

GERINOTES

SECTION ON GERIATRICS, AMERICAN PHYSICAL THERAPY ASSOCIATION

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www.geriaticspt.org

PRESIDENT'S PERSPECTIVE: NOTHING CAN BE CERTAIN...EXCEPT CHANGE

John O. Barr, PT, PhD



Please permit me to amend one of Benjamin Franklin's famous statements: *In this world nothing can be said to be certain, except death and taxes...and change.* While

our Section continually strives through its strategic plan to create positive change for our members, the public, and the patients that we serve...sometimes change is thrust upon us. A significant recent change for us was the unexpected early retirement of our Section Executive, Jessica (Anderson) Sabo.

Components of the APTA, such as state Chapters and national-level Sections, often rely on a paid executive staff member to conduct day-to-day office operations, and to assist their busy physical therapist, physical therapist assistant, or student members who are officers, directors, and committee or taskforce chairs/members to work as efficiently as possible in the support of their components. Despite careful scrutiny, these executives occasionally prove not to work out well for the organization. For example, as Iowa Chapter President in the mid 1980s, I had an executive leave with the annual meeting exhibitor fees in her personal bank account...

Since 1992, the Section on Geriatrics has been blessed with a series of 7 highly competent executives: Sharon Craven

(1992-93), Daphne Morris (1993-95), Darcy Hammar (1995-99), Dara Schumaler (1999-2000), Brennan Harmuth (2000-2001), Monica Baroody (2001-2005), and Jessica Sabo (2005-2008). Those of you who've been members long enough can probably recall a memorable positive interaction that you had with at least one of these individuals. As our most recent executive, Jess Sabo was known for her exceptional hard work, organizational insights, sense of humor, and dedication to enhancing broader member involvement in the Section. With respect to the latter, Jess was an advocate for adhering to election and appointment cycles, and diligently worked to establish specific job descriptions for each position within our organization. The Section's Board of Directors and I offer our sincere best wishes to Jess and husband, Tom on the birth of their first child later this spring. During this transition period, executive duties are being covered by Cindy Sliwa from APTA's Central Meeting Services. We plan to have a new executive in place before mid-April.

There will also be a number of changes in other Section leadership positions during this year. Based upon the strong applications received to date, new chairs will soon be appointed for our Awards and Cultural Diversity committees. Other current volunteer opportunities (ie, manuscript reviewers for the *Journal of Geriatric Physical Therapy*; and members for the Ad-

vanced Clinical Practice Committee, the Membership Committee, the PTA Advocacy Committee, the Website Committee, and the SOG Advocates to the States), complete with job descriptions and application forms, are posted on our website (www.geriatricspt.org). Important elections will take place this fall for the Section's Vice President and a Nominating Committee member. *Nominations for these two positions are due by June 1*, with elections occurring this fall. These elected individuals, and new chairs for the Regional Course and Website committees, will take office at CSM 2009 and serve through CSM 2012.

As Section President, I embrace change as a means by which we advance our Section and the profession of Physical Therapy. As should be apparent from the number of volunteer openings that we regularly have in our organization, we need your active involvement as agents of positive change. Our Board, committees, and task forces are set up to groom members for progressive leadership roles. Do give serious consideration to becoming more involved in the Section on Geriatrics.

Dr. Barr is a Professor in the Physical Therapy Department at St. Ambrose University, Davenport, IA. He also serves on the Editorial Board for the Journal of Geriatric Physical Therapy.

Thank you CSM Booth Volunteers

Sincere thanks to everyone who volunteered at the CSM 2008 Section booth! Because of their efforts, we recruited more new members than ever before, and distributed lots of great information about PT and the aging adult.

Rita Wong
Ruby Kendrick
Jane Morse
Michelle Criss

Sandra Jameson
Lucy Jones
Bill Staples
Jill Heitzman

Cathy Ciolek
Stefanie Diaz
Sandra Cothran
Nancey Bookstein

Priscilla Raasch-Mason
Vicki Gines
Shelia Frances
Others who did not sign in

EDITOR'S MESSAGE

Carol Schunk, PT, PsyD



This issue of *GeriNotes* may seem a bit less than previous issues because it is!! The past two issues, January and March, have run 44 and 48 pages respectively. In both cases I had so much great content that in my enthusiasm I forgot that I am budgeted for a maximum of 36 pages per issue. Therefore this issue has many great articles but fewer pages in keeping with my responsibility as Editor to stay within the budget. Up till now, I have almost always printed every article that was submitted by the deadline, this might change but all articles that meet criteria and are of interest to our readers will be published. I recently completed a draft of "Guidelines for Authors" document. It is currently being reviewed by the *GeriNotes* Editorial Board and our Publishing Editor. The Guide will provide authors with information about submission of articles to *GeriNotes* and details on format and content. During recent communication with the Board, we also decided to publish several focus issues in 2008 and 2009. We have done this in the past with positive feedback. Seems some of the focus issues are the most popular, being used in the classroom for teaching. Possible topics being considered are cardiopulmonary, falls and balance, and pharmacology. Suggestions and input from readers is always welcome on focus topics that would be of interest to you.

Although it was not planned, several of the articles in this May issue follow a theme of decision making. As physical therapists we often are the health care professional that spends the most time with patients/clients and families. Such topics come up and we need to be aware of the issues, provide reliable information, and identify resources. Bill Staple's article about consent to treat when there is the compounding issue

of cognitive impairment is a situation almost everyone has experienced. It is complex but given concerns about risk management one that can not be ignored. Making end-of-life decisions for older adults was written as part of a class to link geriatric professional literature with topics relevant to providing physical therapy to older adults. The research presented verifies that this is a complex topic with many socioeconomic considerations. This article is enhanced by Patricia Antony's detailed definitions of power of attorney issues.

I previously worked for a therapist owned private practice company located in the western states. During the course of my tenure with them, I developed an outcome system that eventually became a national database with over 500 clinics across the country as customers producing over 1700 pieces of data per quarter. Fast forward to today and we have the concept of pay-for-performance that is based on outcomes. John Cheeks article, which was also written for a class, presents the positives and the negatives of reimbursing based on positive outcomes. This is being done in many pilot programs across the country. The idea being if a patient is in the hospital for an

orthopedic procedure like a total knee replacement, the hospital should be reimbursed more if the patient has positive outcomes, for example a positive recovery with no infection. Under the current system, there is greater payment if there is an infection or complicated negative outcome. As a home health therapist, the OASIS is a data collection tool that provides information to allow a consumer to compare the outcomes of various home health agencies in their geographic region. We now have a program in which we get outcomes reported to us by therapists so you can really see how your patients are doing and how you compare. There are many issues still to be solved by this system but it is definitely the way of the future.

Finally I would like to thank Helen Cornely, a member of the *GeriNotes* Editorial Board, for writing on a personal experience with her husband's cancer diagnosis and treatment. As Helen describes in the first of three articles, being on the other side of the fence is very emotional and enlightening. Learning may be formal through a class or a book but the first hand experience, while not a choice, can be focused toward the same goal of improving patient care.

Call for Volunteers

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COGNITION AND CONSENT TO TREAT

William H. Staples, PT, DPT, GCS

INTRODUCTION

This paper will discuss the issue of obtaining informed consent for physical therapy intervention from people who are cognitively impaired. Consent for medical treatment is rooted in case law. Scott¹ writes that every physical therapist has the legal and ethical obligation to obtain informed consent from the patient or their surrogate decision maker. The United States is a highly litigious society, and the risk for health care malpractice is present with any patient encounter. Failure to obtain informed consent may constitute professional negligence. As physical therapists move toward autonomous practice with direct access, the need to follow risk management policy grows. Informed consent should be part of every therapist's risk management policy, no matter what their practice setting.

What is involved in informed consent? Since laws vary between jurisdictions, Bennett² proposes that we follow the guidelines proposed by the World Confederation of Physical Therapy's Declaration of Principles on Informed consent which states that "A competent adult should be provided with adequate, intelligible information about the proposed therapy.

- A description of the treatment to be provided
- A clear explanation of the risks which may be associated with the therapy
- Expected benefits of the therapy
- Anticipated time frames
- Anticipated costs, and
- Reasonable alternatives to the recommended therapy"

While there are ethical and legal issues in obtaining informed consent from any client, it may be very difficult to ascertain when some individuals are not capable of making this decision. This concept has been discussed broadly in the medical research and practice arenas, but has not been specifically addressed in the field of physical therapy.

APTA DOCUMENTS

The *Guide to Physical Therapist Practice*³ states that "Physical therapist obtains informed consent from patient/client in accordance with jurisdictional law." Each state will have different laws, so therapists need to become familiar with the informed consent laws in their location. Additionally, the Guide for Professional Conduct,⁴ an interpretation of the Code of Ethics published by the American Physical Therapy Association (APTA) states under Principle 2 that "A physical therapist shall act in a trustworthy manner towards patients/clients, and in all other aspects of physical therapy practice." Section 2.4 of this document addresses patient autonomy and consent. Subsection e states that "A physical therapist shall respect the patient's/client's right to make decisions regarding the recommended plan of care, including consent, modification, or refusal." These documents can be used to set a standard of ethical care for all physical therapists.

A patient that has a normal mental status can be provided information about specific treatment options from the therapist prior to treatment. Many states allow a person to appoint a health care proxy or surrogate to make health care decisions when a person has lost capacity. If the patient has a legally appointed surrogate (durable power of attorney, designated health care representative), that person would have the decision making power. But what happens when a patient presents themselves for treatment that may have impaired decision making skills? How do we determine the proper course of action in a patient that may be confused or demented? It must be noted here that caregivers or well meaning family members cannot make decisions on behalf of the patient for treatment without legal authorization. It is possible that caregivers or family members may have different needs or agendas than the patient.

In reality, however, therapists frequently rely on family members to gain consent to treat. "This efficient approach to the challenge of informed consent for dementia evaluation [and treatment] has an obvious strong and practical appeal, but it represents a tradeoff that carries significant implications for (deficits in) respecting the dignity and autonomy (self-determination) of the person for whom dementia evaluation [and treatment] is proposed."⁵

Fortunately, there have been very few cases involving physical therapists and informed consent, but enough to make it the focus of this article.²

BIOETHICS

Bioethics and therefore health care are guided by 4 main principles. These 4 principles that make up the ethical framework are autonomy, beneficence, nonmaleficence, and justice are defined by Beauchamp and Childress.⁶ Autonomy is the right for all people to individual self-determination, and can be described as the principle that allows patients to make and carry out their own decisions that arise from unbiased information provided to them. Beneficence reflects the duty to provide care in the best interest and benefit of the patient. Nonmaleficence means that therapists should do no harm, by commission or omission, to the patients under their care. Justice deals with the fairness and equity in which therapists work with their patients. On occasion these ethical principles can conflict with each other. As therapists, we have the obligation to protect our patient's health through beneficence, but must also respect the patient's right to autonomy. This presents an ethical dilemma, is it more important for the therapist to allow autonomy or provide beneficence? This question is not necessarily made easier when dealing with a patient of questionable decision making skills. For a patient with more severe mental deficits a therapist might look at paternalistic behavior to guide

their treatment. Historically, the practice of medicine was paternalistic where physicians used their acquired skills and knowledge to make unilateral decisions for the patient (“I know best”) with little or no input from the patient. In recent years, the courts have not supported this previous standard of care.⁷

Is the therapist responsible for determining decision making competence of the patients he sees? This is not an easy task because the question is not an all or none answer. It may be difficult to ascertain cognitive abilities in mildly to moderately affected individuals. People have degrees of confusion or dementia that affects their ability to comprehend, retain, and process information. Lucidity may vary on a daily or even hourly basis. Are we required to test for appropriate mental status before every intervention? Do we need to perform some sort of mental status screen or get a psychiatric evaluation? That would certainly be time consuming and possibly expensive. Volicer⁸ states that “a health care practitioner must assess a patient’s decision-making capacity before acting on the patient’s consent or accepting the patient’s refusal.” If we over or underestimate a person’s ability to make decisions, we may be denying them the right to autonomous choice.

Decision-making ability or decisional capacity includes 4 components or constructs: understanding, appreciation, reasoning, and expressing a choice according to Grisso and Applebaum.⁹ The patient must first be able to understand the information relevant to the decision, and then be able to apply that information to their specific situation. The patient must be able to use the information given to them in the reasoning process and finally be able to express a consistent choice.

LEGAL STANDARDS

Legal standards vary between jurisdictions. There are 2 primary types of informed consent; the physician-based standard (and presumably other health care workers) and the patient-based standard.⁷ The physician-based standard, used in 25 states requires physicians to inform the patient of the benefits, risks, and treatment alternatives that a “reasonably prudent practitioner” in the field would provide. The patient-based standard, found in 23 states and the

District of Columbia, makes physicians responsible to provide all the information regarding the benefits, risks, and treatment that a “reasonable patient” would find necessary to make a decision regarding their treatment. New Mexico and Minnesota use a hybrid form to define their standard. One exception to informed consent regulations comes from the courts in the state of Pennsylvania which have ruled that informed consent is exclusive for surgical and operative procedures and not for routine health care such as physical therapy.¹⁰

In order for a patient to bring a tort of malpractice litigation against a health care provider that includes lack of consent, the patient (plaintiff) must show that an undisclosed result occurred and that this result caused an injury to the patient. The plaintiff must also prove that he or she would not have consented to the treatment if it had been fully explained (disclosed) to them in the first place.¹⁰

King and Moulton⁷ present the case for a “shared medical decision-making that encourages open communication, shares input and responsibility between patient and physician.” This should lead to better understanding by the physician, or in our case the physical therapist, of the patient’s social condition and better adherence to treatment recommendations made by the physician or therapist. This may be possible for a cognitively normal patient, but Jones¹¹ argues that autonomy can be compromised when the patient is ill, weakened, and dependent on others for his/her well-being.” McParland¹² states that “the concept of autonomy is fragile, inconsistent, and dependent on individual circumstances.” How should we determine clinical consent?

Spicer¹³ lists 4 elements of clinical consent. The first is information which would involve the type of intervention involved. It must be decided here how much information can and should be provided to the patient. Lengthy detail about every possible problem would be lengthy and poorly understood, especially in the cognitively impaired person. It is suggested that a more “serious intervention would merit a higher degree of information transfer than a less serious one.”¹³ The patient’s ability to decide must be weighed against the risk associated with the treatment decision in ques-

tion.¹⁴ For instance, in physical therapy a heat application or modality may need more explanation than performing active exercise. The second element is capacity to decide. The patient cannot make a fully autonomous decision if they are cognitively impaired. The third element is freedom from coercion. Therapists should not provide interventions to patients that have been coerced by others including family members, except a legal surrogate. The final element is that the process has a dynamic status. This means that consent for treatment is an on-going process; patients may change their minds and withdraw consent at any time. One unfortunate consequence of these 4 guidelines is that the people who are more impaired and or may be alone (without surrogate), might be the ones excluded from treatment.

INSTRUMENTS

There does not appear to be a widely accepted method for determining whether capacity to consent is present. Some authors have investigated the use of certain instruments to measure capacity for research and treatment. Moyer¹⁵ compared 3 instruments, the MacArthur Competence Assessment Tool for Treatment (MacCAT-T), the Hoppemont Capacity Assessment (HCAI), and the Capacity to Consent to Treatment Instrument (CCTI) on adults with and without dementia. The authors found that most individuals with mild dementia can participate in the decision making process and should be encouraged to do so. In a separate article Moyer¹⁶ looked at 10 instruments, including the 3 mentioned earlier. The author found it difficult to compare findings across the instrumental studies. The author surmises that the decisional making components are best assessed by different methods. For instance, understanding appears to be best measured by standardized neuropsychological tests whereas appreciation is least related to those same tests because it involves a level of abstraction or personalization not captured on those tests. Moyer¹⁶ also notes that while traditional screening tests do correlate with an impairment of one’s capacity; they are not specific or sensitive for consent capacity. The Mini-Mental State Examination (MMSE) is a much studied test. The USPSTF report¹⁷ lists the sensitivity of the MMSE for demen-

tia ranges between 71% and 92% and the specificity ranges for dementia from 56% and 96%. So while therapists may use the MMSE to assess cognition or screen for dementia it may not have the sensitivity for the therapist to interpret capacity from the test score. Karlawish¹⁸ found that the MMSE was helpful in discriminating capacity from incapacity only when the score was below 19 or above 23, while Hirschman¹⁹ found a score of less than 20 as the level at which the caregiver reported that the patient's involvement in decision-making abilities declined.

Studying the construct of expressing a choice is difficult because it is not likely impaired until the end stages of most disease processes. Moye¹⁶ further states that after reviewing these instruments that there is no gold standard. The author suggests that the MacCAT-T may be the most useful for patients that are psychiatrically disturbed, the CCTI would be the most useful for people with dementia and the HCAI could be most useful for adults in a long-term care setting. She found considerable variability in capacity ratings among patients with similar diagnoses and among those receiving similar levels of medical care. This shows that diagnostic or functional status alone cannot predict capacity. Her assessment is that some of the instruments show promise, but the best protocol may be a simple guided one on one dialogue where information is presented in a manner that maximizes participation by the patient. Framing, order, and phrasing of the information can affect the decision-making process. Two examples of this would be the use of more common wording and phrases to replace medical jargon, and increasing the amount of time that an individual is given to process the information presented.

Dunn²⁰ identified 23 decisional capacity assessment instruments. He found only 11 that tested for all 4 constructs needed for the decision-making process. He states that the MacCAT-T has the most empirical support, but that other tests may be better suited in different situations, and that they all have limitations. The MacCAT-T requires a great deal of training while others do not. Additionally, it does not have a predetermined cutoff score that could be used to determine capacity or lack of capacity.

LOSS OF CAPACITY

Eventual loss of competency or capacity for consent is inherent in Alzheimer's disease. Competency refers to the capacity to consent to medical treatment.²¹ Dymek's²² findings suggest that capacity in that population is a "multidimensional construct represented by neurocognitive factors of verbal reasoning and verbal memory." As these abilities decline, the patient's ability to consent for treatment also declines. In a study by Moye,²³ she found that almost 10% of people initially seen with a diagnosis of mild to moderate dementia were impaired in decision making. Nine months later nearly 25% were then impaired. This should serve notice to health professionals that ability to provide consent can be quite fluid.

In a later study Dymek²⁴ investigated people with Parkinson's disease (PD). He found that executive function deficits may underlie other cognitive impairments such as memory, verbal fluency, reasoning, spatial skills, and complex attention. This loss of executive function would be indicative of patients that would have difficulty making an informed consent. With an estimated 25% to 50% of people with PD also having dementia, this should be an alert to physical therapists about their ability to consent to treatment.

The Alzheimer's Association²⁵ estimates that there are over 5 million people living in the U.S. with Alzheimer's disease, with a new person being diagnosed every 72 seconds. They estimate that by 2030, there may be 7.7 million people and in 2050 perhaps 11-16 million people with Alzheimer's disease. It is estimated that there are 1.5 million people with Parkinson's disease in this country, with 60,000 new cases every year.^{26,27} Estimates vary that from 20% to as high as 70% of these individuals will develop dementia.^{26,27} Another disease process where cognition may be affected is multiple sclerosis. It is estimated that 10% develop dementia and another 40% or more have cognitive deficits including memory, concentration, and problem solving.²⁸⁻³⁰ The therapist should be aware that these diseases may affect the patient's ability to understand consent.

New tools that are being used in the medical community are patient decision aids. According to O'Connor,³¹ there is

mounting evidence that these printed aids serve as adjuncts to counseling when discussing treatment options and consent. The Cochrane database currently lists 55 randomized controlled trials of the decision aids and more than 500 decision aides exist primarily for medical treatments. These are accessible on the internet and have been accessed approximately 9 million times last year. While these aids may help normally cognitive individuals, their use with people with impaired capacity has not yet been addressed.

SUMMARY

Physical therapists have begun autonomous practice, with direct access, in many settings. We have a fiduciary responsibility for all of our patients. It is imperative that therapists understand the concept of informed consent and all of the underlying information that defines this term. Therapists work with people of differing mental capacities. There can be little argument that a patient with full capacity can refuse treatment at any time, even if the decisional process is irrational. But what about a patient with moderate dementia who opposes an intervention that is in his or her best interest? Do we have a therapeutic obligation to people with dementia? It must be pointed out that this author is not an attorney, but it is the opinion of this author that without the appointment of a surrogate the patient's decision to forego treatment must be respected. Not only is this the ethical choice, but respecting the patient's decision can have the affect of preventing or reducing agitation and may even provide some degree of self-appreciation.

The population continues to age and with it the number of people with cognitive impairment. The number of people that are estimated to develop Alzheimer's disease and other diseases that affect cognition is staggering. Therapists should anticipate that these individuals will need physical therapy interventions to improve or maintain their quality of life. Obtaining informed consent will be part of the process which can be challenging in people with less than normal capacity. This would appear to require an improved ability for clinicians to ascertain decision-making abilities of patients. The therapist can also determine a risk to benefit ratio for the treatment

being provided. Modalities, joint mobilization, and mobility training contain some inherent risks for injury, but even the most benign treatment does not escape the need for consent.

It is hoped that a competency testing instrument can be developed that is sensitive, cost effective, and relatively easy to use. Until that time the therapist should develop skills to not only recognize when cognitive impairment may interfere with the informed consent process, but how to deal effectively and legally with this situation for the best patient outcomes. The therapist, in the absence of a surrogate, should defer treatment that have risk and refer the patient for a formal capacity evaluation by an expert.

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certification in 1995. He has served on the Board of Directors and is currently the Treasurer of the Section on Geriatrics. Bill has lectured nationally on a variety of geriatric PT issues. Bill maintains his clinical skills by working part-time in home health care.

END-OF-LIFE DECISION MAKING AMONG OLDER ADULTS

Mary McVeary, SPT and William E. Healey, PT, EdD, GCS

This is another article in a series based on the “Linking Evidence to Geriatric Practice in Physical Therapy Student Education” that have been published in GeriNotes. These articles have described how one physical therapy education program provides opportunities for students to link geriatric professional literature to practice within a course that presents special issues in providing physical therapy care to older adults. One of the course objectives is that students will be able to analyze the professional literature on selected topics that are relevant to providing physical therapy care for older adults. This objective is addressed through the assignment of a Geriatric Physical Therapy Topics Paper, which is designed to provide students with an opportunity to examine and analyze current professional literature on topics that are especially applicable to providing care for older adults.

The students are provided with a list of 19 potential topics that are presented in the form of a clinical question. Students select and research the identified topic and write a paper that includes: (1) a brief introduction of the topic and its importance to the care of older adults; (2) an in-depth, specific discussion of the topic; (3) a discussion of the implications of the researched topic on the physical therapy management of the older adult client; and (4) suggestions for future research.

The following is a Geriatric Physical Therapy Topics paper written by a student who researched the clinical question, “What unique ethical or legal issues do you need to consider when working with older adults in making end-of-life decisions?”

INTRODUCTION

As the aging population continues to expand, the number of older adults who will be making end-of-life decisions is increasing. An important way for individuals to maintain control over these decisions as they experience various losses is through the use of advance directives, which are legal documents outlining a patient’s preferences for treatment at the end of life. Advance directives include “living wills,” which outline the patient’s wishes and refusals, as well as the appointment of a health care proxy, also known as a durable power of attorney to make decisions on the patient’s behalf once they are no longer able to do so. In 1991, the U.S. Congress passed the Patient Self-Determination Act, requiring hospitals, nursing homes, and health care programs to ask patients about advance directives at the time of admission and provide information about these documents. Despite this effort, only 15% to 25% of the overall population has executed a living will, leaving end-of-life care difficult and unclear for many physicians and family members.¹ Many factors contribute to end-of-life decisions, especially with regard to the implementation of advance directives. Sociodemographic factors, culture and race, cognitive status, and psychosocial factors among others, are variables that

need to be considered in end-of-life planning.

SOCIODEMOGRAPHIC FACTORS

Sociodemographic factors including age, gender, marital status, and education have all been shown to influence end-of-life planning and advance directive execution. Interestingly, it has been shown that opposite age groups, young adults and adults over 85, are most likely to make advance directive preferences known to others.¹ It is hypothesized that the oldest adults are more likely to make plans because they know that they have a limited lifespan, and in the case of young adults, they are more informed and proactive consumers of today’s health care system.¹ It has also been indicated that men are more likely to make end-of-life plans than women, which is attributed to the older generation’s traditional gender-role socialization in which women play a lesser role in formal planning, financial decision-making, and acquisition of legal expertise.^{2,3} With regard to marital status, research shows that unmarried individuals are more likely to discuss their end-of-life preferences and appoint a durable power of attorney.^{1,4} It is thought that married adults may not complete advance directives because they assume their spouse knows their medical prefer-

ences and that unmarried individuals are more likely to initiate end-of-life planning discussions with health care providers and family members.⁴ Education has also been found to be a strong predictor of advance directive completion, with higher rates of advance directive planning among those with higher levels of education and often higher socioeconomic status.^{4,5} Conversely, it has also been found that while access to information regarding end-of-life planning is often better for those with a higher education and socioeconomic status, frequently this access does not translate into completion of advance directives.⁶

ETHNIC FACTORS

Ethnic and racial minority populations in the United States continue to grow and it is projected by the U.S. Census Bureau that by 2025, 15% of adults over 65 will be part of a minority group,⁷ thus highlighting the importance of recognizing and understanding cultural influences on end-of-life decision making. Although many patients in the United States value autonomy and the use of advance directives, many cultures see autonomy as isolating and believe that families and communities are also affected by a patient’s illness and accompanying medical decisions.⁸ Some research suggests that 40% of

elderly white patients have advance directives in place compared with less than 16% of elderly African Americans, Hispanics, and Asians.⁸ It is suggested that this low rate reflects distrust in the American health care system especially among African Americans, different religious and cultural perspectives on death and suffering, and different parent-child dynamics.⁸ Compared with Caucasians, African Americans have lower rates of organ donation, a reduced acceptance of hospice care, and also are more likely to want life-prolonging measures taken and change their DNR orders to more aggressive treatment.⁷ In many religions suffering is viewed as spiritually meaningful. Survival alone, even if it involves significant pain can be seen as a demonstration of faith.⁸ Regarding family dynamics, Hispanic and Asian cultures place more emphasis on collective family decision making and have a much stronger focus on the responsibility of children caring for their aging parents.⁹ These insights should direct health care professionals to treat each patient individually and respect racial and cultural differences when making end-of-life decisions.

COGNITIVE FACTORS

Another factor influencing the completion of advance directives is the individual's cognition. Mild cognitive impairment is found in 20% of older adults, and Alzheimer's disease affects 10% of individuals over the age 65 and nearly 50% of those over 85.⁴ The complexity of decisions involved with advance directives presents a major challenge to individuals undergoing cognitive decline. Loss of simple cognitive abilities such as verbal skills may prevent the designation of a health care proxy or the ability to make one's preferences known, while loss of higher order cognitive abilities such as understanding, may alter one's choices and lack consideration of the consequences of treatment choices.⁴ In early stages of cognitive decline, it is advisable to appoint a durable power of attorney so that appropriate medical treatment is attained, yet a common concern regarding patients suffering from dementia is financial exploitation, making this a sensitive area for clinicians to pay attention to.³ Before an advance directive is completed, if cognitive decline is suspected, it is advised that the individual be assessed professionally to ensure their mental ca-

capacity.³ In many cases, individuals who have not planned for the future and do not have the cognition to make their own decisions are left to the judgment of physicians, distressed family members, or court-appointed guardians.

PSYCHOSOCIAL FACTORS

Accompanying these very difficult end-of-life decisions are many psychosocial issues that should be addressed. As mentioned previously, these decisions often affect various family members and can be a great burden if one's medical wishes are not known, leaving the family to guess what the individual would have wanted, evidenced by the case of Terri Schiavo in 2005.⁶ When an individual does complete an advance directive, many factors can affect their decisions. Being overwhelmed by the onset of a new disease or trauma, denial or procrastination, difficulty with confronting the end of life, vulnerability, or distrust in the health care system are all factors that can affect advance directive planning.^{2,6} Too often, individuals wait to make these decisions, putting themselves at a higher risk to be influenced by these factors. Additionally, older adults have a more traditional view of the doctor-patient relationship and do not feel comfortable bringing up concerns about end-of-life planning unless it is brought up to them initially by their doctor.^{10,11} Therefore, it is the duty of physicians and all health care professionals to have that conversation with all patients regardless of age to ensure proper measures are taken and individual rights are respected.

PHYSICAL THERAPY INTERVENTIONS

As physical therapists we often spend more time with our patients than other members of the health care team, allowing us the unique opportunity to learn more about our patients and what is important to them. It has been noted that many physicians are uncomfortable discussing end-of-life issues with their older patients due to time constraints, limited advance directive knowledge, and fear of upsetting them.¹ Therefore we have an opportunity as physical therapists to make a big impact on our patients' end-of-life care. It is our responsibility to not only be knowledgeable about what end-of-life options exist for our patients, but to then go the extra step and impart that knowledge to them.

Something very important to consider when addressing this topic with our older adult patients is that end-of-life decisions are very personal ones. Respect for the patient's autonomy and their wishes is a key component of our professionalism and we should be careful not to impart our own ideas of what the best decisions are. In order to better assist older adults with making end-of-life decisions appropriate for them as individuals, we first need to simply ask them what their wishes are. Also, developing a values history form (Appendix) that can be given to patients at their initial evaluation, may help paint a better picture of what is important to patients and serve as an opener when discussing the topic with them.¹⁰ As discussed previously, taking a patient's cultural background into consideration is also very important. To assist patients from different backgrounds than ourselves, we can look up information on our own, ask friends, and ask the patient about their cultural influences and preferences when dealing with end-of-life decisions. Additionally, the family should always be considered and included when having these discussions as they are often equally affected by the decisions made.

There are also ways physical therapists can help older patients plan for the future and make end-of-life decisions outside of their treatment sessions. One way to do this would be to send out information flyers about advance directives as well as a sample advance directive to patients, or handing them out at the end of a visit. A list with community resources could be provided as well along with information pamphlets available in waiting room areas. Additionally, a PT could host a free seminar about what advance directives are and what options exist in either a clinic or community center. Lastly, we can influence our patients' end-of-life care by educating other health care professionals through an in-service or simply in conversation. These suggestions would be appropriate for any setting because it is important for all adults to consider end-of-life planning, however, they may be most effective in nursing homes, assisted-living centers, and hospice centers.

AREAS TO EXPLORE

While there is a large body of evidence that looks at many factors contributing to end-of-life decision making, there still exist areas that should be explored fur-

ther. With regard to sociodemographic research, there is little information about the correlation between advance directive planning and urban versus rural living. Additionally, the correlation between higher levels of education and higher socioeconomic status is speculative. A separate study to investigate the relationship between socioeconomic status and advance directive completion would help clarify this point. Culturally, many studies suggest the influence of religion in end-of-life decision-making, yet there is no information with respect to specific religions. As clinicians it would be helpful to have a study that examined what older adults of different religions value in end-of-life care to provide more individualized care. Also culturally, it would be interesting to consider the level of English proficiency as well as literacy and how they affect one's ability to make end-of-life decisions in the American health care system. Lastly, after reviewing the literature, it is apparent that the low completion percentage of advance directives has to do with a lack of knowledge assumed to be on the part of the patient. However, it may be part of the reason many health providers do not bring up the topic due to their own paucity of information on the topic. Therefore, a study that surveyed health care professionals about their knowledge of advance directives would provide beneficial information.

Making end-of-life decisions is not a simple process for the older adult and must be approached by physical therapists with respect for the individual and his or her wishes. We should consider sociodemographics, culture, cognition, and psychosocial factors when approaching the topic with our patients and do our best to listen to what is important to them and direct them appropriately. By

educating our older patients and their families about advance directives and available options, we can positively influence an older individual's end-of-life care. Our efforts may begin to address the questions that many health care providers and families must face when planning for the future is not done by the patient.

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Appendix. What is a values history form?

1. A form that can be issued to older patients (or any patients upon admission to the hospital) that asks questions about preferences in:
 - a. specific medical circumstances: ie, artificial nutrition, DNR, etc.
 - b. general values: autonomy vs. family dependency
 - c. medical values: trust vs. mistrust in physicians and the American health care system
 - d. relationship with family members & proximity of family members
 - e. religious views, esp. regarding pain, suffering, and death
 - f. financial preferences
 - g. specific wishes/requests

Developed from themes described by van Asselt.¹⁰

PAY-FOR-PERFORMANCE: A PENDING CHANGE FOR HEALTH CARE REIMBURSEMENT IN THE UNITED STATES

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The following article was written for an Applied Public Policy Course at the University of Indianapolis taught by Dr Jennifer Bottomley.

INTRODUCTION

In 2001 The Institute of Medicine called for better alignment of payment incentives for providers with a national agenda to improve the quality of health care in the United States.¹ In 2005 Congress passed The Deficit Reduction Act directing the secretary of health and human services to develop a plan of value-based hospital payments for those enrolling in Medicare in 2009. Congress also called on the Centers for Medicare and Medicaid Services to develop a plan for hospital value-based purchasing of health care by 2009.²

Since this time, pay-for-performance programs have become the focus of public debate.¹ Despite limited evidence, pay-for-performance has emerged as one of the most widely advocated strategies for accelerating quality improvement in the provision of health care.² Pay-for-performance (P4P) is designed to strengthen the quality improvements in the provision of health care in the United States by rewarding excellence and reversing perverse financial incentives that can deter hospitals and other health care providers from investing in quality-improvement efforts.² Pay-for-performance programs also promote value-based health care by rewarding types of care that lead to a reduction in the need for disproportionate spending on care of patients with severe disease or high risk for disease. Additionally, it promotes a more effective distribution of funds and efforts across the continuum of health care through measurement, transparency, and accountability.³ The rationale behind pay-for-performance is that the quality of health care will improve if physicians can earn bonuses for providing high-quality care.⁴

According to a survey by the Commonwealth Fund, the public's view of the health care system in the United States indicates that 76% of the population believes that the system needs to be fundamentally changed or rebuilt completely.⁵ Also, according to a Commonwealth Fund survey of health care opinion leaders, 89% of the respondents agreed that Medicare should use its leverage to reward providers for quality and efficiency in health care delivery.⁵ The results of a 2004 physician's poll indicated that 90% of physicians thought the current reimbursements system did not reward them for providing high-quality care, and the results suggest that they support efforts to control costs through value-based purchasing.⁶ Because Medicare will spend \$424 billion on health services in 2007, and that figure is projected to double to \$842 billion by the year 2017, there will be tremendous pressure placed on its solvency, as well as the federal budget and the economy as a whole.⁵

Several factors are currently influencing the development of pay-for-performance in the health care system. Among these are employers, federal agencies, health plans, providers, accreditors, and Congress. The National Committee for Quality Assurance is a private, independent nonprofit health care quality oversight organization that measures and reports on health care quality. The committee's recognition programs are an excellent example of the value of measuring structure, process, and outcomes, and rewarding high performance appropriately. The committee unites diverse groups around a common goal of improving health care quality.³

Rosenthal and colleagues surveyed health plans that offered commercial Health Maintenance Organizations (HMO) products in 40 randomly selected markets in the United States where at least 100,000 persons were en-

rolled in the HMOs. More than half of the HMOs, representing more than 80% of the persons enrolled, used pay-for-performance in their provider contracts. Health plans in the South were significantly less likely to use pay-for-performance.¹ Policy makers are considering implementing pay-for-performance on a large scale in the fee-for-service Medicare program.⁴ According to Mark McClellan, administrator for The Centers for Medicare and Medicaid Services, Medicare is working to apply pay-for-performance in every setting in which they pay for care.⁷ This involvement of Medicare in pay-for-performance programs signals a directional change that in the next few years is sure to revolutionize health care.⁸ Under the Hospital Quality Incentive Demonstration, a joint effort between The Centers for Medicare and Medicaid Services and Premier, Inc., quality indicators for 260 participating hospitals are currently being measured. The project has been under way for the past 2 years and scores hospitals on their adherence to 30 nationally standardized measures in 5 clinical areas: acute myocardial infarction, congestive heart failure, coronary artery bypass grafting, pneumonia, and hip and knee replacements.⁹ Recent reports suggest that more than 100 health plans, other public agencies, and employers have implemented pay-for-performance programs already in the United States.¹ Pay-for-performance programs are exploding among private health plans all across the industry according to Managed Care Information Center in Manasquan, NJ. They report that, as of September 2006, there were 112 pay-for-performance programs nationwide compared to 82 in 2004.⁸

THE CASE FOR PAY-FOR-PERFORMANCE

To reach the goals of improving the quality of health care in the United States and reducing the cost of care, financial incentives should be introduced

that reward health care providers for excellent and efficient care. With the current health care system in the United States based on a fee-for-service system that rewards hospitals and health care providers for producing units of care, there is no incentive to control costs even if better patient outcomes could be achieved with fewer services or a less expensive combination of services. This policy of reimbursement may discourage both quality and efficiency by rewarding more care rather than more appropriate, better-coordinated care.⁵

Pay-for-performance would reduce the wide variation across the United States in the spending and outcomes for those with the same conditions. It could also be used to reward the coordination of care across providers and sites of care.⁵ Findings of the Commonwealth Fund Commission in 2006 suggested that Medicare could cut costs significantly and have better outcomes if providers in geographic areas of the country offered both the cost and the quality of the best-performing areas.⁵

There is a cost to poor health care, and pay-for-performance is a win-win situation for everyone. Patients win by receiving better health care and by being healthier. Health care providers win by being rewarded for providing evidence-based/best practices in health care provision. Everyone wins if the cost of health care decreases.¹⁰

Premier, Inc. released an analysis last summer which found that if hospitals nationwide would have followed the same care processes recommended in the demonstration project they conduct jointly with Medicare for pneumonia, heart bypass, heart attack, and hip and knee replacement procedures in 2003, as many as 5,652 fewer deaths and 1 million hospital days could have resulted, with as much as \$1.4 billion in savings to the Medicare program.⁸

The initial results from pay-for-performance pilot projects strongly suggests that measurement coupled with rewards leads to improvement in health care quality. The results indicate that both financial and nonfinancial incentives motivate significant change in health care delivery.³ Data from the National Committee for Quality Assurance's evaluation of the first wave of initial data from pay-for-performance

programs across the board has indicated that measurement provides physicians with a new perspective on their practice and the practices change their process and delivery systems in order to meet program standards.³

When designed effectively, pay-for-performance programs target all 3 measures of clinical performance: clinical quality, efficiency, and patient satisfaction. They hold great potential for enhancing the quality of health care in the United States. Over the 2 years of one study conducted by Lindenaue, et al both pay-for-performance hospitals and control hospitals showed evidence of improvement in each of the in-

The rationale behind pay-for-performance is that the quality of health care will improve if physicians can earn bonuses for providing high-quality care.

dividual and compound measures of performance they were evaluated on. Pay-for-performance hospitals showed a significantly greater improvement than did control hospitals in 7 of the 10 individual performance measures evaluated. Pay-for-performance hospitals also showed a greater improvement in all the composite process measures evaluated. The pay-for-performance hospitals receiving 1% to 2% bonuses for achieving high levels of performance compared to their peers had greater improvements over the 2 years of the study than those receiving no financial incentives. The results showed, even though the incentives were modest, that financial incentives are capable of causing quality-improvement efforts of hospitals already engaged in public reporting of quality outcomes data indicators. Hospitals declining to participate in the pay-for-performance demonstration improved less than did participating hospitals.²

Pay-for-performance can influence referrals to networks of physicians who

are chosen based on quality and efficiency. In these cases, health plans do not increase payments per patient, but increased referrals can increase physician income because the income from these extra patients is mostly profit since the physician incurs few additional practice expenses to see such patients.⁶

Many employers are influencing and implementing pay-for-performance on their own because they believe that quality and cost-effective improvements in employee health care are in the employer's interest. This is evidenced by the program "Bridges to Excellence" where physicians who demonstrate that they provide high-quality care for patients with diabetes, as measured by the criteria of the National Committee on Quality Assurance and American Diabetes Association, can receive \$80 per year per patient in bonus payments. Another prominent employer-sponsored program is the Leapfrog Group, an innovative coalition of employers who provide hospitals with additional payments for implementing the infrastructure for improving quality, such as computerized physician order entry and staffing intensive care units with board-certified intensivists.⁶

The future scenario seems to be that, over time, higher-performing physicians and those demonstrating sustained improvement will receive higher pay, more volume, or other rewards, whereas lower-performing physicians will receive less of each.⁶ It is quickly going to emerge that there will be nonpayment for nonperformance.⁸

THE CASE AGAINST PAY-FOR-PERFORMANCE

Some believe that pay-for-performance is a passing fad and will soon be replaced with the next big idea. Skeptics fear that pay-for-performance will morph into the ultimate clinical cookbook that restricts clinical judgment.⁶

Two assumptions underpin the implementation of pay-for-performance in Medicare: that the primary responsibility for care of a beneficiary can be assigned to an individual physician or practice, and that Medicare can link performance to meaningful financial incentives for those providers. The challenge arises when the care of a beneficiary is dispersed across many providers,

if the provider assigned responsibility for that beneficiary's care changes frequently, or if only a small percentage of the beneficiaries are treated by a provider serve as the basis of performance measurement. Based on the results of a study by Pham, et al of a Community Tracking Study, Medicare beneficiaries saw a median of 2 primary care physicians and 5 specialists, collectively working in 4 different practices. This finding impedes the ability of any one assigned provider to influence the overall quality of care for a given patient and may limit the potential of incentives to improve the quality of care.⁴

Also of concern is the fact that only a minority of a physician's Medicare patients may be assigned to them reducing the size of the maximum incentives available if Medicare structures bonuses proportional to the physician's caseload. If pay-for-performance is restricted to only a physician's Medicare caseload it may in many cases constitute a small portion of the physician's total revenues, especially for specialists.⁴ Medicare deems that only half of the patients assigned to a given physician remain stable and continue to see that same physician. With this instability in assignments, it may decrease the motivation of physicians to invest in long-term improvements in care for patients with chronic conditions, or the ability to target interventions to specific patients if they perceive that the benefits to patients will take years to accrue and along with the fact that many of these patients are unlikely to remain assigned to them long enough for the improvements to result in rewards for care.⁴

Pay-for-performance can result in a clash of cultures. Physicians are concerned with the increased hostility of the medical market place, increased liability risk, increased costs of running a practice, and the declining reimbursement with real threats of further declines in the near future. Hospitals are concerned with medical error rates and the cost effectiveness of preventing these errors versus treating them, and the federal government is concerned with excessive health care cost that is unsupportable at current projection.¹¹

Physicians complain that the large investments by hospitals into medical records systems, utilization review, quality

assurance, and computerized information systems have not improved patient care. They also feel that these investments have drained funds from the acquisition of medical equipment and nursing staff needed for real practice of medicine and surgery.¹¹

Physicians see pay-for-performance as forcing them to implement changes that increase their liability without perception of benefit to themselves or the patients they treat. They feel that implementing these changes is ethically abhorrent. Also cited for a reason for physicians not to buy into pay-for-performance is the failure of HMO plans due to requiring primary care physicians to reduce referrals to specialty consultations and unnecessary diagnostic studies. Instead of serving to reduce cost, the plans erected obstacles to timely referral and impeded delivery of quality medical care and denied benefits.¹¹ Physicians argue that past Medicare cuts have not changed providers into more efficient providers of care, but have only reduced the number of participating providers in the Medicare systems. This has led to an increase in concierge and boutique practices not accepting Medicare patients.¹¹

The lack of class I evidence in the practice of medicine and the difficulty obtaining class I evidence from randomized, blinded control trials in the health care professions has been cited as one of the reasons that pay-for-performance cannot be implemented with any success. The argument here is that where there is satisfactory therapeutic option, withholding treatment or performing sham surgical procedures cannot even be considered.¹¹

Lawrence et al feel that if pay-for-performance is going to be successful and physicians are going to have to prescribe care by a standardized set of criteria they will be measured by, then they need relative immunization from law suits for using best practices regardless of the outcomes. They also are concerned with the utilization of emails to communicate and prescribe care for patients. Their concern is that this opens up additional liability exposure for them to give advice and directions when they are not seeing the patient in the office for a face to face interview and evaluation.¹¹

Another issue causing physicians to feel that pay-for-performance will not

work is that, due to the increased cost of providing care that they face, coupled together with the reduction in reimbursements, they propose that the Stark Law needs to be rewritten. The reason is that they report not being able to implement pay-for-performance measures without obtaining the computerization to do so. Their desire is to have hospitals provide them with financial assistance, currently unlawful under the Stark Law, to meet the rapid information technology implementation requirements of pay-for-performance. These specific requirements are software and training to implement electronic records, prescription programs, and electronic links to hospitals. Fink et al also site the lack of compatible information technology by The Center for Medicare and Medicaid Services to link all organizations and individuals across health care, eliminating the fear of investing in an incompatible system.¹¹

Pay-for-performance is also criticized for causing unintended effects. Effects such as providers reallocating their efforts toward the rewarded dimensions of patient care at the expense of investing in unrewarded dimensions of quality care.¹²

One study hypothesized that better pay for improving measured performance would provide an unintended incentive of adverse selection (avoiding treating the most severely ill patients, thus restricting access to care for this group).¹³

Gaming the system has also been mentioned as a negative effect of pay-for-performance.¹⁴ Another unintended effect of pay-for-performance was "gaming the system" by nursing homes manipulating the program to increase revenues. Nursing homes would claim they were admitting extremely disabled patients who then made a miraculous recovery over a short period of time.¹³ High adherence to quality measures may be illusory as sophisticated "gaming" of quality measurements may also happen with hospitals and physicians become more clever at documenting questionable contraindications to standard therapies.¹⁵

Other studies reported gaming behaviors aimed at improvements in documentation rather than a change in the quality of the health care delivered to

the patients.¹³ Other design problems to be considered are end-of-year compensation that may not influence a physician's behavior as much as an intermittent bonus or concurrent pay and the size of the bonus. If incentives are too small or if they are only provided by some insurers, it may dilute the effectiveness of the program if the number of covered patients in a provider's panel is small.¹³

Peterson et al also reports that the potential for some who provide poor quality care to get a free ride by profiting from the efforts of others in their network or group who provide high-quality care, is enough of an incentive to decrease the efforts of all toward high-quality care and improved outcomes.¹³

A study by Rosenthal, et al proposes several reasons why pay-for-performance under the current Medicare system may have a hard time being successful. One is that HMOs with a large portion of enrollees who were not required to select a primary care physician, a feature shared with Medicare, were less likely to participate in pay-for-performance. Secondly, payers using pay-for-performance in the private sector were found to concentrate heavily in paying medical groups rather than individual providers for performance. Medicare currently does not recognize groups as contract entities. Thirdly, many private payers use rewards greater than 5% of payments. Given the current financial restraints of Medicare, it may not be feasible for Medicare to meet this benchmark without reducing base payments to physicians. Enrollment in private HMO plans continues to decline, and if this trend continues, pay-for-performance may become less viable.¹

With the proliferation of pay-for-performance programs, there is concern that the existing electronic health record systems cannot accurately capture the data required for providers to participate in the programs. Just the sheer amount of the performance measures and the lack of standardization among them limits the ability of software vendors to incorporate them into their systems. The worry is that vendors will rush to incorporate quality measures into their systems before they are fully accepted by the field. This could result in problems for most current quality initiatives because they rely on administrative and billing data rather

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than clinical data to ensure that providers who do not have electronic medical record systems are able to participate in pay-for-performance. Because of the lack of providers with electronic medical records systems that can participate in pay-for-performance, it is argued that clinical data should not be used as pay-for-performance may be consolidated and standardized on something that does not work in the long run. Many of the current electronic records systems are still text-based and are not powerful enough for reporting and extracting information for pay-for-performance as they were created for patients, not for collecting aggregate performance data. This requires much more standardization and common terminology.¹⁶

Transparency of process and outcomes data on provider performance has to date not significantly affected patient decision making about choosing a physician or health plan.⁶ Some physicians oppose pay-for-performance because they preclude the judgment of physicians by forcing them to adhere to a set of measurable standards and if not followed may result in a demotion on the quality rating by their pay-for-performance record surveys.¹⁷

They are also concerned by some agreements like in West Virginia where Medicaid patients are asked if they want a Medicaid Member Agreement for which they are rewarded for compliance with 4 requirements of the program. The requirements for participation in this enhanced Medicaid Plan are: (1) to keep their appointments, (2) to receive

screenings as recommended by their physicians, (3) to take their medications as directed by their physicians, and (4) to follow health improvement plans given them by their physicians.¹⁷ For this compliance, the patient receives enhanced diabetes care, cardiac rehabilitation, education in nutrition, chemical dependency, no limit on their monthly prescriptions, and mental health services. The catch, according to the author, is that if the patients fail to comply with any of these measures they are removed from the enhanced plan and placed back on the basic plan without these benefits. The author explains how easy it is for these individuals to fail to comply with these measures due to hardships with transportation, family difficulties, illiteracy, job demands, mental illness, compulsive addictions, cultural prohibitions, educational deficiencies, or medication side effects. The fear is that these individuals would then be told that their health problem is no longer covered as they failed to comply with their agreement.¹⁷

Physicians want more hard evidence that pay-for-performance works. With the link of pay-for-performance to better quality, they are not ready to adopt an unproven strategy for reimbursement any more than they are to adopt new surgical techniques or medical therapies. They insist on hard evidence before adopting new approaches prematurely. Before Medicare adopts a single new payment system for all of Medicare, they must recognize that pay-for-performance is fundamentally a social experiment likely to have only modest incremental value. A series of regional models could accelerate learning and allow Medicare officials a chance to find out the effect of differing levels of incentives and formulas for payment. Timely evaluation of any policy adopted seems critical to ensure that we achieve high performance without unintended consequences.¹⁸

THE FUTURE DIRECTION OF PAY-FOR-PERFORMANCE

There is evidence of low-quality care throughout the Medicare Program in the United States. In fact, quality of care is not higher in areas where Medicare spending on health care is greatest. Actually, some studies point to the conclusion that Medicare beneficiaries

are often less likely to receive recommended care in regions where Medicare spending is highest. Tom Scully, the former Medicare administrator states that within a given Medicare hospital region, Medicare pays “the exact same amount for hip replacement and the same amount for heart bypass, if you are the best hospital or the worst hospital.”¹⁹ The Medicare Payment Advisory Commission states:

In the Medicare program, the payment system is largely neutral or negative towards quality. All providers meeting basic requirements are paid the same regardless of the quality of services provided. At times providers are paid even more when quality is worse, such as when complications occur as the result of error.¹⁹

In order for pay-for-performance to be accepted in the medical profession, it must be based on hard empirical evidence that providing financial incentives for the provision of best practice/evidence based medicine works.

Early results are mixed, with studies containing both positive and negative results when financial incentives are used.¹⁹ One thing seems to be clear, health care in the United States is more expensive than the rest of the world, with no better quality than can be seen in other countries where health care costs are less.²⁰ Due to the mixed results of early demonstration project reports on both private and Medicare pay-for-performance projects, more research needs to be done to validate pay-for-performance. Pay-for-performance has many good components and a great potential to reshape health care in the United States. However, it is too early in the process to accept it universally as the new pay system for health care payment as a whole. With very little evidence currently available to say that evidence-based care relates to higher-quality care or that pay-for-performance delivers less costly high-quality care, a strong emphasis should be placed on additional research. We are making great strides in this direction as there are currently 10 demonstration projects underway related to the adoption of pay-for-performance reimbursement by Medicare. Additionally, there are a number of P4P initia-

tives already under way in both public and private sectors with Aetna, Pacific-Care, WellPoint, and Highmark Blue Cross Blue Shield experimenting with pay-for-performance programs.¹⁹ Many health care professionals are trained to research and review the current medical literature to determine what evidence is available to them regarding the care of the individuals they care for. This process is called the development of answerable clinical questions. It is a specific process where clinicians can determine the best evidence available at any moment in time by searching the medical research literature. The process works by the clinician asking a specific question about the potential intervention they would like to provide and then searching for the answer in the medical literature. Unfortunately, this process does not seem to be widely used. Students in many medical specialty programs are now being taught this skill set before graduation, but many practicing professionals do not understand or use this skill. There needs to be more emphasis on research in the medical community with employers recognizing that changes to the health care delivery system seem eminent. Having employees abreast of current research developments and able to access the latest finding and results of these various studies will assist in advancing the more rapid deployment of this information into clinical practice. The current fee-for-service system limits this because research does not produce direct reimbursement to the facilities and researchers performing the work. It does not produce units of care. Until a greater emphasis is placed on the development of high-quality, valid and reliable research study designs and they are carried out, the effect of evidence-based medicine and its carry over as a basis for pay-for-performance systems success will not be known. There seems to be more demonstration projects being currently pursued by those responsible for reimbursing the cost of health care in the United States this year over last year. Also, according to The American Medical Association Physician’s Consortium for Performance and Improvement, there are almost 100 performance measures currently being used in physician’s practices and government

pay-for-performance demonstration projects.²¹ Hopefully, within the next few years, the results of long-term studies related to the use of evidence-based/best practice and pay-for-performance results will shed more light on the reliability and validity of these approaches to help change the health care crisis in the United States.

CONCLUSION

Evidence-based medicine and pay-for-performance have a unique potential to redefine health care delivery in the United States. However, it is being questioned if we are ready for the implementation of pay-for-performance on a broad scale due to conflicting results of the early demonstration projects currently under way. It would behoove Medicare to spend a longer period of time researching the various effects that pay-for-performance will have on the delivery of health care in the United States before jumping in and making it the reimbursement policy for Medicare as a whole even by 2009.

By the year 2030, approximately 1 in 5 Americans will be 65 years of age or older, and by the year 2050, 1 in every 10 Americans will be over the age of 85 years.²² Due to the increasing number of individuals depending on Medicare as their source for health care funding, and the fiscal problems facing Medicare’s future, we as health care providers, public policy advocates, and gerontologists have a moral and ethical responsibility to thoroughly research proposed solutions to our health care crisis before recommending their implementation in the Medicare system as a whole.

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CREDENTIALLED RESIDENCY PROGRAM

DURABLE POWER OF ATTORNEY

Understand What you Sign!

Patty Antony, PT, CGS

Due to the many recent articles and media attention on advanced directives and their impact, more and more clients that we see in our practice are coming in with these directives in hand. That's the good news. The bad news is that many of them are printing these documents off of the internet or buying them preprinted from an office supply store rather than having them drafted by an attorney to meet their individual needs. This is a major mistake in the case of the Durable Power of Attorney (DPOA) document.

The Durable Power of Attorney is a document that enables you (referred to as the "principle") to designate someone to act in your behalf if you should become incapacitated. Exactly what you are empowering this person to do for you needs to be stipulated in the document. Generally, these powers include selling a car, home, or other property; signing a contract; applying for public assistance benefits if applicable; handling financial transactions; paying taxes; and signing legal documents to name a few. This document can include just about anything depending on the individual needs and wants of the person who is delegating the power. Of course, this also depends on the level of trust that this person has in the person he/she is delegating to.

ATTORNEY IN FACT

The person that is on the receiving end of a Durable Power of Attorney is called the "attorney in fact." This person needs to be fully informed of what is expected of them before they are named to perform this task. Many people who are named "attorney in fact" are totally unaware of it! Do NOT assume that your spouse or children will happily take this on. Your attorney in fact should be someone that you trust implicitly and is financially responsible. There needs to be discussion about what may

be involved, and the individual should consent to this before he/she is named. Most attorneys now require that the attorney in fact sign an acceptance form when the DPOA is drafted. Keep in mind that the individual has the right to decline the responsibility.

Another key area in a DPOA is assigning a back up to the attorney in fact. It is really better and easier to name an individual with a back up than it is to name "either/or" attorney's in fact. Some banks will not accept DPOAs that have either/or assignments of attorney in fact. If they do, they may require signatures from both parties in order to complete a transaction. This can get complicated if both parties live apart or don't agree on something. It is important to have a back up attorney in fact in case the primary attorney in fact is unable or unwilling to serve. It is not uncommon for an attorney in fact that is a spouse to pre-decease the principle. This is a disaster if there is no back up named and the principle is now incapacitated and unable to draft a new Durable Power of Attorney.

When a principle has a DPOA drafted, the Elder Law Attorney needs to instruct them on how to have their attorney in fact sign paperwork when acting as the principle's representative. Again, this involves the attorney in fact being involved in the process. As a general

rule, if you are acting as an attorney in fact for someone, you should always sign "*your name, DPOA for principle's name.*" In some cases, Elder Law Attorneys may have you do it the other way: "*principle's name, your name DPOA.*" In either case, the important point is to NEVER just sign your own name without making it clear that you are acting as attorney in fact for the principle. By just signing your own name and not clarifying your relationship, you could be signing to be personally responsible. For example, if you are signing your mother's admission papers to a facility, by signing your own name and not defining yourself as her attorney in fact, you can be held personally responsible for her bills. If you designate yourself as her attorney in fact, you are only agreeing to assist her in paying her own bills. Of course you have to read the documents carefully to avoid other snags. I always recommend that families take contracts home to read at their leisure and not to be afraid to alter wording to suit needs.

COMPETENCE ISSUES

You can only design and sign a Durable Power of Attorney if you are capable of knowing what you are signing and the implications of what you are doing. This can get to be a gray area when it comes to people having memory loss. There are many people who aren't sure where they are or what day it is, but are still very clear on who they want to handle their affairs. These individuals may still be able to sign a Durable Power of Attorney, but the person witnessing and notarizing their signature must ensure that they know what they are signing. I have had many clients who are "sundowners" but have very clear lucid times in the morning where I feel confident that they are aware of what they are doing. Timing is everything. If a physician has documented that a principle is incapacitated, that principle

The Durable Power of Attorney is a document that enables you to designate someone to act in your behalf if you should become incapacitated.

cannot sign a durable power of attorney until the physician reverses that ruling. This is why doctors are so reluctant to label a patient incapacitated. It is really never that black and white, and the physicians don't want to unnecessarily limit the person and their families from moving forward.

Another consideration with DPOA documents is the timing on when the attorney in fact should take over. Some documents require certification from 2 different MDs stating that the principle is incapacitated in order to enact the attorney in fact powers. This is to ensure that an attorney in fact does not railroad a competent principle who is still able to make their own decisions and handle their own affairs. Many older people are fearful of signing a DPOA because they feel that they will be giving the power to someone to take away their independence and "put them in a home." They need to understand that they can include language in the document to safe guard against this. On the other hand, too strong a language can limit the attorney in fact on making living arrangement decisions that may be vital to the care of the principle. Having an Elder Law Attorney draft the document can really make this easier and more practical. These individuals are specialized in tweaking advanced directives to meet the individual needs of the principle.

CHANGING A DOCUMENT

All powers of attorney documents can be revoked or modified as long as the principle is competent to understand and make the changes. Attorneys in fact cannot modify a document on behalf of the principle. The document is what it is at the time of signing unless the principle is able and competent to draft and sign a new document. This is why it is so important to get it right the first time.

STATE ISSUES

Durable Power of Attorney documents and restrictions vary from state to state. If a principle has a DPOA drafted in their home state of New York and then moves to Florida, he/she will need a new document drafted. Preferably, the principle will have valid documents for both states. What takes place if something happens when the principle is traveling? Unfortunately, this is where it really gets hairy. If the principle becomes incapacitated in a state other than one in which they have a valid DPOA, it really is up to the state where they are to decide what to do. Most states will recognize and attempt to honor DPOAs from other states. In most cases, there really isn't an issue. The problems arise when someone contests the validity of the document. This can end up in a legal mess. Fortunately, there is a strong movement working towards universal advanced directives. The general consensus is that

these documents are very beneficial to have even if it isn't a perfect world.

BOTTOM LINE: WATCH WHAT YOU SIGN

The bottom line is that persons of all ages should take some time to think about who they would trust to handle their personal and financial affairs, and set up written agreements so that things can flow smoothly in a crisis situation. Failure to do so can lead to major hardships for those who are trying to act in your best interest. Use professionals with appropriate skills to draft documents to suit individual needs, and most important.....watch what you sign!!!



Patty Antony is a physical therapist with 24 years of experience. She graduated from Florida International University in 1981 with a bachelor's degree in physical therapy. She is also a board certified geriatric clinical specialist. Patty is the founder and President of Elder Advocates Incorporated. She has extensive background in long-term care, teaching, and lecturing. She can be reached at patty@elderadv.com.

KNOW THE DIFFERENCE BEFORE YOU SIGN

The Limited Power of Attorney gives the attorney in fact authority to conduct a specific act within a specific time period. For example, the principle may want to delegate the ability to sell a home out of state to an attorney in fact that lives local to the where the home is located. The Limited Power of Attorney limits the authority to that specific act.

A General Power of Attorney typically gives the attorney in fact very broad powers to perform any legal act on behalf of the principle. The specific powers should be stipulated in the document. This type of document might be used in the instance of a principle leaving the country for a specific time and delegating the authority to an attorney in fact to handle their affairs while he/she is away.

A Durable Power of Attorney stipulates an attorney in fact that will take over the affairs of the principle when that individual becomes incapacitated. This document is similar to the General Power of Attorney, but contains a special provision that continues the powers after the principle becomes incapacitated.

HOW MEDICATIONS INFLUENCE A PATIENT'S RESPONSE TO PHYSICAL THERAPY: A CASE REPORT

Eileen Worrell, PT

INTRODUCTION

Physical therapists play a critical role in implementing interventions that work in conjunction with pharmacology to achieve the most optimal results for the patient. Therefore the therapist should understand not only the clinical use for each drug their patient is taking but also that these medications can influence the patient's response to physical therapy in both positive and negative ways.

PATIENT HISTORY

The patient was a 55-year-old male who was referred to physical therapy for exercise and conditioning. The patient reported his only activity was walking to and from the mailbox every day. Over the last few weeks, the patient developed shortness of breath and complained of feeling poorly. The patient saw his physician who diagnosed him with congestive heart failure (CHF) and Type 2 diabetes. At that time, the patient was put on digoxin (Lanoxin), furosemide (Lasix), and metformin hydrochloride (Glucophage) and physical therapy was ordered. The patient's past medical history was significant for chronic obstructive pulmonary disease (COPD), tobacco use for 25 years (quit 3 years ago), and a lobectomy 3 years ago. The patient also reported taking 2 bronchodilators, ipratropium bromide (Atrovent) and salmeterol xinafoate (Serevent), for his COPD.

CURRENT MEDICATIONS

Ipratropium Bromide (Atrovent)

Clinical Use. Ipratropium bromide is an inhaled anticholinergic bronchodilator used in the long-term treatment of bronchoconstriction associated with COPD.¹

Side Effects. Inhaled ipratropium is associated with very few side effects because the drug is poorly absorbed into the systemic circulation.¹ Possible side effects include: dry mouth, blurred vision, constipation, urinary retention, tachycardia, confusion, and irritation from aerosol.¹

Salmeterol Xinafoate (Serevent)

Clinical Use. Salmeterol xinafoate is an inhaled beta-adrenergic agonist bronchodilator used in the treatment of bronchoconstriction associated with COPD and asthma.¹ Salmeterol is considered to be a long-acting agent which allows the drug to provide more sustained bronchodilation.¹

Side Effects. Inhaled salmeterol is associated with few side effects because the drug is delivered directly to the respiratory tissues with very little of the drug being absorbed into the systemic circulation. Prolonged use of inhaled salmeterol, however, may increase bronchial responses to environmental irritants.¹ Prolonged use may also cause airway irritation, resulting in an increase in the frequency and severity of asthma attacks.¹ Tolerance to the drug may also develop with prolonged use of salmeterol.¹

Digoxin (Lanoxin)

Clinical Use. Digoxin is a cardiac glycoside used primarily in the treatment of CHF.¹ Digoxin improves cardiac contractility resulting in improved blood circulation and decreased fluid volume thereby improving the symptoms of CHF.¹ Digoxin also decreases excessive sympathetic stimulation of the heart which helps stabilize heart rate and cardiac excitation, further decreasing stress on the failing heart.¹ Digoxin is commonly prescribed along with a diuretic to assist in the elimination of excess fluids associated with CHF.¹

Side Effects. Cardiac glycosides have a number of possible side effects. The most serious side effect is digoxin toxicity which is fairly common and potentially fatal. The most common signs of toxicity include nausea, vomiting, diarrhea, abdominal pain, drowsiness, fatigue, confusion, visual disturbances, arrhythmias, and tachycardia.¹

Furosemide (Lasix)

Clinical Use. Furosemide is a loop diuretic used in the treatment of hypertension and other conditions requiring elimination of excess fluid from the body,

including CHF, liver cirrhosis, and kidney disease.¹ Furosemide increases renal excretion of water and sodium, thus decreasing the amount of fluid in the vascular system.¹

Side Effects. Diuretics have a number of side effects, with the most serious being fluid depletion and electrolyte imbalance. A decrease in blood volume may cause a reflex increase in cardiac output and peripheral vascular resistance which may produce excessive demands on the heart.¹ The increased cardiac workload is especially serious in patients with heart failure. Diuretics also produce sodium and potassium depletion. Electrolyte imbalance can produce serious metabolic and cardiac problems which could be life-threatening in some individuals.¹ Other possible side effects include gastrointestinal disturbances, weakness, fatigue, orthostatic hypotension, altered mood, and confusion.¹

Metformin Hydrochloride (Glucophage)

Clinical Use. Metformin hydrochloride is an oral biguanide agent used in the treatment of Type 2 diabetes.¹ Metformin inhibits glucose production and increases the sensitivity of peripheral tissues to insulin.¹

Side Effects. Metformin can cause a very rare, but potentially fatal, side effect known as lactic acidosis which is a buildup of lactic acid in the blood.¹ The risk is highest in individuals with CHF, poor liver or kidney function, multiple medical problems, or those taking multiple medications.² Symptoms of lactic acidosis include dizziness, extreme weakness, fatigue, light-headedness, low body temperature, rapid breathing, dyspnea, sleepiness, slow or irregular heartbeat, unusual stomach discomfort, or unusual muscle pain.²

CLINICAL IMPLICATIONS

The physical therapist needs to consider that the medications involved in the treatment of COPD, CHF, and diabetes can have both positive and negative effects on the patient's response

to physical therapy interventions. If the patient's medications are able to control the symptoms that limit his activity tolerance, he will likely have an improved ability to exercise.³ Because inhaled ipratropium inhibits bronchoconstriction and mucus production, the patient will have increased tolerance for exercise.⁴ Exercise tolerance can also be expected to improve with digoxin since the heart is able to pump blood more efficiently both at rest and during exercise.⁴

Many of the side effects of the patient's medications can also have an affect on physical therapy. Furosemide can cause orthostatic hypotension; therefore, the physical therapist should be cautious to avoid activities or exercises that require any sudden changes in position. The physical therapist should be aware of the signs of digoxin toxicity and lactic acidosis so that the physician can be notified and the drugs can be discontinued before the adverse effects become life-threatening. Glucophage does not usually cause hypoglycemia, however the risk increases if the patient misses a meal, uses alcohol, or engages in strenuous physical activity. Therefore the physical therapist should be on the lookout for any signs of hypoglycemia (confusion, fatigue, sweating, nausea) during and after exercise.¹ The therapist also needs to be aware of any signs that may indicate worsening of CHF, including weight gain of 2 or more pounds within a 2-day period, increased heart rate, and worsening dyspnea and fatigue.⁴ If any of these symptoms occur, the patient should be sent immediately to his physician for evaluation.

The therapist should monitor the patient's blood pressure, heart rate, and rating of perceived exertion (Borg rating) at the beginning of each treatment session and at periodic intervals during the therapy sessions to monitor for (1) hypotensive episodes, (2) signs of digoxin toxicity (bradycardia or sustained tachycardia), (3) signs of lactic acidosis (bradycardia or dyspnea), and (4) signs of worsening CHF (increased heart rate, worsening dyspnea). These measurements can also be used to monitor the patient's response to each intervention in order to determine the appropriateness of each intervention and when the patient is ready to progress. For instance, the Borg rating of perceived exertion can be used to monitor the patient's level of dyspnea which is one of the most common complaints for patients with CHF.⁵ When the patient is able to perform an activity that

previously produced moderate dyspnea (3/10 Borg rating) with mild or no dyspnea ($\leq 2/10$ Borg rating), then the activity can be progressed.⁶

Patients with lung disease are often limited in exercise by their respiratory rates. The use of supplemental oxygen can improve the patient's breathing pattern which may allow the patient to tolerate activities of daily living and exercise to a greater extent.⁷ The patient should also be instructed in the use of pursed-lip breathing during exercise. Pursed-lip breathing during exercise has been shown to be an effective way to decrease dyspnea which may also improve the patient's tolerance to activities of daily living and exercise.^{8,9}

The therapist also needs to take into consideration that removal of an entire lobe of the lung (lobectomy) causes a 10 to 20 percent permanent loss of lung function.³ However, the overall loss of lung function may be felt less by the patient if the lobe that was removed was not functioning fully before removal.

Education should be a major component of this patient's plan of care. The patient should be educated on the early signs of digoxin toxicity, lactic acidosis, hypoglycemia, and worsening CHF. The patient should be reminded to avoid skipping a meal before their physical therapy sessions or before exercising to help avoid a hypoglycemic event. Dehydration increases the likelihood of developing lactic acidosis so the patient should be reminded to notify his physician if he experiences significant fluid depletion from vomiting, diarrhea, fever, or some other condition. To minimize irritation of the mouth and throat, the patient should be educated to rinse with water after using the inhaled medications. Rinsing the mouth will also decrease the possibility of ingesting the drug which will assist in decreasing systemic side effects. The physical therapist should also reinforce the importance of diet, exercise, compliance with pharmacologic management, and routine follow-up with his physician to manage his diseases.

CONCLUSION

The mobility required to participate in activities of daily living is often times restricted in patients with CHF and COPD, thus making even a simple walk to the mailbox difficult.⁵ Research has shown, however, that patients with CHF and COPD can benefit from structured exercise programs which can lead to im-

proved functional status.^{10, 11} The effects of cardiopulmonary medications should improve a patient's ability to participate in all aspects of their rehabilitation program. However these medications also have side effects that can negatively affect a patient's response to activity. Physical therapists can not only implement an appropriate exercise program but they can also educate their patients on the importance of proper diet, weight loss, and other lifestyle modifications that may help them obtain the best results and possibly even decrease their reliance on medications.³

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CANCER: THE PERSONAL EXPERIENCE

Helen Cornely, PT, EdD

Cancer—it is a dreaded diagnosis despite all the recent improvements in treatment and cure. This year, about 565,650 Americans are expected to die of cancer, more than 1,500 people a day. Cancer is the second most common cause of death in the US, exceeded only by heart disease. In the US, cancer accounts for 1 of every 4 deaths (Cancer Figures and Facts 2008. Available at: <http://www.cancer.org/downloads/STT/2008CAFFfinalsecured.pdf>. Accessed April 10, 2008).

No one ever thinks cancer will happen to them or to their family. Unfortunately, this is not true. Three out of every four American families will have at least one family member diagnosed with cancer. There are more than 10 million people in the US today who are cancer survivors (Life After Cancer Treatment, National Cancer Institute. Available at: <http://www.cancer.gov/cancertopics/life-after-treatment/all>. Accessed April 9, 2008).

As a physical therapist and professor, I have treated and I have taught students how to treat individuals with cancer diagnosis. I had all the evidence based practice information on how to best intervene for my patients with cancer. I had all the right words to say. I had coached many students in empathetic responses in working with individuals undergoing the travails of cancer management with chemotherapy, radiation, surgery, and then dealing with the sequelae and rehabilitation following. I had everything, (at least I thought I did) but the personal experience.

I am writing this series of articles to share with other therapists my journey as a physical therapist professor who finds herself a caretaker of a person with cancer. It is not about references and resources. It is about reflection on how physical therapy can impact patients with cancer. The first article focuses on diagnosis, the second treatment intervention, and the third rehabilitation and life after cancer. In this journey I

reexamined my focus as a health professional and gained new perspectives on the health care system. This journey into the forays of cancer is life altering for all involved. As I became immersed in the health care system from the receiving not giving end, I relearned what qualities are essential in caring for our health. It is this reawakening and perspective I want to share with my fellow therapists. Perhaps many of you have gone through this journey and my words will be affirmation of what you went through. Or perhaps my words will bring new insight into how we approach each individual as they prepare for or have gone through the fight of their lives, the fight to beat cancer. I will share with you my lessons learned.

THE DIAGNOSIS

The journey began when my husband was referred to a Head, Neck, and Throat (HNT) oncology surgeon. He had been to his primary physician who had prescribed antibiotics to decrease the swollen lymph nodes on the left side of his neck and his persistent throat clearing habit. But after 2 weeks and no change, he was referred to a HNT specialist. This physician listened and palpated and examined, and while finding nothing conclusive about the swollen lymph nodes and throat clearing, he wanted to be sure there was no other problem. I often think many physicians would have stopped here, but for the fact that my husband is an attorney. So we found ourselves in Sylvester Comprehensive Cancer Center speaking to the HNT oncology surgeon. Obviously, we did not belong here. Cancer was not an option. A needle biopsy was performed on the lymph nodes although the surgeon assured us there really was nothing to worry about. And indeed the biopsy came back benign and any worries were gone. However, to be certain, an endoscopy was ordered. Two weeks later, once again at Sylvester, my husband was prepped for surgery

ready to have a minimal neck dissection of the enlarged nodes. But, the surgery was not performed. In the operating room, the cancer behind the left tonsil was discovered.

Now we did belong in Sylvester Comprehensive Cancer Center. The journey moves forward. My husband could not even say the word cancer. It was as if the word was a curse. He did not want anyone to know. His perception of cancer was one of death, fear, and weakness. He would be different. He would get through this with no one even noticing. He was in denial, a common coping strategy. He had time, but no focus on what to do to get himself prepared for what was coming--cancer treatment. I really did not know how to help either. We just walked around each other, contemplating what the next steps would hold in store.

LESSON LEARNED

It is at this moment that we as physical therapists are missing a golden opportunity. It is after diagnosis and before treatment that physical therapy should intervene. Now is the time to baseline the individual's current physical function. If done now, post treatment you have a definitive goal to try and reach. You also have time to build muscle strength, endurance, to perform stretching, and to teach relaxation and stress relief BEFORE it is needed. You have time to refer to dietetics for proper nutrition counseling. With intervention precancer treatment, we could make the later interventions easier and give us baseline objective measures to produce outcomes for reimbursement or disability insurances.

It is also important to realize that physical activity helps the psychological impact of a cancer diagnosis. There is much literature written on the positive benefits of exercise on alleviating the symptomology of depression. We are aware most patients with cancer experience some level of depression. Why not

start on prescribing regular exercise as frequently as antidepressant medication?

If we would prescribe exercise pre-cancer treatment, we also empower the individual early on. In the later stages of cancer treatment, so much is lost. The individual feels out of control of the most basic of life skills. Again, we need to front load the physical therapy intervention.

Needless to say, none of the above occurred with my husband's medical care. And worse I, as a physical therapist professional, was not clearly seeing the impact I could have had early on in the process. It really does not matter what type of cancer or what treatment, physi-

cal therapy can offer hope, empowerment, and improved physical function.

So the journey continues with 4 months of chemotherapy and radiation. We truly had no idea the extent of where our journey would lead us. But I will save that for next installment of the series: the intervention.



Dr. Helen Cornely is Associate Dean in the College of Nursing and Health Sciences at Florida International University (FIU), Miami, FL. Prior to her promotion to Associate Dean she was Chair of the Department of Physical Therapy and held the rank of Associate Professor. Dr. Cornely received

a BS in Physical Therapy from the University of Pennsylvania, a Master's degree in psychology from Nova University, where the focus of her studies was Gerontology and her Doctoral Degree in Adult Education with a Specialty in Gerontology from FIU. She worked as a physical therapist in home health care for over 18 years in Dade and Broward Counties. She has presented her research on fall prevention and health and wellness for the older adult both nationally and internationally.

Annual Fundraiser for APTA's Minority Scholarship Fund

The 16th Annual Fundraiser for APTA's Minority Scholarship Fund Celebration of Diversity is scheduled for Saturday, October 4, 2008 at the Heard Museum of Native Cultures and Art in Phoenix, AZ. The fundraiser is being co-hosted by the Academic Administrators and Clinical Education Special Interest Groups of the Section for Education. Single ticket prices for the dinner/dance are \$100. Contributions of any amount are welcome. You can also participate by donating items for the Silent Auction. Ad space in the souvenir book may be purchased at \$500 for a full page, \$250 for a ½ page, and \$100 for a business card. For further information, please contact APTA's Department of Minority/International Affairs at 800/999-2782 ext 8554.

APTA Foundation

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2007/2008 MATCHING CAMPAIGN

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Geriatric Fund 

More information about the Geriatric Endowment Fund: www.apta.org/foundation

CONGRATULATIONS GERIATRIC CLINICAL SPECIALISTS

The Section on Geriatrics and the Geriatric Specialty Council members would like to congratulate our newly certified geriatric specialists. This is quite an accomplishment which required hard work and dedication to geriatric practice. It is an honor to have so many highly qualified individuals become certified specialists in geriatrics!

Debra Aaron, PT, DPT, GCS

Dr Aaron earned a doctoral degree in physical therapy from Boston University in 2006.

Morton Aime, PT, GCS, OCS

Mr Aime graduated from Louisiana State University Health Sciences Center - New Orleans with a bachelor's degree in physical therapy in 1995.

Babatunde Akomolafe, PT, DPT, GCS

Dr Akomolafe graduated from the University of Lagos, Nigeria in 1991 with a bachelor's degree in physical therapy. He graduated from AT Still University of Health Sciences in 2006 with a doctoral degree in physical therapy.

Marlon Alaan, PT, GCS

Mr Alaan earned a bachelor's degree in physical therapy in 1992 from the University of the Philippines Manila.

Theresa Alt, PT, MPT, GCS

Ms Alt earned a master's degree in physical therapy in 1999 from the University of Iowa.

Dipika Amin, PT, GCS

Ms Amin graduated with a bachelor's degree in physical therapy from the University of Illinois at Chicago in 2000.

Natalia Ashley, PT, DPT, GCS

Dr Ashley earned a doctoral degree in physical therapy in 2006 from Loma Linda University.

John Banogon, PT, DPT, GCS

Dr Banogon earned a doctoral degree in physical therapy in 2006 from Simmons College.

Stephanie Beaman, PT, GCS

Ms Beaman was awarded a master's degree in physical therapy in 1999 from the University of Delaware.

Jaime Bellace, PT, MPT, GCS

Ms Bellace graduated in 2000 from MCP Hahnemann University of the Health Sciences with a master's degree in physical therapy.

Wendy Bradfield-Scheck, PT, GCS

Ms Bradfield-Scheck is a 1982 graduate of Pacific University Oregon with a bachelor's degree in physical therapy.

Bruce Bradley, PT, DSc, GCS

Dr Bradley earned a doctoral degree in physical therapy from Loma Linda University in 2006.

Connie Brignole-Sawicki, PT, GCS

Ms Brignole-Sawicki earned a postbaccalaureate certificate in physical therapy from Hunter College in 1978.

Steven Brodnicki, PT, GCS

Mr Brodnicki graduated from Grand Valley State University with a master's degree in physical therapy in 2001.

Patrick Brody, PT, GCS

Mr Brody was awarded a master's degree in physical therapy in 1995 from Old Dominion University.

Lisa Butler, PT, DPT, GCS

Dr Butler in 2003 earned a doctoral degree from Creighton University in physical therapy.

Stephen Cannon, PT, DPT, GCS

Dr Cannon graduated from the University of Massachusetts Lowell in 1984 with a bachelor's degree in physical therapy. He earned a doctoral degree in physical therapy in 2005 from the same institution.

Gino Chincarini, PT, MBA, GCS

Mr Chincarini graduated in 1994 from US Army-Baylor University with a certificate in physical therapy. He was awarded a master's degree in business administration from the University of Texas Health Science Center at San Antonio in 1982.

Keonhwa Choi, PT, GCS

Ms Choi graduated with a bachelor's degree in physical therapy in 1988 from the College of Health Science, Yonsei University.

Chen-Hsiu Chou, PT, GCS

Ms Chou was awarded a master's degree in physical therapy in 2000 from the University of Maryland - Baltimore.

Iris Cledera-Bona, PT, GCS

Ms Cledera-Bona graduated with a bachelor's degree in physical therapy in 1987 from the University of Santo Tomas.

Amber Daman, PT, GCS

Ms Daman was awarded a master's degree in physical therapy in 2002 from Central Michigan University.

Karen Drake, PT, GCS

Ms Drake was awarded a master's degree in physical therapy in 1994 from Boston University.

Lane Duger, PT, GCS

Mr Duger graduated in 1995 from SUNY Buffalo with a bachelor's degree in physical therapy.

Julie Echipare, PT, GCS

Ms Echipare graduated with a bachelor's degree in physical therapy in 1999 from Fatima Medical Science Foundation.

Anna Evans, PT, GCS

Ms Evans graduated with a bachelor's degree in physical therapy from the University of Santo Torras in 1988.

Michael Feldt, PT, GCS

Mr Feldt graduated from the University of Missouri in 1993 with a bachelor's degree in physical therapy.

Michael Ferdun, PT, GCS

Mr Ferdun was awarded a master's degree in physical therapy in 1992 from Columbia University.

Susan Griffin, PT, MS, GCS

Ms Griffin graduated with a bachelor's degree in physical therapy from the University of Wisconsin - Madison in 1984. She was awarded a master's degree in human kinetics in 1995 from the University of Wisconsin - Milwaukee.

Julie Hartmann, PT, GCS

Ms Hartmann graduated with a bachelor's degree in physical therapy from Marquette University in 1985. She was awarded a master's degree in health education in 1994 from Penn State University.

Kelly Hawthorne, PT, DPT, GCS

Dr Hawthorne earned a master's degree from Saint Louis University in 1999. In 2004, she earned a doctor of physical therapy from the same institution.

Sarah Hichborn, PT, GCS

Ms Hichborn was awarded a master's degree in physical therapy from Des Moines University - Osteopathic Medical Center in 1993.

Lori Holz, PT, DPT, GCS

Dr Holz was awarded a master's degree in physical therapy in 2001 from the University of Nebraska Medical Center. She earned a doctoral degree in physical therapy in 2005.

Carrie Jensen, PT, MPT, GCS

Ms Jensen was awarded a master's degree in physical therapy in 2004 from Mayo School of Health Related Sciences.

Lori Kessenich, PT, GCS

Ms Kessenich graduated with a bachelor's degree in physical therapy in 1977 from the University of Wisconsin-Madison.

Nina Kim, PT, GCS

Ms Kim graduated with a bachelor's degree in physical therapy in 1984 from the University of Michigan - Flint.

Maya Kirpalani, PT, DPT, GCS

Dr Kirpalani graduated in 2000 from California State University, Fresno with a master's degree in physical therapy. She earned a doctoral degree in physical therapy in 2003 from Rocky Mountain University of Health Professionals.

Grace Knott, PT, GCS

Ms Knott graduated with a bachelor's degree in physical therapy from Kansas University in 1978.

Megan Ledyard, PT, GCS

Ms Ledyard graduated from Regis University with a master's degree in physical therapy in 2000.

Joseph Libera, PT, DPT, MPH, GCS

Dr Libera graduated from SUNY-Upstate Medical University in 1979 with a bachelor's degree in physical therapy. He was awarded in 2004 with a master's degree in health policy and administration from UNC-Chapel Hill. He subsequently earned a doctoral degree in physical therapy.

Karlene Madill, PT, GCS

Ms Madill graduated from the College of St Scholastica in 1998 with a master's degree in physical therapy.

William Mashtalier, PT, GCS

Mr Mashtalier was awarded a master's degree in physical therapy from Loma Linda University in 1997.

James Milani, PT, MPT, GCS

Mr Milani graduated in 2001 with a master's degree in physical therapy from the University of Pittsburgh.

Amy Miller, PT, MPT, GCS

Ms Miller graduated in 1999 with a master's degree in physical therapy from Northwestern University.

Bridgette Miller, PT, MSPT, GCS

Ms Miller was awarded a master's degree in physical therapy from the University of Kentucky in 1997.

Cherri Miller, PT, GCS

Ms Miller graduated with a bachelor's degree in physical therapy in 1984 from the University of Puget Sound.

Marilyn Moffat, PT, DPT, GCS

Dr Moffat graduated from Boston University with a master's degree in physical therapy in 1990. She earned a doctoral degree in physical therapy from Simmons College in 2004.

Jason Musni, PT, DPT, GCS

Dr Musni earned a bachelor's degree in 1995 from Angeles University, Phillipines. In 2006, he was awarded a doctor of physical therapy from Creighton University.

Jennifer Neveu, PT, GCS

Ms Neveu earned a master's degree in physical therapy in 1999 from Northeastern University. In 2004, she was awarded a doctor of physical therapy from MGH-Institute of Health Professions.

Jacqueline Osborne, PT, DPT, GCS

Dr Osborne earned a doctoral degree in physical therapy from Arcadia University in 2003.

Robin Pawelec, PT, GCS

Ms Pawelec was awarded a certificate in physical therapy in 1987 from Cleveland State University.

Manuel Plata, PT, GCS

Mr Plata graduated from De'La Salle University in 1997 with a bachelors degree in physical therapy.

John Rabbia, PT, DPT, GCS

Dr Rabbia graduated in 2003 from Ithaca College with a master's degree in physical therapy and earned a doctoral degree in physical therapy from Temple University in 2005.

Theresa Ruby, PT, PhD, GCS

Dr Ruby was awarded a master's degree in physical therapy from SUNY-Downstate Medical Center in 1971. She earned a doctoral degree in mental health counseling from Cambridge College in 2003.

Mark Schafer, PT, GCS

Mr Schafer graduated with a bachelor's degree in physical therapy from the University of Montana in 1992.

Sarah Shearer-Smith, PT, DPT, GCS

Dr Shearer-Smith was awarded a master's degree in physical therapy from Loma Linda University in 2006. She earned a doctoral degree in physical therapy from the same institution in 2006.

Ronald Simmons, PT, MPT, GCS

Mr Simmons was awarded a master's degree in physical therapy from the University of Utah in 1998.

Emily Smith, PT, GCS

Ms Smith graduated from Northeastern University with a bachelor's degree in physical therapy in 1988.

Karen Smith, PT, GCS

Ms Smith graduated from Oakland University in 2002 with a master's degree in physical therapy.

Nileshkumar Soni, PT, DPT, GCS

Dr Soni was awarded a master's degree in physical therapy in 1993 from the University of Bombay India. He was awarded a doctor of physical therapy from New York University in 2005.

Tawana Spann, PT, MS, GCS

Ms Spann graduated with a master's degree in physical therapy from Saint Louis University in 1996.

Yvonne Steffens, PT, GCS

Ms Steffens graduated in 1994 from Emilio Aguinaldo College with a bachelor's degree in physical therapy.

Melanie Sutton, PT, DPT, MHS, GCS

Dr Sutton graduated with a bachelor's degree in physical therapy from the University of Tennessee Chattanooga in 1994. Massachusetts General Hospital - Institute of Health awarded her a doctorate in physical therapy in 2005.

Mary Thane, PT, GCS

Ms Thane is a 1989 graduate of the University of Montana with a bachelor's degree in physical therapy.

Gregory Thompson, PT, MSPT, GCS

Mr Thompson was awarded a master's degree in physical therapy in 2000 from Boston University.

Tara Thompson, PT, MSPT, GSC

Ms Thompson was awarded a master's degree in physical therapy in 2000 from Boston University.

Kimberly Umstead, PT, GCS

Ms Umstead graduated in 1998 with a bachelor's degree in physical therapy from the University of North Florida.

Patrick Van Beveren, PT, DPT, OCS, GCS

Dr Van Beveren graduated in 1972 from Ithaca College with a bachelor's degree in physical therapy. Rocky Mountain College of Health Professions awarded him a doctoral degree in physical therapy in 2004.

Kasthuri Veeraraghavan, PT, GCS

Ms Veeraraghavan graduated with a bachelor's degree in physical therapy in 1990 from the College of Physiotherapy.

Sangita Verma, PT, DPT, GCS

Dr Verma is a 2006 graduate of the University of Medicine & Dentistry of NJ with a doctoral degree in physical therapy.

Ronald West, PT, DPT, GCS

Dr West earned a doctoral degree in physical therapy from A.T. Still University of Health Sciences in 2004. He had graduated from the University of Miami with a master's degree in physical therapy.

Wesley Williams, PT, GCS

Mr Williams is a 1993 graduate of the University of Tennessee with a bachelor's degree in physical therapy.

Mark Willingham, PT, GCS

Mr Willingham graduated with a bachelor's degree in physical therapy from the University of New Mexico in 2000.

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Age does not diminish

THE EXTREME DISAPPOINTMENT OF HAVING

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