp-
ing our evaluations for the older adult, systems review for balance and falls, disease specific factors in fall risk (such as Parkinson’s Disease) and so much more!

The BFSIG would like to thank outgoing Chair, Mariana Wingood, for her service, dedication, and innovation to progressing the group towards the operation it is today. Thanks to her tenure as Chair, clinicians across the country benefited from the evidence and resource dissemination promoting optimal balance and falls management within the older adult population. We are truly grateful for Mariana’s efforts and will strive to continue to meet your expectations.

If you are interested in joining the BFSIG, please refer to the weblink: https://geriatricspt.org/special-interest-groups/

For questions, comments, or requests on projects/content, please email the BFSIG at agptbalanceandfallsig@gmail.com.

REFERENCES

Jennifer Vincenzo, PT, MPH, PhD, GCS, Certified Health Education Specialist, is an Assistant Professor in the Department of Physical Therapy at the University of Arkansas for Medical Sciences where she also serves as Chair of the Admissions Committee and the Neurological Curriculum. She teaches adult neurological content, geriatrics, integumentary, and health promotion and wellness courses. Jennifer is Chair of the Balance and Falls SIG and the Arkansas State Advocate for the AGPT, a member of the Arkansas State Falls Coalition, and is on the Arkansas Governor’s Advisory Council on Aging.

Mariana Wingood, PT, DPT, GCS, CEEAA, is a physical therapist at University of Vermont Inpatient Rehab Department. The former Balance and Falls SIG Chair, she is very enthusiastic about fall prevention as well as knowledge translation/implementation. Mariana is the Evidence in Motion Geriatric Program Director and is currently pursuing her PhD at the University of Vermont.

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Yoga is practiced by over 36 million people in the United States today. Yoga's popularity has exploded, as evidenced by reported participation more than doubling since 2008, when “yoga as medicine” was declared as the next “great wave” or trend in yoga. Yet, only 6.5% of health care providers recommend yoga, despite the vast majority (over 75%) of Americans believing that “yoga is good for you.”

But what is yoga? “Yogas cittavrtti-nirodah.” This Sanskrit passage is yoga sutra 1.2 from The Yoga Sutras of Patanjali. Translated into English, one interpretation is “Yoga is the settling of the mind into silence.” It is simple, but not easy.

The difficulty of “settling the mind into silence” gave rise to the creation of the postures that we often associate with yoga in the west. In the late 19th century, the nature of yoga’s identity was as controversial as it is today. Some believed that yoga postures were not a part of yoga and that only a spiritual philosophy should constitute yoga. So-called “postural yoga” may claim its creation to thousands of years ago, created to help men and young boys sit in meditation. But modern postural yoga, or the postures we know and recognize today, was birthed only at the turn of the 19th century.

The intention behind the postural and breathwork of yoga (known as hatha yoga) was perhaps to make meditation easier. However, it is plausible to consider that the practice of hatha yoga has actually taken us further away from the essence of yoga itself. In western culture, many yoga practitioners have become lost in the physicality of yoga practice in search of settling into silence.

Unfortunately, yoga offers no magical path to healing or well-being. Instead, it offers practitioners the ability to find peace with the path that lies ahead, no matter how arduous. It offers a tool box equipped with physical exercise, breath practices, and mindful awareness with the goal of experiencing meaningful participation in life despite the path laid before the practitioner. Sadly, yoga has been misused by many, so having an understanding of yogic history along with some basic guidelines for safe practice is paramount, especially in the geriatric population.

LAYING THE GROUNDWORK
The familiar biopsychosocial approach to health care that invites health care professionals to look beyond the biomedical reason for illness is alive and well in the yogic philosophy model. The biopsychosocial model emphasizes the importance of considering behavior, psychology, and social support in addition to the biomedical reasons an individual is experiencing disease. It is through the application of the biopsychosocial model that rehabilitation providers can be experts in the health care arena with regards to how yoga is used in health care. Let’s begin with a discussion of how yoga can be used safely to impact fall risk in the older adult population.

Yoga postures offer therapists efficient tools with which to provide skilled intervention. Currently within the health care field, there is inadequate methodology and evidence to support the specific use of certain poses or a certain “type” of yoga to decrease fall risk or improve postural control in older adults. However, medical therapeutic yoga does offer a method to emphasize safety and overall patient well-being within its 10 precepts, or guidelines to evidence-based yoga practice.

The first 4 precepts are reviewed below. The evidenced-based practice of yoga in rehabilitation and wellness practice should:

1. View the person and the potential for injury or disease through a culturally sensitive partnership of two biopsychosocial models of assessment: the yogic [panca (five) maya (pervading] model described in the Taittiriya Upanishad, and the World Health Organization’s (WHO) International Classification of Functioning (ICF), Disease, and Health.

2. Encourage interdisciplinary integrative yoga education in health care in order to protect the consumer of yoga and maximize clinical efficacy. Best evidence for health and medical education points toward interdisciplinary, integrative instruction. We must evolve our pedagogy in order to end troubling health literacy between professions so that health care providers will understand the services their colleagues provide in medicine or rehabilitation.

3. Attend to the breath before the postures. Respiratory function should be a first line psychophysiological intervention.

4. Advocate for biopsychosocial stability as a primary focus and mobility as a secondary focus, with structural alignment of postures guided by 6 physiological principles. Six evidence-based neurophysiological principles guide yoga’s use in rehabilitation. They include kinesthetic awareness and sensory modulation, sensitivity to pain and trauma history, respiration, stabilization, support, mobilization, and meditation.

APPLICATION TO AGING AND FALL RISK
Determining fall risk has long been considered multifactorial and difficult to assess. A recent article published in the Journal of Geriatric Physical Therapy tackled this topic by looking at outcome measures that help predict fall risk. Included in their recommendations were the usual suspects such as the Berg Balance Test, Timed-Up and Go, and Single Limb Balance. However, what made this article unique was their recommendation of using tools like the Geriatric Depression Scale as well as specific subjective questions regarding use of psychoactive medications and fear of falling. While the authors did not specifically advocate for using a biopsychosocial model to improve our ability...
to calculate fall risk, their recommendations are consistent with the model of practice. This model of care points to the need for integrative interdisciplinary education within health care as discussed in the above precepts. Yogic philosophy as a whole invites health care providers to seek to understand the value and role of all team members in helping older adults obtain optimal outcomes.

Yoga breathwork and postures have the potential to aid in reducing fall risk and stress when they are performed safely. By attending to the breath and proximal stability first, we can offer exercises that support pain management through neuromodulation, promote improved postural control, as well as increased strength and flexibility. But let’s separate yoga breathwork and postures (Hatha Yoga) from yoga as a philosophy. They are two separate but synergistic things. Instead of just prescribing exercise, therapists could ask patients to become more mindful of why they are not engaging in physical activity and why they are afraid of falling. Diving deeper into these obstructions to practice (kleshas) in order to address patient adherence, motivation, self-efficacy, and locus of control, all major behavioral science variables, are known to be some of the most important drivers in optimizing patient outcomes.9,10

As therapists our primary goal is to help improve participation. We can use a yogic tool box to help our patients when we choose to approach care from a biopsychosocial perspective. By listening to understand what barriers limit older adults from participating in life, by helping them unpack and overcome their fear of falling, by getting them help for depression or substance abuse, and finally through the use of evidence-based exercise intervention, we can help decrease the number of falls older adults are experiencing.

**CLINICAL BOTTOM LINE**

Aging is not for the weak hearted. The path ahead for adults is filled with unknowns. All too often older adults, especially those with inadequate resources, rely on substance abuse to cope with stress and lack of social support.12 Sadly, the number of older adults relying on substance abuse to cope with their path ahead is growing.12

Older adults require integrated biopsychosocial care that is focused on patient safety. Yoga offers a means to provide such care through the use of skilled motivational interviewing, breathwork and postures known to impact postural control, flexibility, and strength simultaneously as well as improve vagal tone, sleep, and depressive symptoms.1-3,14,15

The video links provided below serves to offer instruction in how to guide older adults through a brief yoga practice using breath and proximal stability while also serving as a tool for home exercise. In a subsequent issue of GeriNotes, we will discuss important considerations when recommending yoga to people with osteoporosis.

**Video Links**

https://vimeo.com/325301680  
(standing yoga exercises)  
https://vimeo.com/325232487  
(Setting up a Space to Practice)  
https://vimeo.com/325233749  
(Motivational Interviewing)

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15. Patel NK, Newstead AH, Ferrer RL. The effects of yoga on physical functioning and health related quality of life in older adults: A systematic review and
levels of learning such as application and provided many opportunities to use higher level tools, and designing the study process falls risk study for a local community of independent older adults. The process of selecting the target group, selecting the assessment tools, and designing the study provided many opportunities to use higher levels of learning such as application and synthesis. The project itself was an outstanding opportunity for the students to interact with the community, practice instructing clients in exercise techniques, administering assessment tools, and to facilitate a research study that may result in positive health changes in the participants.

Falls prevention is desired by all parties in the community. The owners of the facilities want to reduce risk, the health care providers want healthy patients/clients, and the community dwelling elderly want to remain in good health to maintain functional abilities. According to the latest statistics released by the Centers for Disease Control and Prevention (CDC), the rate of death from falls in US residents aged 65 and older increased 31% between 2007 and 2016.1 Per the authors of this 10-year-long study, Elizabeth Burns and Ramakrishna Kakara, if this trend continues, an estimated 43,000 people will die from falls in the year 2030. Furthermore, if the acceleration rate is not slowed, the mortality rate may rise to 59,000 people in the year 2030.1 In their study, Burns and Kakara stressed the importance of health care providers prescribing specific interventions such as “assessing gait and balance, reviewing medications, and prescribing interventions such as strength and balance exercises or physical therapy.”

The study design was based upon the hypothesis that the Otago Exercise Program (OEP), developed by John Campbell and Clare Robertson at the University of Otago, New Zealand3 will improve the performance on falls risk assessments in elderly people.4

METHODS

A local independent community of older adults in Lancaster Pennsylvania was selected as a pool of potential study participants. The study was initiated on January 18, 2018, during the annual health fair. During the fair, the students set-up an attractive display with falls risk prevention information, information about the study, and information about the students’ PTA program at Central Penn College in Lancaster, PA. Enthusiasm was high and there were 40
individuals who agreed to participate in the study. Each participant was asked to complete a permission form, waiver, and the Physical Activity Readiness Questionnaire that included questions about recent falls, hospitalizations, blood pressure, feelings of dizziness, hearing and vision concerns. Once the forms were collected, the students completed both the Timed Up and Go (TUG) and the Functional Reach (FR) on each participant. There is a strong correlation between the time taken to complete the TUG and the level of functional ability in community dwelling adults. The FR is considered a practical and valid measure for limits of stability in older adults, according to Newton. These tests were selected for their statistical reliability and for ease of administration. After the pre-test, the participants received education in the positive effects of exercise in the prevention of falls and instruction on the Otago Exercise Program to be completed on their own. The OEP was selected for use as the intervention because of its reputation for being an effective fall prevention program for older adults designed to be delivered in the home.7

Each study participant received a packet containing illustrated OEP instructions along with a form to journal their participation. The students were responsible for instructing the participants in proper exercise technique. The participants were then asked to return in 6 weeks to complete a posttest of the TUG and the FR. During the 6 weeks, the students contacted each participant twice with a written letter of encouragement along with a reminder to return on March 2 to complete the posttests.

Due to poor weather conditions, which included snow and high winds, the number of study participants who arrived to complete their posttests was only 12. Unfortunately, the number of returning participants was lower than expected but those who came back were enthused and excited to be tested again. Once the posttests were completed, the participants provided their completed journals to the students. Upon evaluation of the journals, it was discovered that each participant averaged at least 3 exercise sessions per week; many included detailed accounts of their exercise activity. The students were very impressed and the interactions between the participants and the students were extremely positive and sincere.

RESULTS

This study involved comparing the results from the FR and TUG performed both before and after the implementation of the OEP over a 6-week period. The hypothesis was that the OEP improves performance on falls risk assessments such as the TUG Test and the FR in community dwelling elderly people.

On the first day of data collection, there were 40 participants. Twelve of those participants arrived for the posttest 6 weeks later. Each participant completed a journal of their participation in the OEP, identifying the dates and exercises completed. These 12 participants consistently followed the protocol of the OEP for the duration of the 6 weeks. The before and after scores on each test of those 12 participants were used for analysis.

Despite the drop in the number of participants, the results were significant. Looking at the results from the first test day and comparing them to the second test day, all of the participants demonstrated an average increase of 2.31 inches in distance for the FR and an average decrease in time of 2.08 seconds for the TUG. A two-sample t-test of hypothesis, using paired dependent samples, was performed on the differences between before and after measurements. This test was used to determine if there was a statistically significant difference caused by the OEP. A 95% confidence interval was determined for each test. The t-test scores were calculated based on a sample size of 12.

The post-test scores of the individuals are shown in the bar graphs, 1 for the FR and 2 for the TUG.

Analysis of the FR Test data showed an average increase of 2.31 inches with a standard deviation of 1.55 inches. This resulted in a t-score of 5.16. Based on a one-tailed test of hypothesis with 11 degrees of freedom, the p-value is 0.0000157, which is less than the chosen alpha level of 0.05. This p-value indicates a statistical significance between the before and after data sets. The 95% confidence interval for the mean increase in reach distance is 1.33 to 3.29 inches.

The TUG test analysis showed an average decrease of 2.08 seconds with a standard deviation of 0.85 seconds. The calculated t-score is 8.48 with the p-value again being less than 0.0001, which is less than the chosen alpha level of 0.05. This p-value indicates a statistical significance between the before and after data sets. A 95% confidence interval for the mean decrease in time is 1.54 to 2.62 seconds.

The statistical results indicate that falls risk assessment test scores such as the TUG and the FR improve as the result of participation in the OEP in the elderly population. The OEP has been found to be effective in improving scores in other falls risk assessments. A study by Youngju Park and Moonyoung Chang found the OEP improved scores on the Fall Efficacy Scale in elderly stroke patients.8 Another study

![Graph 1](image)

Graph 1

![Graph 2](image)

Graph 2
by Ha-Na Yoo and colleagues supports the positive impact of the OEP on balance and gait in addition to falls efficacy in elderly women.9

CONCLUSIONS

The study demonstrated a positive correlation between performances on falls risks assessments, specifically the TUG and FR, after completing the OEP for 6 weeks. The study results may further suggest that if the participants’ scores improved on the falls risk assessments then the participants’ risk for falls may be reduced. Additional research may be completed on data collected on the first day such as any impact on balance noted in participants’ hearing or vision impairments. This data was not evaluated and may show a relationship between falls risk and their sensory impairment.

The students who participated in this study provided important falls risk information, reinforced positive behaviors, and witnessed both personally and statistically the benefits of exercise on improving test performance. The planning and execution of the event was a lesson in organization, communication, and professionalism. The many personal interactions with the study participants provided opportunities to work on communication and conversational skills with an older population. As their professor, I witnessed a genuine sense of purpose and enjoyment in my students. The students who took part in this study were excited to participate in a real research project and were pleasantly surprised to have their hypothesis proven correct.

Gina de Vitry, a recent graduate of the PTA program at Central Penn College was responsible for the statistical analysis of this study. These are her thoughts. “Participating in this study was a valuable part of my learning experiences in the PTA program. It provided the opportunity to actively work with the study subjects and practice administering the Timed Up & Go Test. Phys Ther Sci. 2000;80(9):896-903.

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As Payment Driven Payment Model (PDPM) changes loom, skilled nursing facilities (SNFs) looking to stay afloat in today’s health care environment better get to the drawing board. Medicare’s impending overhaul of the “more therapy, more money” reimbursement model will radically change how and when therapeutic care is delivered. Tentatively, nursing will see increases in Medicare reimbursement while physical therapy, occupational therapy, and speech language pathology (perhaps the worst off) see a decrease. According to CMS, the net change in total reimbursement amounts based on current discipline utilization rates should be zero. In practice this remains to be seen. Any changes to the Medicare reimbursement model should be taken seriously as other health insurers generally follow suit and do not nearly offer the same profit margin as Medicare. Of note, Medicare beneficiaries are often not the majority and the national SNF median margin when considering all payers and lines of business (such as hospice, ancillary services, home health care, and investment income) in 2016 was +0.7%, down from +1.6% in 2015 and +1.9% in 2014. When Medicare coverage is removed, margins become negative with the 2016 median at -2.3%, down from -2.1% in 2015 and -1.5% in 2014.1 These margins are not sustainable and will likely lead to insolvency. Moreover, the trends are not changing. Absent of additional revenue flow from other revenue structures like assisted-living (AL) or independent living (IL) to offset year over year losses, SNFs either go belly up, downsize/ restructure, or become opportunists when it comes to how and when they deliver care. As the competition for dollars intensifies, we need improved ways of promoting best practice and measuring the capacity of a therapist to bring value to the health care system. For too long, we as a profession, have been chasing reimbursement and letting finances drive our decision-making rather than trusting our own intuition and training. If the outcomes are meaningful, then I fully believe reimbursement will follow appropriately.

Archaic health delivery systems and methods (ankle pumps anyone?) will not work anymore as payers and referrers begin tracking outcomes in more detail. Skilled nursing facilities who have fostered a community encouraging best practice will likely weather the storm the longest as hospitals are already changing their referral patterns to SNFs. Hospitals are targeting their referrals to SNFs with the shortest lengths of stay and best outcomes that are both competitive and enticing to referring hospitals, the challenge to keep costs low while providing a valued service remains. We need to rethink how and when we deliver care. Interestingly, when Medicare conducted its own analysis of 12,125 SNFs, only 8% (970) of facilities were able to keep their costs relatively low while maintaining a high level of quality. They referred to this number as “Many SNFs” which I can only find humorous.1 Regardless, it seems the current trend points to fewer and higher quality SNFs receiving the bulk of post-acute stays in conjunction with facilities who have lower cost structures primarily serving long-term residents.

So what can we do? I do not pretend to have all the answers, but I have ideas, perspective, and would be delighted to discuss more than what space will allow here. To start, if they have not already, rehabilitation departments need to begin collecting data at a minimum on average length of stays for the most common admitted diagnosis, re-hospitalization rates, and outcomes. They need to analyze their data and drill these metrics down to the therapist and therapist assistant level. They will

An Opinion Piece:
Skilled Nursing Facility—A Whiff of the Past?

Gabriel Alain, PT, DPT

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gain insight into the overall impact their clinicians make. They may also discover some therapists are especially effective with certain diagnoses while others not so much. This creates an opportunity for other clinicians to learn from each other and practice at a higher level. To a degree, clinicians will also drive reimbursement through Section GG. Therefore, rehabilitation departments should also be ensuring clinicians are consistent across the board with how Section GG is scored. Skilled nursing facilities may also want to experiment with a salary-based pay model for staff and/or moving to a 7-day a week model with rotating weekend coverage. The big idea here is to prevent large swings in treatment times throughout the weekdays and also give the PT autonomy to decide who gets treatment and when. We all know of many cases where some patients could benefit from more therapy while others just need consistency or reminders. Since Day 20 is the cutoff for when Medicare reimbursement begins to decrease by 2% a week, I can already hear some rehabilitation managers thinking how they are going to keep higher level patients until Day 20 and push out others before in order to maximize reimbursement. This fallacious and simplistic thinking completely ignores the changes in behavior of referral sources and misses the point of chasing outcomes not reimbursement.

Managers need to be willing to change heavily ingrained business practices and be receptive to change. Physical therapists need to self-reflect on just how much of their time is spent lowering a patient’s risk for an adverse event and what lasting effect they have on a patient when the patient is alone. For example, can I objectively say progressing from 100 ft to 150 ft of ambulation actually lowers the risk of re-hospitalization? Is it even worth my time to document that or could I spend that time somewhere else making a more meaningful difference? I strongly believe patient education and a home exercise program (if complied with) are the most permanent effects we can have on a patient post discharge. Either way, more of the same simply will not work for SNFs who want to survive. To quote James P. Lewis, “If you always do what you’ve always done, you’ll always get what you always got.”

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Getting to the Core

Linda McAllister, PT, DPT; Carole Lewis, PT, DPT

Ever wonder if you are using the best technique to strengthen the core for older persons? Fortunately, there have been a number of excellent studies that have addressed this question. In 2001, Kay published an extensive literature review of exercises that produce the most intense firing of the lumbar multifidus. He found that the exercises that cause the highest co-contraction for stabilization were (1) bridging with resisted pelvic rotation, (2) resisted knee rocks, and (3) isometric resisted seated trunk rotation. (See picture below of seated trunk rotation)

Lee et al looked at seated exercises to activate the abdominal muscles and found activation of the rectus abdominus and obliques was significantly higher in shoulder extension and horizontal abduction than in flexion in the seated position. They even suggested that TheraBand resisted shoulder extension and horizontal abduction “can be recommended for low back pain patients who cannot perform trunk stabilization exercises directly.”

Another simple but effective exercise is laughter. In 2013, Wagner et al compared Yoga Laughter to crunches and back lifts. They found that internal obliques had higher activation doing yoga laughter and that multifidus, erector spinae, and rectus were activated half as much with yoga laughter.
External obliques were activated equally. So, brush up on your sense of humor!

Moving out of the sitting position and looking at other means of activating the core, we found a study on the body blade by Moreside and colleagues. They found that large amplitude oscillations that were vertically oriented with the Bodyblade resulted in the greatest activation of obliques and this activation was much less when performed horizontally. In addition, poor recruitment was noted with bad technique. The Bodyblade did have higher compressive forces than other abdominal exercises, so if compression intolerance is an issue, using the Bodyblade is not appropriate.

A discussion of compressive forces would not be complete without reviewing Axler and McGill's research on which exercises activate the abdominals and were safest and most challenging. They found that partial sit-ups generated the highest muscle challenge to spine cost indices. In other words, they generated the greatest contraction with the lowest spinal compression load.

Finally, Arokoski et al have published interesting research on activation of the back and hip extensor musculature. They found that the following exercises were the most effective:

1. backward and forward rocking in sitting,
2. trunk rotation with stick behind the head,
3. shoulder flexion and extension with weights while on balance board,
4. prone extension,
5. shoulder flexion and extension against resistance while standing or sitting, and
6. walking with arm swing on trampoline.

From laughing to partial sit-ups, we have given you 13 different exercises that can be performed at all levels of independence. You cannot go wrong if you select from this list of core strengthening exercises, all of which are backed by research.

REFERENCES

In Memoriam
This article is dedicated to Judith H. who died in her home at age 98. She lived independently all those years. She was always generous with her time and on multiple occasions allowed us to take pictures and videos of her for educational purposes. I only knew her the last 4 years of her life, but if those 4 years represented the first 94 years, she had quite a life.

Trunk Chair Rotations
Sit up as straight as you can in a chair and turn your trunk and press your elbow into the back of the chair. Hold 10 seconds being sure to sit up straight and use your back and tummy muscles to help you press into the chair.

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Editorial Note: We apologize that Ms. McAllister was not properly acknowledged for her contribution to the previous GetLit article.
The Problem of Debt and Geriatric Physical Therapy

David B. Gillette, PT, DPT; Todd E. Davenport, PT, DPT; Alicia Rabena-Amen, PT, DPT

The cost of higher education continues to rise: student loan debt has progressively become a greater concern. In the United States, the price of a public and private non-profit “4-year” (undergraduate) college degree has increased at a rate much greater than predicted by inflation. An analysis of self-reported student loan debt from a cohort of graduating college seniors in 2015 indicated almost 70% of graduates reported a debt balance that averaged a record value of $30,100; almost 20% of the debt was in private (nonfederal) loans that tends to be associated with higher costs and fewer protections. In 2012, those graduating with a doctoral degree had $120,000 or more in cumulative student loan debt.

IMPACT ON THE INDIVIDUAL AND THE PROFESSION

Student loan debt greatly affects the individual borrower. Student loan debt correlates with subjective well-being, mental health, and substance use disorders. Student loan debt is also associated with life choices including living with parents, formation of their own family (getting married or having children), saving for the future, and availability of discretionary spending. Increased overall debt can have a negative impact on physical and mental health, including stress, depression, and high blood pressure.

Student loan debt can affect the profession through the borrower. Student loan debt is known to associate with career choices, including completing further training for pharmacists and nurses, reducing likelihood of specialization for dentists, and influencing the choice of specialty for medical school graduates. Thus, the issue of student loan debt has great relevance to the financial, physical, and psychological well-being among graduating students, and the potential future of the profession. Most of the data available are for undergraduate students and medical students, so trends and potential impacts on physical therapists of their educational costs remains unclear.

Many health professions in the United States, including physical therapy, require a graduate degree for licensure. The process of professionalization in physical therapy has involved an increase in level of the first professional degree required to enter the field and obtain licensure to a professional doctorate. Additional education up to 3 to 4 years post baccalaureate are required to accommodate the Doctor of Physical Therapy degree. This increased training time represents more direct and indirect costs of education to students. Direct costs include tuition and fees associated with the educational experience. Indirect costs include living expenses and lost time for remunerative employment. Thus, although surveys specifically related to United States physical therapy education have not been conducted over time, it seems reasonable that increased training costs also may have resulted in an increased accumulation of student debt among practicing physical therapists. Physical therapy graduate education is largely self-funded through savings, limited work, and loans.

Because physical therapy graduate education is self-funded through savings and loans, there may be a correlation between the cost of education and student debt. Understanding the cost of physical therapy education helps to understand the debt burden in the profession, with potential impact on not only graduates but the profession as a whole. Graduates may experience physical and mental health ramifications, may make decisions of where to practice based on salary, and may choose not to pursue further training such as residencies or research doctorates. Additionally, there are indications that new graduates in physical therapy may be overleveraged with educational debt too high for the salary of a new graduate. This may impact the profession by creating areas of practice either in specialty or geography with a dearth of physical therapists, reducing the number of residency or fellowship trained therapists, and reducing the number of research therapists even further, weakening academic institutions and progress in rehabilitation research.

A BRIEF LOOK AT HISTORICAL DATA

To understand the concern of student debt and geriatric physical therapy, one should look at the historical trends of 3 things in relation to the Consumer Price Index (CPI): tuition, salary, and Medicare expenditures (Table 1). The CPI records the price paid for various goods and services and is used to calculate inflation. We took the value for each September starting in 2009.

Students have limited opportunity to work during school. Funding must come through savings or loans, so tuition could be viewed as a proxy for the estimate of student debt. Using CAPTE’s annual reports since 2009 when 86% of the programs were awarding the DPT, it can be observed that tuition has increased annually for both public and private institutions.

In looking at the historical data of the salary of physical therapists during the same time period, the assumption was made that the 10th percentile is a new grad, 25th is a new professional, and mean is the mid-career salary. Comparing these annual changes to the change in tuition, one can see that salary is not rising as quickly as tuition.

Geriatric physical therapy is in all settings – acute, skilled nursing, home health, and outpatient. What is consistent is the payor source–Medicare. However rules, diagnosis codes, and payment criteria change every year, which creates a challenge when trying to collect historical data. No studies have been conducted to look at the changes in payment for physical therapy services across multiple settings. It would be a fair assumption however to say that the relative amount that physical therapy receives as a whole for Medicare expenditures has not significantly increased.
WHY SHOULD WE CARE ABOUT DEBT?

When all these changes to the CPI are compared as a measure of inflation, there are several disconcerting observations that can be made when looking at the annual rate of growth (Table 2). First, salaries are not keeping up with the rise in tuition. If students are taking on the majority of their tuition as loans, this can become a problem where they become overleveraged in debt.\(^{19,27}\)

Second, Medicare expenditures are not keeping up with salaries. If physical therapy reimbursement is keeping steady as a percentage of Medicare expenditures, this will increase productivity pressures to keep company profits and salaries up. This may lead to increased burnout of new graduates. Third, salaries are also not keeping up with inflation. This is a concern not just for the student or new graduate, but also for the profession.

Rising student debt among early career physical therapists eventually could limit participation in residency, fellowship, and research training programs in geriatric, neurologic, orthopedic, and other areas of physical therapy. In turn, there will be fewer clinical specialists available to serve patients and train new specialists. In addition, there may be future adverse effects of physical therapy education total program costs on the number of rehabilitation scientists who can inform geriatric physical therapy practice.

Taken together, these observations raise several concerns. First, the current trend of tuition in relation to salaries, reimbursement, and the CPI is unsustainable for individuals and the profession. Second, post-graduate training opportunities only will be accessible to physical therapists who can afford them, which also could lower the representation of physical therapists from economically disadvantaged backgrounds in clinical specialist roles and the academe.

WHAT WE CAN DO

Advocate: be involved with the American Physical Therapy Association, and contact your legislators with the Action Center when called upon about reimbursement. This will not fix the problem as debt is rising too faster, but it can help.

Be fiscally responsible. As a student, limit your use of credit and stick to a budget, and use any resources or assistance your program may have. As a physical therapist, diligently pay off your student loans. See if your employer has an assistance program. Both students and licensed therapists should call on the American Physical Therapy Association and its components, including the Academy of Geriatric Physical Therapy, to assist their membership in seeking and obtaining debt management and financial counseling services, in order to maintain optimal financial health.

Call on the American Physical Therapy Association and physical therapy education programs to examine not only the efficacy of their educational modalities, but also their cost effectiveness. There is a great diversity in the length and nature of physical therapy education programs, which primarily appears driven by judgments of face validity. It is time for physical therapy educators to weigh the costs of their educational modalities to students with their effectiveness. Perhaps even more importantly, administrators in charge of setting physical therapy tuition and fees should consider the cost burdens with regard to managing student debt following graduation, in addition to the relative size and competitiveness of applicant pools. Universities should consider if continuing to increase the cost per credit is responsible and sustainable, particularly as programs have been lengthened to accommodate the doctoral degree. Programs need to decide if it truly is in their best long-term interest to continue leveraging supply and demand economics to achieve increasing profits.

### Table 1

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<thead>
<tr>
<th>Financial markers</th>
<th>Annual rate of growth, 2009-2016</th>
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<tbody>
<tr>
<td>Consumer Price Index</td>
<td>1.60%</td>
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<tr>
<td>Public cost</td>
<td>5.50%</td>
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<tr>
<td>Private cost</td>
<td>3.70%</td>
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<tr>
<td>Salary - 10th percentile</td>
<td>1.40%</td>
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<tr>
<td>Salary - 25th percentile</td>
<td>1.60%</td>
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<tr>
<td>Salary - mean</td>
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<tr>
<td>Medicare expenditure</td>
<td>1.30%</td>
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### Table 2

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considering the detrimental effects on our profession discussed above.

As indicated earlier, there is no systematic survey of student loan debt in physical therapy. Other professional organizations, such as the American Psychological Association, conduct periodic surveys of graduate students to measure the financial health of their professionals. The American Physical Therapy Association and its components should develop a similar mechanism to survey student physical therapists, physical therapist graduates, and practicing clinicians at various time points. Potential variables of interest to measure would be the amount of student loan debt; the originator, guarantor, and servicer of student loan debt; income, affect, and mental health related to debt management; and career choices related to debt management. Analyses from these data would allow for a deeper discussion of the potential issues facing physical therapists as they relate to paying for their training costs.

REFERENCES


23. Commission on Accreditation in Physical Therapy Education (CAPTE). Aggregate program data 2017 – 2018 physical therapist edu-


David Gillette, PT, DPT, GCS, is an Assistant Professor at University of the Pacific where he teaches several classes including geriatrics. Dr. Gillette is a board certified clinical specialist in geriatric physical therapy. He has had experience in skilled nursing and outpatient care, and is now seeing patients in the home.

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An Overview of the Skilled Nursing Facility Patient-Driven Payment Model webinar is now available at http://apta.adobeconnect.com/pch0i3flsz1w/ The webinar was put together by the Post-Acute Care Educational Collaborative and was done by AGPT and HPA members along with APTA staff. The webinar recording is open to all members and non-members.

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