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All other correspondence is via e-mail. Nominate yourself or a peer.
Contact GeriNotes Editor, Carol Schunk, PT, PsyD
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CORRECTION

Author Kathy Brewer’s complete credentials were omitted in the July issue of GeriNotes. It should have read Kathy Brewer, PT, GCS, MEd. We apologize for this oversight.
By now you’ve probably heard about APTA’s initiative to “brand” the physical therapist. Perhaps you attended APTA’s official roll out of the brand at the Combined Sections Meeting in Las Vegas, or read about it on APTA’s Moving Forward blog. Because of the far-reaching implications of this initiative, I want to provide all Section members with some background information and offer suggestions for getting us on the brandwagon in a manner that benefits our profession and the clients/patients we serve.

In 2007, APTA hired the national public relations firm of CRT/tanaka to draft guidelines for a brand campaign aimed at better and more accurately defining physical therapists to various audiences. CRT/tanaka commissioned a telephone survey of 400 scientifically-selected heads of household nationwide. This survey showed that:

- Nearly 90% of respondents had a positive impression of PTs.
- 80% were likely to consider using a physical therapist (PT) in the future.
- 68% of respondents who hadn’t used physical therapy in the past were likely to consider using it in the future.
- 84% of physical therapy users would refer a friend or family member to their PT.
- 88% of physical therapy users said their care was very or somewhat beneficial.

It was also determined that respondents primarily thought of PTs in terms of rehabilitation. Thus, a primary aim of the branding campaign was focused on expanding the public’s perception of physical therapy from predominantly “rehabilitation” to “motion.” No matter which specialty or setting a PT practices in—geriatrics, acute care, women’s health, wellness, private practice, or hospital, etc.—motion is necessary for life. Appropriately, Move Forward, followed by the descriptor Physical Therapy Brings Motion to Life, has been chosen to help describe what physical therapy and physical therapists are all about. Respondents also noted that they’d be more likely to see a PT if physical therapy would improve/restore their mobility, provide a cost effective alternative to surgery, and help them avoid the side effects of prescription medication. With that in mind, the core message of the campaign was developed: Physical therapists can help your mobility and quality of life without surgery or prescription medication.

The campaign also focuses on “brand personality”—that is, how PTs are seen in the eyes of consumers. Two particular personalities have been identified and merged—providing a unique professional personality for PTs. The first personality, The Sage, helps people act smarter, feel more confident, is known as a coach/teacher, delivers knowledge, offers independence, focuses on understanding, and is an expert/advisor. The second personality, The Hero, helps people perform at their upper limits, is known as a rescuer/warrior, delivers courage, offers mastery, focuses on proving, and is a motivator. The physical therapist as a Sage Hero merges the independence gained from a teacher/coach with the strength and mastery offered by the hero, and lifts up the role of the physical therapist in the eyes of consumers.

Also based on the research, requirements to “living the brand” were identified. The APTA chose 3 to concentrate on at this time:

1. Flawless and thorough documentation.
2. Introductions with full name and title. (“Hello, I’m Jim Smith, doctor of physical therapy” or “Hello, I’m Emily Jones, physical therapist assistant.”)
3. Maintaining a professional personal appearance. (Appropriate professional attire for physical therapists. Professional work casual outfit for physical therapist assistants. Name tag with name, professional designations, and title.)

Educational and other resources for APTA members can be found at the BrandBeat link on the APTA web site (www.apta.org/brandbeat). This information includes more detailed information about the brand, brand tools (e.g., “Marketing to Health Care Professionals Tool Kit”), news about the brand (posted monthly since February), a link to the “Move Forward PT” video on YouTube, and a by state listing of Brand Champions (PTs who are advocates for our brand). These Champions are acting as local resources for other PTs and PTAs who want to become more actively involved and they will also be directly spreading the word among APTA members; later this year, they will take the message on the road to referral sources.

You are strongly encouraged to visit this web site and familiarize yourself with this information.

A key element of the branding initiative was the development of a related consumer Web site, www.moveforwardpt.com. Topics on this site include: Why a Physical Therapist?, Find a physical therapist, Improving mobility and motion (with links to the topics of: Live with diabetes, Recover from stroke, Improve balance and prevent falls, Reduce the risk of injury), How to avoid surgery, Eliminating pain without medication, and a range of Consumer tips (e.g., PT and low back pain, Stroke prevention and rehabilitation, Treating neck pain, Prevent in-flight cramping and blood clots). It will be important to make sure that you are enrolled in the “find a physical therapist” feature of the Web site; APTA does not automatically list you. Additionally, in order for consumers, clients, and patients to be aware of this wonderful resource information, all of us will need to more regularly include www.moveforwardpt.com on patient education materials, as part of public relations/news releases, and in any articles that we write.
EDITOR’S MESSAGE: OPTIMAL AGING

Carol Schunk, PT, PsyD

Optimal health is the focus of the Section on Geriatrics mission statement and vision. It is probably a phrase we all use but difficult to define or to give the specifics. For those who have been therapists for many years, we experienced a clinical paradigm shift from illness to wellness. This reorientation is captured in the phrase of optimal health and allows us as geriatric therapists to expand our scope of practice in a very positive way that is of great benefit to our clients. It makes our practice with older adults so much more multidimensional, we are not just involved with the rehabilitation of the disease process but in returning them to an optimal healthy life. Many, many years ago when I started to practice, goals were general using phrases like “highest functional level.” While this was totally not measurable, if you consider the broad concept, it was oriented toward what we call today “optimal health.” Today goals, I mean outcomes, must be objective, functional, and measurable—a dramatic and positive improvement. But the best part of our progressive profession is the realization that we play a role in the patient’s/client’s achievement of “optimal health.”

To expand on this topic and related issues, we feature in the September GeriNotes a Round Table discussion. I asked Section leaders, primarily the members of the Board of Directors, to answer 7 questions that deal with optimal health, how it is implemented in the clinical and educational setting, and the role of the Section. The questions are listed below. Before reading the views of the Section leaders, I invite all the readers to mentally think of how you would answer the questions. Think about it, jot down a few ideas. These questions could even provide the foundation for an interesting discussion at a department in-service. All Section members should and probably do have an opinion as optimal aging is integral in our practice. What do you think????

1. What are the key components/definition of optimal aging?
2. What is the SOG doing to advocate for optimal aging?
3. For those of you in clinical practice, describe an innovative program you are involved with that promotes optimal aging?
4. For those of you in education, describe an innovative educational activity that promotes the students knowledge of optimal aging?
5. What can SOG members do in their community to promote wellness and prevention among the older adults?
6. What can the SOG do to promote optimal aging for our patients/clients among APTA members who are in other Sections?
7. How will the concept of optimal aging change in the next 10 years? With your thoughts in mind, take the time to read the input from those who are the leaders of the Section in the article Optimal Health: a Round Table Discussion on page 5.

Along a similar topic, this issue also contains the Candidate Statements for those who are running for Section offices. This year is a first in that you will be able to vote electronically. The Section is very interested in increasing participation of the members and so budgeted to make the transition to electronic voting (paper is still an option). I have the privilege of serving on the Section Nominating Committee with Chair, Lucy Jones and Rita Wong. I have been on many nominating committees and it is always a treat when there is an active membership that produces many individuals who are interested in running. I think this is a very positive sign of a healthy dynamic organization when people want to serve. Our thanks to those who consented to run and to those who were selected to be candidates. The future looks good for Section Leadership!

WANTED ARTICLES FOR GERINOTES

Topics:
anything related to older adults
Clinicians:
send me an article or an idea
Students at any level:
send me papers you wrote for class
Educators:
send me student papers
Everyone
loves to publish and it is easy
Contact Carol Schunk,
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OPTIMAL AGING
WHAT IS IT? WHERE IS THE SECTION GOING?

The Mission and the Vision of the Section on Geriatrics remind us of the importance of optimal aging. To provide further insight on this topic the SOG Board of Directors and other leaders were invited to respond to questions on optimal aging and the role of the Section on Geriatrics. The discussion below is interesting and shows the progressive nature of our Section leaders.

Carol Schunk, Editor

MISSION
To further our members’ ability to advocate and provide best practice physical therapy for optimal aging.

VISION
The physical therapist will be the practitioner of choice for achieving optimal health, wellness, fitness, and physical function for the aging adult.

PANEL MEMBERS
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Ruby Kendrick, PT, MS, GCS
Secretary
William Bill Staples, PT, DPT, GCS
Treasurer
Ellen Strunk, PT, GCS
Director

I. WHAT DO YOU THINK ARE THE KEY COMPONENTS/DEFINITION OF OPTIMAL AGING?
Ciolek--Optimal aging involves staying healthy, functional, and having the best quality of life for as long as possible and compressing disease or loss of function for as short a period as possible. After that, it is really unique to each individual what pieces are most important to their quality of life.

Kendrick-Optimal aging can be defined as the capacity to function in the following domains: physical, functional, cognitive, emotional, social, and spiritual--to one’s satisfaction. Maintaining health, preventing disease/injury/disability; maximizing independence and maintaining active participation with the community are key components in achieving optimal aging.

Bell--Optimal aging is aging in a way that maximizes one’s potential to realize all that is possible physically, psychosocially, mentally, and spiritually. Optimal aging is about achieving the best possible outcome based on leveraging all of the resources available to an individual.

Parker--Dr. Robert S. Tan of the University of Texas-Houston defines optimal aging as “a concept that deems that we can maintain our youth through knowledge and active participation in our own health by prevention.” I strongly believe that with proper nutrition, good physical activity, and positive outlook one can achieve optimal aging.

II. WHAT IS THE SOG DOING TO ADVOCATE FOR OPTIMAL AGING?
Barr--We are vigilant in reminding the APTA (eg, key departments, Board, House, & other components) about the importance of aging related to practice, research, education, reimbursement, legislation, etc. We encourage and provide resources for our members to advocate directly with legislators and health policy makers.

Staples--The importance of exercise and activity levels is an integral part of optimal aging. The Section is the best resource for information regarding evidence-based benefits of exercise for our clientele. In addition to exercise, as physical therapists we can stress healthy habits including eating well, relaxation, getting health screenings, and reducing risk.

Hartley--Section’s Balance and Falls, Bone Health, and Health Promotion and Wellness SIGs each address optimal aging directly through consumer education projects, member publications and resources, and programming at conferences. The Section as a whole does this as well, on a broader scale. Other committees, like the Advanced Clinical Practice Committee, offer resources to improve and promote advanced patient care, which supports the concept of “improved quality of life through higher quality of care.”

Jones--The SOG is undertaking the Physical Aging Conference in Indianapolis, IN the summer of 2010 to help broaden the practitioner’s view of the older adult and the rehabilitation back to their lives. Also, the Section is now undertaking the Certification of the Exercise Expert for the Aging Adult, a 3-part series of exercise training and education for the older adult.

Strunk--The SOG is actively involved in many areas of advocacy related to increasing access for Medicare & Medicaid beneficiaries to health care benefits that will assist them in their quest for optimal aging. We are working both inside our profession (APTA) and outside (The Elder Workforce Alliance, CMS, and in local communities) to promote the role of physical therapists in helping older adults preparing for and maintaining an active lifestyle.

III. DESCRIBE AN INNOVATIVE CLINICAL PROGRAM YOU ARE INVOLVED WITH THAT PROMOTES OPTIMAL AGING?
Heitzman--A program that we had in my previous employment in Iowa included allowing patients to buy punch cards to continue exercising in our PT clinic after discharge. This enabled the
Aging adult to use equipment they were familiar with after having PT, and to have the therapists around to answer questions as they exercised. The program was then added as a benefit to members of the hospital Prime Time Alive program including a one time, one-on-one session with a therapist.

Ciolek—One thing our clinic has adopted this year was testing each individual who comes to our clinic for height, weight to determine BMI (along with BP/HR/O2 vital stats). We are counseling our clients on ways to increase physical activity (at whatever level possible) and they can re-calculate their BMI later if they are interested in doing so.

Hartley—Optimal aging involves all the body’s various systems. Having an interdisciplinary team evaluate patients with chronic illness or disease allows the patient to get expert advice from a variety of professionals, including PTs, OTs, SLPs, nutritionists, MDs, RNs, and psychologists, to name a few. Having interdisciplinary outpatient clinics which focus on patients with specific needs (eg, Parkinson’s disease, frequent fallers, cardiopulmonary disease, diabetes, osteoporosis) brings the concept of coordinated care, which is often seen in inpatient environments, to the outpatient environment. The whole idea is to promote optimal aging and high quality of life by looking at all aspects of the individual collectively—at the same time. I believe these types of outpatient services will become more and more popular in coming years.

Jones—Our Pulmonary Rehabilitation provides endurance, strength, and balance rehabilitation that must happen with breathing coordination for the oxygen dependent individuals. They come with various diagnoses for COPD to lung reduction, transplant, to pulmonary fibrosis. We are often their last hope for improved function. We can make a direct impact on the quality of life and mental outlook as they gain confidence in mobility with pacing and energy conservation.

Bell—I would say that all of our programs are targeted at promoting optimal aging. Some examples include sponsoring educational programs for older adults to provide them with information related to exercise and activities that will maximize functional potential as well as information related to chronic disease state management and prevention programs. Our programs embrace the concept that the potential to overcome medical and physical challenges is not decreased simply by chronology. Every individual has the potential to respond positively to a program that seeks to leverage their strengths and work toward those things that are most meaningful on a personal level. Promoting optimal aging from a programming perspective is about respecting the potential that all individuals have to be stronger, better, more successful with the right amount of support and resources.

IV. DESCRIBE AN INNOVATIVE EDUCATIONAL ACTIVITY THAT PROMOTES THE STUDENTS KNOWLEDGE OF OPTIMAL AGING?

Staples—I have a disability day in which students acquire a disability or aging condition during which time they must go through a cafeteria line and eat a meal and then perform a group exercise program. This enables the students to see impairments from a different perspective and how they can relate to an older population that has a disability. It is very eye-opening for the students. We discuss how some of these effects of aging can be counter-acted by a more active life style that should include a regular exercise program. I have the students participate in group exercise programs including yoga, tai chi, and “Dancin’ to the Oldies” so they can see alternatives to the exercise programs they may be involved in.

Barr—Community-dwelling older volunteers at a community center and a monastery with many chronic conditions submit a short list of physical concerns (eg, walking endurance, safe stair walking, fall prevention) they’d like help with; students perform an evaluation, educate in a home program, and provide recommendations over two supervised sessions.

Bell—Although not formally involved in education I do provide full day seminars and shorter lectures to Physical Therapy students. My focus is on insuring that students understand the important role physical therapists play in working with older adults from a preventative as well as a rehabilitative and restorative perspective. I also work to dispel some of the myths young people have about aging and older adults and educate them on the distinctions between the physiological changes associated with “normal” aging and those associated with pathology or disease. Finally, I work to impart the important role we play as advocates for our patient population and what it means to be professionally committed to the community you serve.

Ciolek—One issue I try to teach/explore with my entry level students is to understand the difference between normal aging and pathology. Students often have a vision of all older adults as “sick” or “declining” so we have added sessions with healthy older adults and added information on sports activities for older adults—so they can better understand and appreciate all that this population has to offer.

V. WHAT DO YOU THINK SOG MEMBERS CAN DO IN THEIR COMMUNITY TO PROMOTE WELLNESS AND PREVENTION AMONG THE OLDER ADULTS?

Bell—Educate, educate, educate! Be active advocates and role models. Take every opportunity to influence the content and focus of activities and programs that are being developed to support older adults. Share information whenever possible about the importance of staying active physically and mentally, and that it’s never too late to make meaningful changes and positive choices. Do everything you can to insure older adults have access to the resources and tools they need to optimize their potential.

Barr—Opportunities abound to perform screening and intervention activities (eg, blood pressure, balance/falls, osteoporosis/fracture prevention) at sites frequented by older individuals (eg, houses of worship,
senior/community centers, shopping malls. This should be done with regularity throughout the year, not just for PT Month! It can be as simple as leading an exercise class at your church or local community center, at least where direct access allows. Groups are always looking for speakers for meetings.

Hartley--Many communities are looking for help in this area as the baby boomer generation is nearing it's critical peak in the coming years. Several cities and towns in my area have funding for these types of things as the health/wellness of this generation comes to the attention of a nation. Community programs for fall risk assessment in low income elderly housing (at risk populations), yoga or Tai Chi classes in senior centers or churches/synagogues, health and fitness fairs, starting a walking club, or participating in local support groups are a few examples of quick and easy things PTs and PTAs can do.

Strunk--Get involved in local community groups to teach and volunteer. Promote the role of physical therapy in whatever environment you work in (home health, SNF, hospital, outpatient). Help other health care professionals to understand the expanded role we can play in prevention, rather than just treating post-illness/injury.

Kendrick--We must seize the rein of opportunities to educate the public about the importance of prevention and wellness. These opportunities exist via venues of community health fairs at the malls or at churches; talks at senior retirement communities, assisted living facilities, or civic organizations--just to name a few. People need to know that declines in mobility and physical function lead to activity restriction, dependence, disability, social isolation, and decreased quality of life, thus affecting the realm of optimal aging. They also need to know the importance of knowing about their health risk and the benefits of health screening tests in mapping their path to improved health and wellness. We can encourage participation in these tests.

VI. WHAT CAN THE SOG DO TO PROMOTE OPTIMAL AGING FOR OUR PATIENTS/CLIENTS AMONG APTA MEMBERS WHO ARE IN OTHER SECTIONS?

Heitzman--The SOG is working to get the CEEAA course advertised to other sections and sending the CEU modules from GeriNotes to other Sections' members. As a research article in PT Journal stated a few years ago..."More than 75% of PTs work with an aging adult in their clinic" we need to all challenge the aging adult to return them to their lifestyle.

Staples--One of the signs of a good society is how it treats its elder citizens. We should view aging as a dynamic process, not chained to chronology or deterministic genes. In this section people learn that chronological and biological time are not irrevocably bound together. Expertise in geriatrics, gerontology, and optimal aging can be provided at various levels, not just from a geriatric point of view. Other sections may see younger individuals who may want to be proactive in their own healthy aging, or be educated about the process of aging. They can use the wealth of knowledge the Section provides.

Jones--Promote optimal aging to our colleagues out of SoG: CEEAA and Physi cal Activity Conference expanding the awareness of the older adult. It is critically important to make sure we direct the resources of APTA at large toward initiatives that promote health and wellness along the life continuum and that we advocate for older adults as an organization. We also need to seek opportunities to collaborate with other sections and APTA committees and task forces to mobilize our collective resources in a meaningful way to meet the needs of older adults.

Barr--Continue to cosponsor continuing education programs at CSM and promote more of these at Annual Conference and via home study and distance education. We need to publish more aging-related case studies and research in Physical Therapy and other Sections' journals.

Parker--Other APTA members and sections/chapters look upon our Section on Geriatrics to be the expert and gatekeeper of resources on optimal aging. We may want to consider having a special column that is dedicated to Optimal Aging. We would welcome new members to join our Section. Geriatrics is not confined to the treatment of the elderly in nursing homes. Our Section deals with the treatment and prevention for a multitude of conditions such as those found in acute settings, orthopedics, neurology, and women's health.

VII. HOW WILL THE CONCEPT OF OPTIMAL AGING CHANGE IN THE NEXT 10 YEARS?

Staples--Gaining understanding of aging is one of the most complex issues facing 21st-century science. The question will not be, how can we live longer?, but how can we live better into old age? Giving old age meaning, a purpose for the extra years will be the prime concept to explore. Will people want or be able to routinely work into their 80s? What other options will be available for this growing population? Will the idea of retirement become "old-fashioned?" Those questions will guide the concept into the next decade.

Ciolek--What would be ideal is to have our nation adopt a "prevention" mind set; it would be great if each older adult could have a consultation with PTs who focus on enhancing what they can do already and prevent avoidable consequences of immobility. We could see a revolution in healthy older adults!

Hartley--I believe we will see more focus on the obesity epidemic that plagues our country. Obesity is linked to so many chronic diseases, which, in the next 10 years, will likely increase in prevalence, at least until this problem is under better control. Geriatric PTs have an opportunity (or obligation?) to educate younger groups in the effort to optimize aging. After all, successful aging begins at birth.

Jones--I feel the term "optimal aging" is soon to be outdated. No one wants to optimally age. I think the term needs to profess the older adult to be as self-sufficient as possible within their capabilities, as seen in the Eden project, and an emphasis on SNFs reinventing themselves into "care centers" rather than "hallways," and communities seeing the capability of the older adult, not "how will we take care of them?"

Bell--I hope and believe that we will continue to learn more about positive steps we can take to age well, and tools and resources we can access to assist our patients to achieve their most optimal levels. It is critically important that we use all of our resources, those of our patients, and those...
of the nation in the most responsible way in order to produce the most positive outcomes. I believe we will continue to see older adults staying active and vital well into their 90s and 100s and our profession will be afforded the opportunity to contribute to a more wellness-oriented model of service that will best serve individuals as they age. I truly hope that we will spend as much time assisting people to prevent adverse events as we do treating them after an adverse event occurs. I hope that as a profession we will embrace the concept of optimal aging as a very personal thing and embrace the goals of our patients and support them in their efforts to achieve them regardless of age.

Parker—Baby boomers will demand more products and services that cater to the aging population. I envision wellness and prevention programs to be more prevalent and ‘accepted’ by all insurance companies and most employers. There is a niche market for optimal aging services, that’s for sure.

Heitzman—More and more research is coming out on what can be prevented and changed with aging. What was seen as a “normal part of aging” in the past is no longer considered acceptable. As the population of aging adults increases and are more active, more and more of these adults are going to be searching for the experts to keep them in their home, on the sports field, and in the workplace. Physical therapists need to be in the forefront to lead the way.

**PANEL MEMBERS**

Violet Acuna-Parker, PT, MBA is the Regional Sales Manager for Aegis Therapies in Florida. Violet also serves as a member of the Board of Physical Therapy Practice in Florida.

John O. Barr, PT, PhD is President of the Section on Geriatrics. He is a professor in the Physical Therapy Department at St. Ambrose University, Davenport, Iowa, where he co-teaches course components related to aging and geriatrics.

Alice Bell PT, GCS is employed by Genesis Rehab Services as the Director of Clinical Services for Physical Therapy and the Senior Director of Clinical Operations Technology Integration. Alice is the Representative for the Coalition of Rehab Therapy Organizations, American Physical Therapy Association to JCAHO.

Cathy Ciolek, PT, DPT, GCS is the Director of Clinical Education/Service Learning and MS Clinic Director of Geriatric Physical Therapy Residency and Associate Director of Neurologic and Older Adult Physical Therapy Clinic at the University of Delaware.

Greg Hartley, PT, MSPT, GCS is Director of Rehabilitation and Assistant Hospital Administrator at St. Catherine’s Rehabilitation Hospitals and Villa Maria Nursing Center in Miami, FL. He is also Program Director of the Geriatric Residency located there and is an adjunct professor at the University of Miami.

Jill Heitzman, PT, DPT, GCS, CWS, FACCWS graduated from St. Louis University with her PT degree in 1978 and returned to get her DPT degree at Creighton University as one of the first members of their t-DPT graduation class in 2002. Dr Heitzman serves on the Board of Directors for the Section on Geriatrics and also is program chair for CSM. She is a member of the faculty for the Certified Exercise Expert for the Aging Adult series and teaches for the College of St Scholastica in Duluth, MN. She has written and lectured nationally on various topics related to the aging adult and is self employed providing contract physical therapy services in the Auburn, Alabama area.

Lucy Jones PT, GCS, MHA is a Clinical Coordinator for the three facilities of Advantage Therapy Centers of Cherry Hill, NJ, a certified outpatient rehabilitation facility. The clinics provide services to a broad scope of physical therapy practice including pulmonary rehabilitation, vestibular rehabilitation, cardiopulmonary rehabilitation, orthopedic, neurologic, and pelvic floor physical therapy.

Rubye Kendrick, PT, MS, GCS is a traveler with Protocol Staffing, currently on assignment at a SNF in Henderson, TX. She was previously the Director of Rehab at Hallmark Rehabilitation, a 120 SNF in Tyler, TX. The majority of her clinical practice has been in SNFs and home health.

William “Bill” Staples, PT, DPT, GCS is an assistant professor at the Krannert School of Physical Therapy at the University of Indianapolis. He received his specialist 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.

Ellen Strunk, PT, GCS is Managing Director for Restore Outpatient Services and Restore Staffing Solutions. She works in skilled nursing facilities, home health and assisted living facilities, and outpatient settings.
INTRODUCTION
Aging alters the ability to process information. Decrement in information processing has been noted particularly with motor tasks that are externally paced, rapid, complex, and dependent upon rapid decision-making and multiple responses. The slowing of the cognitive process has been cited as one explanation of age-related differences in the performance of mental and physical tasks. As the aging population continues to increase, the need to understand these processes also increases. Every individual faces the reality of aging. Statistics on the general population demonstrate the aging of our society as a whole. In July 1994, there were 33.2 million elderly aged 65 or older, totaling one-eighth of the total population. Growth rates of the aging groups will be dramatic during the years 2010 to 2030 as the Baby Boomer generation ages into the 65+ group. The US Census Bureau projections state that 1 in 5 Americans will be in this aging group by the year 2030 as compared to 1 in 8 in 1994. The rehabilitation clinician needs to recognize how to enhance learning in the aging adult for successful aging to occur. The purpose of this review is to explore information regarding changes in physical, mental, or perceptual performance with age and to attempt to apply this information to improving the rehabilitation outcome of the aging adult.

INFORMATION PROCESSING AND AGING
The aging process affects the ability to detect visual and auditory cues from the environment. This becomes a challenge for the aging adult to "filter" relevant information from extraneous stimuli. An even greater challenge is to transform incoming information into meaningful messages, and to properly store the information for future retrieval. The stages of information processing as related to motor learning will be discussed as a closed feedback loop, adapted from Schmidt. These 3 stages are as follows:

1. Perception of a stimulus
2. Decision making or response selection
3. Motor response programming

This model begins with the input of information from the environment through one or more of the sensory organs, considers what happens to this signal once inside the system, and then processes the signal in various ways until eventually an output is seen as an observable motor activity. The stages and age-related changes are discussed in the following sections.

PERCEPTION-STAGE ONE
Visual
Visual changes are related to the growth of the lens, yellowing of the lens, and adjustments to the dark and light, and decreased visual field. In regards to the growth of the lens, the lens of the eye continues to grow as one ages. Cells become more closely compacted until there is a loss of elasticity. Far sightedness or presbyopia is a result of these changes. The aging adult has a decreased ability to focus for near vision and this becomes more apparent in performing daily activities. With regards to the yellowing of the lens, the screen of dark green, blue, and violet light rays impacts the ability of aging people to see. Red, yellow, and orange become more vivid for the aging adult. Due to the difficulty in adjusting to light and dark, an aging adult’s eyes are not able to handle the extreme brightness and darkness. Adjustment to the changes in light is not slower than younger people but final accommodation is less complete then at a younger age. The decrease in visual field is a result of changes in circulation and, therefore, the metabolism of the retina are reflected in the reduction in the borders of the lateral sides of the visual fields.

Auditory
Perception of information processing through auditory changes is related to presbycusis, volume, and pitch. Major hearing loss that occurs in later life is called presbycusis. Presbycusis is characterized by progressive bilateral loss of hearing for tones of higher frequency due to the generative physiological changes in the auditory system as a function of aging. With aging, there is also a reduced ability to hear sounds as loudly as before. Speaking more loudly may only be helpful if there is not competing background noises. An aging adult has a decreased ability to filter out background noise. Reduction in the ability to hear high pitched sounds becomes apparent as well in the aging population. Unvoiced consonants such as s, c, t, p, and g are high pitched and are very difficult to hear.

Information Processing
The perception of information process as regards to neurogenic influence includes the sensory and somatosensory changes. Sensory changes include demyelination, decreased nerve conduction velocity, and changes in the receptor function including decreased vibration and perception sense as a result of the decreased number of receptors. Visual information presented during a motor learning experience dominates the learning experience for the aging adult. Misleading visual information was found to be more problematic than absent vision. This may be one of the most critical factors in causing falls in the aging adult due to the inability to select and weigh conflicting visual information with compromised somatosensory input.

Rehabilitation Application
By considering the first stage of information processing when planning an intervention session, the therapist could facilitate a better motor learning experience by: (1) maintaining eye contact with the learner at their level; (2) speaking with adequate amplitude and with a lower pitch of voice; (3) communicating with the learner at a relatively close distance; (4) reducing the interfering noise, that is turn off the TV, radio, etc;
(5) addressing the learner by name to secure their attention before speaking; (6) informing the individual of the importance of performing the motor task and asking for understanding; (7) speaking slowly and use verbal cues in the form of words or short phrases; (8) obtain continuous feedback on whether the learner is understanding what is being said; (9) make sure the environment for the intervention is well lighted and objects are easily defined by shape or color.

RESPONSE SELECTION-STAGE TWO
Memory
Memory is defined as information gained through sensation and perception with covert rehearsal and short-term memory or into permanent storage into long-term memory. Selective attention is used to determine which information to focus upon or enter into short-term memory. Short-term memory is important in learning skills. Selective attention to only relevant information and not being distracted by irrelevant input deteriorates as one ages.10 Age related declines affect short-term memory by impeding the decision making abilities more than the ability to store information.

Reaction Time
Reaction time is the time between presentation of the stimulus and motor response. Reaction time increases with advancing age especially with regards to complex stimuli.3 People move more slowly as they age with results suggesting a preference towards cautious movement slowly as they age with results suggesting a preference towards cautious movement slowly and use verbal cues in the form of words or short phrases; (8) obtain continuous feedback on whether the learner is understanding what is being said; (9) make sure the environment for the intervention is well lighted and objects are easily defined by shape or color.

MOTOR –STAGE THREE
Motor Unit Changes
The motor unit changes are beyond the scope of this paper but include a(n): decreased number of anterior horn cells, decreased nerve conduction velocity because of loss of large diameter fibers, demyelination of large axons, increased connective tissue, decreased axonal transport rate, regressive changes at the neuromuscular junction, and decreased force control because of the greater number of motor units activate at smaller workloads.5 There are also inherent muscle changes that include decreased muscle mass, decreased elasticity of the muscles, increased connective tissue and fat, and increased slow twitch with decreased fast twitch fiber types.12

Rehabilitation Application
The application for this stage of learning response needs to include strategies which consider motor response changes. These could include: (1) asking the person to focus their attention on body movements; (2) asking the person questions about the sensation accompanying the movement; (3) providing verbal feedback about the quality of the bodily movement which should be positively stated, specific, based on behavior, and offered on a consistent basis.

CONCLUSION
While working with the aging adult presents motor learning challenges due to multiple age related changes, the clinician must be aware of the best environment and conditions necessary for learning to take place. The controlled environment of most rehabilitation departments does not simulate the demands encountered by the aging population in the home environment. Challenging the aging adult in a variety of contexts to increase the likelihood of skill learning and retention becomes important. Having variables within a facility to simulate the multitude of sensory changes in the home will enable a greater carryover once the patient is discharged. Variables within the home will simulate challenges that will be encountered once they are no longer home bound. Speed variables should be incorporated into the program to improve motivation and to draw upon previous knowledge. Ultimately, the degree of challenge in the rehabilitation world must prepare the aging adult to function in his or her own “real world.” This type of motor performance will not be defined by what we can teach the client to do but instead by what the client learns he can achieve.

REFERENCES
Pam Dehne practices in Home Health at Mary Greeley Medical Center in Ames, IA. She is pursuing her Masters Degree in Gerontontology at Iowa State University. She has presented many topics on home health issues and physical therapy including balance and fall prevention, decision making on when to move out of the primary residence, and developing community screening programs. She has worked with builders on developing safety within the home.

Jill Heitzman graduated from St. Louis University with her PT degree in 1978 and returned to get her DPT degree at Creighton University as one of the first members of their t-DPT graduation class in 2002. Dr Heitzman serves on the Board of Directors for the Section on Geriatrics and also is program chair for CSM. She is a member of the faculty for the Certified Exercise Expert for the Aging Adult series and teaches for the College of St Scholastica in Duluth, MN. She has written and lectured nationally on various topics related to the aging adult and is self employed providing contract physical therapy services in the Auburn, Alabama area.

CALL FOR NOMINATIONS FOR SECTION ON GERIATRIC AWARDS
DEADLINE: NOVEMBER 1

Clinical Educator Award
This award recognizes a physical therapist or physical therapist assistant for outstanding work as a clinical educator in the geriatric health care setting.

Clinical Excellence In Geriatrics Award
This award recognizes a physical therapist for outstanding clinical practice in geriatric health care settings. Any current member of the Section on Geriatrics may nominate a physical therapist who meets the award criteria.

Distinguished Educator Award
The intent of this award is to recognize a Section on Geriatrics member for excellence in teaching.

Joan Mills Award
This award, established in 1980 in honor of the Section on Geriatrics’ first President, Joan M. Mills, is presented to a member who has given outstanding service to the Section.

Lynn Phillipi Advocacy for Older Adults Award
This award recognizes projects or programs in clinical practice, educational, or administrative settings which provide strong models of effective advocacy for older adults by challenging and changing ageism. A member of the Section on Geriatrics must nominate individuals or organizations whose advocacy for older adults meets the intent and criteria of the award.

Outstanding Physical Therapist Assistant Award
This award recognizes a physical therapist assistant who has significantly impacted physical therapy care in geriatric practice settings. To be eligible for this award, the nominee must be an advocate for older adults, a current member of the Section on Geriatrics, have been involved in clinical practice in geriatric settings for a minimum of 5 years, and demonstrate exemplary care and innovative teamwork in meeting the physical therapy needs of older adults.

Volunteers in Action Community Service Award
The intent of this award is to highlight the significant contributions in prevention and/or intervention for elders in typically underserved populations. This may include, but is not limited to work with elders who are homeless, who are homebound, live in very rural areas, live in poverty, or those of ethnic groups facing significant cultural barriers to necessary health care.

RESEARCH AWARDS
Adopt-a-Doc Award
The purpose of the Section on Geriatrics Adopt-a-Doc program is to provide support to doctoral students interested in pursuing faculty positions in physical therapy education.

Excellence in Geriatric Research Award
The individual nominated must be a physical therapist who has been the author (or co-author) of a paper dealing with clinical geriatric physical therapy research. This paper must have been published in a recognized journal (eg, Physical Therapy, Journal of American Geriatric Society, etc.) November 2007/6 and May 2009.

Fellowship for Geriatric Research
This Fellowship is intended to provide partial financial support to physical therapists pursuing research in geriatrics. The research may be conducted as part of either a formal post-entry level academic program or a mentorship with an established investigator. The Fellowship applicant must be a physical therapist who is a current member of the Section on Geriatrics.

Student Research Award
This award is intended to facilitate interest in geriatric research among entry-level physical therapy students. The award recognizes outstanding research-related activity completed by entry-level physical therapy students. A member of the Section on Geriatrics must nominate the entry-level student. The nominator will submit a letter of support which addresses the extent of the student’s involvement in the research process (during a period not to exceed more than 2 years of graduation from an entry-level program).

THE DEADLINE FOR ALL AWARDS NOMINATIONS IS NOVEMBER 1, 2009. We ask that all submissions be received electronically: no paper, please. For additional information on the criteria and selection process for section awards, please visit the Section on Geriatrics website at www.geriatricspt.org or contact the office by email at geriatrics@apta.org or by phone at 800/999-2782 ext 3238.

Consumer Brochure Contest for students
Submissions due November 20, 2009 *students do not have to be APTA members

Student Membership Award
Nominations due January 08, 2010

See www.geriatricspt.org for details.
INTRODUCTION
Therapists working with the geriatric population need to recognize the importance of assessing a client’s “vestibular system” and be encouraged to obtain further training if needed to be proficient and effective in addressing this critical system. The primary objective of this article is to identify a major problem—vestibular hypofunction—and to provide guidelines that can lead to a solution of this problem. The benefit for the client and the measureable improvement of outcomes are well worth the effort of learning and incorporating new skills.

PROBLEM
The rate of incidence of dizziness in the geriatric population is 30% to 61%. Approximately 50% of dizziness is caused by benign paroxysmal positional vertigo (BPPV) by the age of 80, compared to about 20% for all ages considered together. Schubert and Minor identified data that shows for patients over 75 years of age, dizziness is the most common reason they see a physician. Unfortunately, it is estimated that there are many people that do not report their issue to their physician and just accept it as a “normal part of growing old.” However, dizziness is an indicator that signals a potential problem with a person’s vestibular system. Although there are many causes of dizziness, there is often an underlying vestibular hypo-function present.

The prevalence of dizziness is so common researchers are classifying dizziness as a possible geriatric syndrome. This syndrome is directly linked to increased falls and a significant decrease in quality of life. However, this syndrome is not inevitable! The impact of dizziness on a person’s balance is obvious. The risk for fall increases dramatically when a person does not have an accurate sense of their body position in space. A person that has episodes of dizziness has a 12-fold increase risk of falling.

A person who experiences dizziness will limit their activities due to their fear of falling. The best case scenario for the geriatric client is that they change only a few aspects of their life, eg, change their gait pattern, use an assistive device, go out only with assistance, etc. However, as this cycle of limiting activity progresses, social isolation occurs along with a progressive decline in function. A classic sign of this progression is the “nesting” habit. The individual sits in a comfortable chair with everything they need within arms reach. This behavior of inactivity leads to a myriad of problems and exacerbates many co-morbidities.

At the core of dizziness and other balance disorders is the vestibular system. There are numerous vestibular dysfunction disorders that result in a condition referred to as Vestibular Hypofunction. Insults to the vestibular system are many: BPPV, sedentary lifestyle (ie, if you don’t use, it you lose it), injuries, medications, illness, vascular issues, normal aging, etc. Unfortunately as a person ages, dysfunctions of the vestibular system become more apparent especially with the waning of the other systems (eg, musculoskeletal, visual, somatosensory, etc.) that impact balance.

It has been my experience that many therapists look at the issue of balance deficits from a limited perspective. Until this past year, I included myself as being one of these many therapists who performed a battery of balance tests and assessments but not specifically addressing vestibular dysfunction. I thought that designing a specific vestibular rehab program required extensive training and that true vestibular dysfunctions were not that common. Consequently, I fell into the trap of treating the obvious musculoskeletal deficits and addressed balance deficits from more of a substitution perspective versus providing specific training that facilitated the strengthening of the vestibular system in an evidence-based manner.

Evidence supports that age does not significantly influence the beneficial effects of vestibular rehabilitation for person with vestibular disorders. The problem of dizziness has causes other than vestibular dysfunction but the vestibular system is often central to the problem. Treatment of vestibular dysfunctions is well within the domain of physical therapy practice. Considering the multiple co-morbidities present in many of our geriatric clients a whole person approach is essential.

SOLUTION
Although vestibular issues are often multifactorial, the physical therapist plays a critical role in addressing the issues of dizziness and vestibular dysfunction. Studies show that an individualized vestibular rehab program is effective. A whole person approach in the physical therapy assessment is critical. Examination of the musculoskeletal system as a source of a patient’s movement disorder or injury is the first and most obvious step (see Table 1). In gathering the patient’s history, it is important to identify other potential issues that may impact their balance and mobility. Starting with a performance oriented mobility test such as the Tinetti (40 point version), the Berg or the Dynamic Gait Index (DGI) is a great place to start, especially including the task that requires the patient to pick up an object from the floor. The feedback from these tests will reveal much about the patient’s balance.

The next part of the assessment now goes beyond the obvious and that is testing the patient’s vestibular system. This is done by assessing the central vestibular and peripheral vestibular system via bedside/treatment table tests. These clinical tests do not require expensive specialized equipment. See Tables 1 and 2 for detail. A great reference source for these tests is from Susan J. Herdman’s text, Vestibular Rehabilitation, 3rd edition. The text also comes with a DVD that contains video clips of tests and the resultant eye movements.

The specific “how to” performance of vestibular tests is not covered in this article. There are comprehensive clinically oriented courses available that can provide a great foundation of these required skills. However for the visual learner, the “how to perform” the tests is available in Susan Herdman’s text. The Balance Assessment Handbook is a great place to start, especially including the task that requires the patient to pick up an object from the floor. The feedback from these tests will reveal much about the patient’s balance.

Bill Walsh, PT, GCS, MA, MBA
Table 1.

<table>
<thead>
<tr>
<th>Assessment</th>
<th>Clinical Rationale</th>
<th>Treatment Considerations</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Musculoskeletal System: ROM and Strength with key problem areas noted and the impact on function.</strong></td>
<td>Obvious- this is what we do as physical therapists. Reminder, it is important to document the link between muscle weakness and function. A strength goal not linked to function is not worth paying for in the “eyes” of insurers.</td>
<td>This is where we shine as physical therapists. Wherever possible incorporate functional movement patterns into exercises- especially as the program progresses.</td>
</tr>
<tr>
<td>Equipment: goniometer, manual muscle tester (optional)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Somato-Sensory:</strong> Equipment: Semmes Weinstein Monofilament (5.07/10g filament)</td>
<td>Testing the 10 sites (5 on each foot) of the diabetic foot screen test is recommended even when the client does not have diabetes. If the person can sense 6 or less points it is an indicator of loss of protective sensation. This will impact proprioceptive feedback normally provided by the foot/ankle complex. There are many causes outside of diabetes that can cause decreased sensation: e.g venous or arterial insufficiency, chronic edema from diagnoses such as CHF, etc.</td>
<td>Two approaches can be taken one is to provide substitution training- facilitating the client to use other balance mechanisms to compensate- vision- eg, utilizing lighting to assist visual feedback. The second approach is to implement Infrared light therapy (aka ILT or MIRE) to increase circulation which in turn will typically increase sensation.</td>
</tr>
<tr>
<td>Checking of lower legs and feet for edema, lesions, deformities, etc. Equipment: none</td>
<td>Conditions of the feet and lower leg can impact balance reactions, motivation for progressing exercise (if the feet hurt motivation may be limited).</td>
<td>May need to contact/include physician regarding management of swelling (eg, medication management), recommendation of appropriate foot wear, compression stockings, etc. Increased swelling can also indicate that the client is heading into more serious trouble, e.g, exacerbation of CHF, potential for onset of cellulitis.</td>
</tr>
<tr>
<td><strong>Gait Assessment- using a standardized tool, eg, Tinetti Balance/Gait Assessment, Berg Balance Scale, Dynamic Gait Index (DGI), Timed Up and Go (TUG). Equipment:</strong> 2 Standard chairs (17” high) one with arm rests, one without arm rests, ruler, foot stool or step, stopwatch or wristwatch, up to 20 ft walkway.</td>
<td>Testing client with a performance oriented mobility test to identify fall risk and areas of deficit. Provides objective data that is recognized by payer sources and other professionals.</td>
<td>Treatment activities can focus on the deficits that impact function. Example: exercises designed to increase ROM of knee to facilitate normal swing phase of gait cycle.</td>
</tr>
<tr>
<td><strong>mCTSIB</strong> Equipment: dense foam pad, stopwatch or wristwatch</td>
<td>This test assesses the effect of removing visual cues on postural stability. Assesses the influence of vestibular, somatosensory; and visual inputs on postural control. (8 p 286, 10)</td>
<td>The “conditions” of the test can be incorporated into treatment session.</td>
</tr>
</tbody>
</table>

has a detailed description for conducting the Modified Clinical Test of Sensory Integration on Balance (mCTSIB). It is important to note that these tests can be performed in almost any therapy practice setting.

The function of the Vestibulo-ocular Reflex (VOR) is to maintain stable vision during head motion. Testing and activation (eg, stimulating via gaze stabilization exercises) of the VOR at various speeds is important because of the role it plays in many functional activities. Normal walking, walking quickly (as when going to answer the phone), driving a car, grocery shopping, many instrumental activities of daily living (IADL), etc. increases head movement and use this mechanism. The speed of this reflex is much faster than the process of visual feedback.13

Incorporating head neck movements in a variety of activities plays an important role in vestibular rehab and is a key component of the majority of physical therapy balance programs. Integrating the components of specific exercises in functional activities is easy. The following are examples that can either be simulated in a clinic or actually performed in the home setting. Reaching down to pick up an item and then looking up to place the item in another higher position--such as unloading a dishwasher and putting the dishes away. Walking down a hallway and turning to one direction and then the other. Making quick head turns in standing as would be done when hearing the telephone ring. Providing competing visual stimuli while the patient is walking with light perturbations applied (the goal is to provoke the skills needed to go shopping in a grocery store). The patient will be able to provide many other examples from their description of what functions they need to perform.

As with many other physical therapy interventions certain symptoms or manifestations may arise initially. During gaze stabilization exercises and other movement patterns of the head “errors” will occur and the patient will complain of feeling dizzy or “just not feeling right.” Facilitating the patient to move out of self restricted head movements is uncomfortable but necessary. The VOR, an important component of the vestibular system, can be enhanced with gaze stabilization exercises. Susan Herdman's text and attached video provide examples of gaze stabilization exercises. Another resource is the VHI series of therapeutic exercises.14 These make great handouts for the patient.

The tables that follow provide an overview of assessment and treatment of the geriatric patient. Tables 1 and 2 are not intended to represent a comprehensive assessment, but highlights the specific items that can provide valuable information impacting the development of the client’s Plan of Care (POC) or the need for further testing. As mentioned before,
Table 2.

<table>
<thead>
<tr>
<th>Assessment</th>
<th>Clinical Rationale</th>
<th>Treatment Considerations</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Vestibular System:</strong></td>
<td>These tests provide objective feedback to the client’s</td>
<td>Incorporate vestibular rehab exercises/activities in</td>
</tr>
<tr>
<td>Perform Oculomotor tests.</td>
<td>issue of dizziness. Many geriatric clients have been</td>
<td>program. If vestibular deficits are not addressed,</td>
</tr>
<tr>
<td><strong>Tests for Central Vestibular lesions:</strong></td>
<td>substituting for vestibular deficits for so long that</td>
<td>exercise and gait training alone will not be as effective in</td>
</tr>
<tr>
<td>• Spontaneous Nystagmus</td>
<td>many do not even recognize they have a problem. DVA provides</td>
<td>reducing risk for falls.</td>
</tr>
<tr>
<td>• Smooth Pursuit</td>
<td>objective data that can indicate vestibular hypo-function. Note:</td>
<td></td>
</tr>
<tr>
<td>• Gaze Evoked Nystagmus</td>
<td>once a person has been</td>
<td></td>
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<tr>
<td>• Sacades</td>
<td>trained to perform these tests it takes less than 10</td>
<td></td>
</tr>
<tr>
<td><strong>Equipment</strong></td>
<td>minutes to complete all of the tests.</td>
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<tr>
<td>object like a pencil that is a couple of</td>
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<tr>
<td>inches long with a bright color eraser on the</td>
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<td></td>
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<tr>
<td>end, standard chair</td>
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<tr>
<td><strong>Vestibular Ocular reflex (Peripheral Vestibular</strong></td>
<td>our goal is to incorporate a whole person approach, perhaps</td>
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<tr>
<td><strong>lesions:</strong></td>
<td>expanding what we as therapists typically assess and treat.</td>
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<tr>
<td>• Focus on target with head moving at 1 Hz.</td>
<td>Table 3 provides a framework for including components of</td>
<td></td>
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<tr>
<td>• Head thrust (unexpected provides best</td>
<td>vestibular rehab with the more “traditional” physical therapy</td>
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<tr>
<td>feedback) with eyes focused on target.</td>
<td>interventions of strength, balance, and mobility training.</td>
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<tr>
<td>• Dynamic Visual Acuity test performed</td>
<td><strong>SUMMARY</strong></td>
<td></td>
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<tr>
<td>with head static and dynamic- 2 Hz movement</td>
<td>The problem of dizziness is significant in the geriatric</td>
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<tr>
<td>pattern.</td>
<td>population. Although dizziness can have many “causes,”</td>
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<tr>
<td><strong>Equipment</strong></td>
<td>vestibular dysfunction is often a key contributing if not</td>
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<tr>
<td>Standard chair, DVA requires a visual</td>
<td>primary cause of dizziness. The impact that physical therapy can</td>
<td></td>
</tr>
<tr>
<td>acuity chart (See reference 9).</td>
<td>have on this problem is significant. Research shows that an</td>
<td></td>
</tr>
<tr>
<td><strong>Provoking BPPV/Vestibular dysfunction</strong></td>
<td>individualized vestibular rehabilitation program when combined</td>
<td></td>
</tr>
<tr>
<td>symptoms:</td>
<td>with exercise and mobility training will have outcomes superior</td>
<td></td>
</tr>
<tr>
<td>• Dix Hall-pike and Roll test- if indicated</td>
<td>to that of traditional therapeutic exercise and mobility training</td>
<td></td>
</tr>
<tr>
<td>by subjective history or results of other</td>
<td>will provide objective feedback to the client.</td>
<td></td>
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<tr>
<td>tests.</td>
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<tr>
<td>• Have pt. move head in a variety of positions</td>
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<tr>
<td>during assessment- e.g. bend over to pick up</td>
<td></td>
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<tr>
<td>an item, look up to retrieve an item from</td>
<td></td>
<td></td>
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<tr>
<td>above eye level, quickly turn head when</td>
<td></td>
<td></td>
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<tr>
<td>ambulating, look for client making “en bloc”</td>
<td></td>
<td></td>
</tr>
<tr>
<td>movements.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Equipment</strong></td>
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<td></td>
</tr>
<tr>
<td>Surface where patient can be in supine</td>
<td></td>
<td></td>
</tr>
<tr>
<td>position with neck extended or head in</td>
<td></td>
<td></td>
</tr>
<tr>
<td>trendelenburg position</td>
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</tbody>
</table>

Table 3. Treatment Examples

<table>
<thead>
<tr>
<th>Conventional Therapy Training</th>
<th>Combined Conventional &amp; Vestibular Training</th>
</tr>
</thead>
<tbody>
<tr>
<td>Shallow knee bends (with or without support)</td>
<td>Shallow knee bends while standing on an unstable surface (eg. foam pad, chair cushion, etc.) Advantage: dampens umano sensory feedback providing greater challenge to the vestibular system.</td>
</tr>
<tr>
<td>Knee extensions in a seated position- with or without weights</td>
<td>Knee extensions while sitting on a dynamic surface (eg. vestibular disc) Advantage: works on postural control and abdominals.</td>
</tr>
<tr>
<td>Gait training with appropriate assistive device and focus on gait quality, eg, step length, heel strike, etc</td>
<td>Gait training that incorporates quick turns, gait speed changes, light to moderate perturbations, ambulating in a circle with the affected limb on the inside, turning head from one side to the other, looking up and down, etc. Advantage: provides “real world” stimulus to vestibular system.</td>
</tr>
<tr>
<td>Bed mobility- moving from side lying to seated position</td>
<td>Integrate Brandt-Daroff exercise for 2 – 3 cycles. Advantage: ex. Used as habituation technique for dizziness can also used an alternative method to Epley maneuver.</td>
</tr>
<tr>
<td>Sit to stand to sit</td>
<td>Sit to stand to sit – have pt. perform sets with eyes closed. Advantage: removal of visual system to challenge vestibular system.</td>
</tr>
<tr>
<td>Pt. resting after series of exercise</td>
<td>Pt. sitting performs gaze stabilization exercise for 1 minute. Advantage: activity strengthens VOR an integral part of their vestibular system.</td>
</tr>
<tr>
<td>Static standing balance without use of assistive device</td>
<td>Shift static standing balance to dynamic with weight shifts anterior/posterior. This can be broken down to practicing each one and use a wall as a support that is at the limit of the client’s stability. Advantage: activity allows for the client to develop their own righting/equilibrium strategies.</td>
</tr>
<tr>
<td>Gait training over varied surfaces</td>
<td>Gait training over varied surfaces with variable speed. That is, have the pt. change speed quickly, eg. normal gait speed for 5 – 10 feet then cue client to ambulate as quickly as possible for same distance followed by as slow as possible. Advantage: provides “real world” adjustments to postural control, eccentric and concentric muscle groups in trunk &amp; lower Extremities.</td>
</tr>
<tr>
<td>Gait training with least restrictive device (ie, progressing client from a wheeled walker to a single point cane)</td>
<td>Same activity but includes Gaze Fixation (a compensatory strategy) on a stationary target at eye level while walking toward it. Advantage: provides a strategy that the pt. can use in day to day activity and is a safe addition to a home exercise program.</td>
</tr>
</tbody>
</table>


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*Applications are accepted year round.*

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**IT’S TIME TO SHOWCASE OUR EXCELLENCE!**

Nominate A Peer For A Section Award

Excellence refers to the highest quality or to a person who possesses the highest degree of qualities. There is certainly no lack of excellence within the Section on Geriatrics! It’s time to celebrate the excellence among us…

But we need your help! Take a moment and reflect on the physical therapists, physical therapist assistants, and students that you know who are working so diligently to advance the care of the geriatric population. These individuals are propelling our profession, the Association, and our section forward into the next realm of excellence. By nominating these individuals for one of the Section on Geriatrics awards you have the chance to personally say thank you but you also afford the Section on Geriatrics the opportunity to acknowledge and congratulate the excellent of the members of our sections.

Details on the awards are below or go to www.geriaticspt.org/members/awards for more information.
The Centers for Medicare and Medicaid Services (CMS) has implemented in December 2008 a Five-Star Rating System that serves as an enhancement of the Nursing Home Compare Web site established to provide objective information to consumers when comparing the quality of a nursing home. This CMS initiative has brought much discussion and active debate throughout the long-term care industry as providers determine how the ratings might affect both their operations and consumer’s perceptions. Over the past several months, CMS continues to refine the process; therefore, it remains a work in process.

This article will define the Five-Star Rating System. The Five-Star Rating System assigns to every Medicare and/or Medicaid certified nursing home in the United States a rating of between 1 and 5 stars based on a comparison to other nursing homes in the same state.

5***** Much above average
4**** Above average
3*** About average
2** Below average
1* Much below average

When calculating the star rating system there are 3 sources of information which comprise the ratings: health inspections, staffing, and MDS based Quality Measures.

Currently, the distribution of scores for nursing homes across the country is:
- 5 star-12%
- 4 star-23%
- 3 star-21%
- 2 star-21%
- 1 star-23%

HEALTH INSPECTIONS
This rating is derived from the last 3 years of onsite standard and complaint surveys. The most recent survey results are weighted more than prior years. A facility must have at least 2 standard surveys otherwise it will be rated “too new to rate” or “data not available.” Points are assigned based on the Scope and Severity ratings as well as on the number of revisits needed to correct the deficiencies that received a score of “F” or greater.

The survey results are updated monthly as new survey results are added to the CMS database. Since the implementation of the five-star system, duplicate deficiencies were eliminated; therefore, if a facility received the same deficiency either at the time of the standard survey and/or at two weeks prior to or after the standard survey, then the duplicate deficiency will not be counted.

Health Inspection Score: Weights for Different Types of Deficiencies

<table>
<thead>
<tr>
<th>Severity</th>
<th>Scope</th>
<th>Isolated</th>
<th>Pattern</th>
<th>Widespread</th>
</tr>
</thead>
<tbody>
<tr>
<td>Immediate Jeopardy</td>
<td>J</td>
<td>50 points (25 Points)</td>
<td>K</td>
<td>100 points (125 Points)</td>
</tr>
<tr>
<td>Actual Harm</td>
<td>G</td>
<td>20 points</td>
<td>H</td>
<td>35 points (40 Points)</td>
</tr>
<tr>
<td>No Actual Harm-Potential for more than Minimal Harm</td>
<td>D</td>
<td>4 Points</td>
<td>E</td>
<td>8 Points</td>
</tr>
<tr>
<td>No Actual Harm- Potential for Minimal Harm</td>
<td>A</td>
<td>0 Points</td>
<td>B</td>
<td>0 Points</td>
</tr>
</tbody>
</table>

Note: Figures in parentheses indicate points for deficiencies that are for substandard quality of care. The criteria used within a state are:
- The top 10% (lowest 10% in terms of health inspection deficiency score) in each state receive a five-star rating.
- The middle 70% of facilities receive a rating of two, three, or four stars, with an equal number (approximately 23.33 percent) in each rating category.
- The bottom 20% receive a one-star rating.

NURSING STAFF
This rating is obtained from the average number of hours care is provided to a resident by nursing staff.

The rating for staffing is based on two case-mix adjusted measures:
- Total nursing hours per resident day
- RN hours per resident day
These hours are derived from the Online Survey and Certification Reporting (OSCAR) information collected from the facility during a standard survey.

Data collected is:
- RN hours per resident day. Includes registered nurses, RN director of nursing, and nurses with administrative duties
- LPN hours: Includes licensed practical/licensed vocational nurses
- Nurse aide hours: Includes certified nurse aides, aides in training, and medication aides/technicians

Because of the variable ratings on health inspections across the country CMS’ Five-Star quality are based on the relative performance of facilities within a State. The criteria used within a state are:
- The top 10% (lowest 10% in terms of health inspection deficiency score) in each state receive a five-star rating.
- The middle 70% of facilities receive a rating of two, three, or four stars, with an equal number (approximately 23.33 percent) in each rating category.
- The bottom 20% receive a one-star rating.

These hours do include agency hours but not hours from other nursing home staff such as therapy, dietary, administrative, physicians, and housekeeping.

These hours are case mixed adjusted based on the distribution of the MDS Assessments Resource Utilization Group (RUG-III) scores. (Data from the 1995-1997 CMS Staff Time Measurement Studies were used to determine a baseline measure of the number of RN, LPN, and nurse aide minutes associated with each RUG-III group.) In February CMS revised the case mix adjusters for the staff measure by using the quarter nearest to when the staffing data was re-
The CMS Five Star System:

- **Quality Measures**
  - The quality measure rating contains 10 different physical and clinical measures for nursing home residents collected on the MDS.
  - The facility rating for the Quality Measure is based on performance on a subset of 10 (out of 19) of the QMs currently posted on Nursing Home Compare. The measures were selected based on their validity and reliability, the opportunity in which the measure is under the facility’s control, statistical performance, and importance.

**Long-stay residents:**
- Percent of residents whose need for help with daily activities has increased
- Percent of residents whose ability to move in and around their room got worse
- Percent of high risk residents with pressure sores
- Percent of residents who had a catheter inserted and left in their bladder
- Percent of residents who were physically restrained
- Percent of residents with urinary tract infection
- Percent of residents who have moderate to severe pain

**Short-stay residents:**
- Percent of residents with pressure ulcers (sores)
- Percent of residents who had moderate to severe pain

- **Staffing Points And Rating**

<table>
<thead>
<tr>
<th>RN rating and Hours Total staffing rating and hours (RN, LPN, Aide)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
</tr>
<tr>
<td>---</td>
</tr>
<tr>
<td>&gt;25&lt; percentile</td>
</tr>
<tr>
<td>1</td>
</tr>
<tr>
<td>2</td>
</tr>
<tr>
<td>3</td>
</tr>
<tr>
<td>4</td>
</tr>
<tr>
<td>5</td>
</tr>
</tbody>
</table>

**Points received for Quality Measure based on the percentile:**

<table>
<thead>
<tr>
<th>Percentile</th>
<th>ADL Quality Measures</th>
<th>Other Quality Measures</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; 20&lt; percentile</td>
<td>20</td>
<td>12</td>
</tr>
<tr>
<td>20&lt; - &lt; 40&lt; percentile</td>
<td>15</td>
<td>9</td>
</tr>
<tr>
<td>40&lt; - &lt; 60&lt; percentile</td>
<td>10</td>
<td>6</td>
</tr>
<tr>
<td>60&lt; - &lt; 80&lt; percentile</td>
<td>5</td>
<td>3</td>
</tr>
<tr>
<td>80&lt; percentile or greater</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

When facilities have missing data mostly due to insufficient number of residents available for calculating the Quality Measure, the missing values are based on the state wide averages for the measure or facilities that have the data for 4 of the 7 long stay measures, the missing values are derived from the state average.

**Points are assigned as in the above table. For missing values on 2 out of 3 post-acute measures the points are assigned as in the above table.**

If the long stay measures are missing on 3 or fewer measures, the data is based solely on the short stay measures. Likewise if the short stay measures are with a 0 or one short stay measure, the points are based on the long stay measures. The mean values for the missing short-stay Quality Measures are not imputed.

Based on these guidelines the facilities will receive a Quality Measure rating in 1 of the 3 categories:
- They have points for all of the Quality Measures
- They have points for only the 7 long stay measures
- They have points only for the 3 short stay measures
- No values are imputed for nursing homes with data on fewer than 4 long stay measures and fewer than 2 short stay measures

All facilities are scored using the same 136 point scale and points are rescaled for long and short stay facilities by:
- If data is based on 3 short stay measures (36 available points), the score is multiplied by 136/36
- If data is based on 7 long stay measures (100 possible points), the score is multiplied by 136/100

Finally once the Quality Measure score is determined for each facility the five star rating is assigned based on the nationwide distribution of the scores as:
- Top 10% of facilities receive a five star rating
- Middle 70% of facilities receive a rating of two, three, or four stars with equal rating of 23.33 in each category
- Bottom 20% receive a one star rating

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posted on Nursing Home Compare. A telephone help line is maintained on a quarterly basis to align with the quarterly updates of the quality measures. The CMS experts are available in July, October, January, and April at 1-800-839-9290 for these telephone conversations. Additionally, a provider can email bettercare@cma.hhs.gov to communicate with officials regarding technical issues or suggestions to enhancements for the program.

How Therapy Can Affect the Five Star Rating System
• Ensure you are aware of your facility’s star rating
• Become knowledgeable of updates to the survey regulations and determine how you can affect the survey process in your facility
• Maintain an active program to identify resident’s changing functional needs
• Develop new clinical programs which can improve maintaining the quality of life of a resident
• Conduct routine educational programs in your facility which assist with ensuring staff is aware of how therapy can affect a resident’s function
• Participate in facility meetings/activities and discuss residents at risk for falls, skin integrity issues, and etc
• Review your facility’s quality measures reports and strategize with the care plan team for interventions

RESOURCES
Nursing Home Compare: www.medicare.gov/NHCompare
Five-Star Quality Rating System: www.cms.hhs.gov/CertificationandCompliance/13_fsqrs.asp

Carol Knudson is a clinical consultant for RehabCare, St. Louis, Missouri in the Skilled Nursing and Rehabilitation Division. In this role she conducts clinical training and implements therapy programs in the SNF and outpatient therapy clinics.

TOPICS IN GERIATRICS: VOLUME 5
An Independent Study Course Designed for Individual Continuing Education

Evaluation and Treatment of the Patient With Diabetes Post Amputation—Terri Nuccio-Youngs, PT, DPT
Differential Diagnosis in the Management of the Integumentary System—Paula Simon, PT, DPT, GCS
The Role of the Physical Therapist in Health Promotion for Older Adults—Jason Hardage, PT, DSc,PT, NCS

The Aging Skeleton: Lower Quarter—Holly Lookabough-Deur, PT, DSc, GCS
Osteoarthritis in the Upper Quarter—Leon F. Bradway, PT, MS, CMT

For more information, visit www.geriatricspt.org for online or regional courses available.

CSM 2010 Preconference Course: Section on Geriatrics
Members of the Section on Geriatrics register at a discount.

Clinical Residency 101: Getting Started and Doing It Well
Tuesday, February 16, 2010, 8:00 am–5:00 pm
7.5 Contact Hours
Presenters: Greg W. Hartley, PT, MS, GCS, Teresa L. Schuerrmann, PT, DPT SCS, ATC, CSCS, Kim Nixon-Cave, PT, PhD, PCS

Mentoring the Clinician Towards Advanced Practice: Skills, Knowledge, and Behaviors for Successful Residency and Fellowship Mentoring
Wednesday, February 17, 2010, 8:00 am–5:00 pm
7.5 Contact Hours
Presenters: Carol Jo Tichnor, PT, Ivan Matsui, PT, FAAOMP, Gail M. Jensen, PT, PhD, Cathy H. Ciolek, PT, DPT, GCS

The Therapeutic Use of Yoga to Prevent Falls and Reduce the Risk of Falling in Older Adults
Wednesday, February 17, 2010, 8:00 am–5:00 pm
7.5 Contact Hours
Presenter: Kathleen K. Zettergren, PT, EdD
Note: Participants will actively participate in yoga moves.

More detailed descriptions of each preconference course will be in November’s issue.

Course space is limited—Visit www.apta.org and click events to register today!
CULTURAL DIVERSITY POSTER AWARD
THE INFLUENCE OF ARTHRITIS ON THE HEALTH-RELATED QUALITY OF LIFE AMONG OLDER MEXICAN AMERICANS

Saad Bindawas, PT, PhD

The following abstract was a poster presentation at CSM 2009 and was the winner of the Section on Geriatrics 2009 Cultural Diversity Poster Award. Our congratulations to the author, Saad Bindawas.

THE INFLUENCE OF ARTHRITIS ON THE HEALTH-RELATED QUALITY OF LIFE AMONG OLDER MEXICAN AMERICANS

AUTHORS (LAST NAME, FIRST NAME): Bindawas, Saad1; Al Snih, Soham1; Ottenbacher, Kenneth J.1; Protas, Elizabeth J.1

INSTITUTIONS (ALL): 1. Rehabilitation Sciences, University of Texas Medical Branch, Galveston, TX, USA.

ABSTRACT
Purpose/Hypothesis: Arthritis has a considerable impact on health-related quality of life (HRQoL), particularly among older populations. However, little is known about the effect of arthritis on HRQoL in older Mexican-Americans, one of the fastest growing ethnic groups in the United States (US). The purpose of this study was to examine the association between self-reported physician-diagnosed arthritis and health-related quality of life. Number of Subjects: A population-based sample of 839 noninstitutionalized Mexican-American subjects aged 75 years and older residing in the southwestern United States. Materials/Methods: This cross-sectional study used data from the Hispanic Established Populations for the Epidemiologic Study of the Elderly (H-EPES), an ongoing longitudinal study of older Mexican-Americans age 65 and over residing in Texas, New Mexico, Colorado, Arizona, and California. Measures included self-reported physician-diagnosed arthritis, socio-demographic variables, medical conditions, body mass index (BMI), and the physical and mental composite scales from the Medical Outcomes Study Short Form 36 Health Survey (SF-36). Results: Of the 839 subjects, 518 (62%) reported physician-diagnosed arthritis. Subjects with arthritis had significantly (P<0.0001) lower scores on the physical composite scale (PCS) (mean =35.3, SD =11.3) of the SF-36 compared to subjects without arthritis (mean =42.9, SD =10.9). Additionally, subjects with arthritis had significantly (P<0.0001) lower scores on the mental composite scale (MCS) (mean =53.5, SD =10.8) of the SF-36 compared to subjects without arthritis (mean =57.0, SD =8.80). Multiple linear regression models revealed that arthritis was significantly associated with decreased PCS and MCS (model estimates = -5.74 and -3.16; both P < 0.0001), respectively, after controlling for all covariates. Conclusions: Arthritis is a highly prevalent medical problem associated with a decreased physical and mental health in older Mexican-Americans. Such research could improve current clinical and public health interventions developed for adults with arthritis, and guide efforts in reaching the Healthy People 2010 goal of increasing the quality and years of healthy life for people with arthritis. Clinical Relevance: Arthritis is a major and growing public health problem and constitutes the most common reason for disability in the US. Health-related quality of life outcome measure is an important source of information to clinical decision making process for physical therapy practice.

Key Words: quality of life, arthritis, elderly

The above abstract is an essential part from my dissertation project that aimed to examine the effect of arthritis on the physical function, disability, and HRQoL in older Mexican-Americans, a population that suffers high rates of arthritis and disability. The following paragraphs outline the importance of eliminating racial disparities in health among Mexican-Americans, who represent 2/3 of Hispanics.

HISPANICS AND HEALTH DISPARITIES

The more than 35 million Hispanics in of the United States are the largest minority group in the United States (US), comprising 12.5% of the population. The Hispanic population encompasses wide diversity in country of origin, race, migration experience, spatial distribution, and socio economic status. With the exception of Cuban-Americans, US Hispanic populations have high rates of poverty, and low educational and job classification levels. Census data show that 21.2% of Hispanics live in poverty, compared to 22.1% of African-Americans, and 7.5% of non-Hispanic whites. In 1998, 35% of Hispanics were uninsured for at least part of the year compared to 12% of non-Hispanic whites and 22% of African-Americans.

Despite the generally low socioeconomic standing of the Hispanic population, the all-cause mortality rate for persons of Hispanic origin in the United States is lower than that for non-Hispanic Whites. Hispanics have lower death rates from leading causes of death, including cardiovascular diseases and cancer, when compared to non-Hispanics Whites in the United States. The absence of a major mortality disadvantage for Hispanics has been viewed as a paradox, because lower education and economic standing are strongly correlated with higher all-cause mortality.

There are 3 important reasons to focus attention on the determinants of Hispanic health status. First, the Hispanic advantage is transitory. The advantage is rooted in part in social and cultural practices that decline as a function of assimilation. Identification of the precise resources and practices within Hispanic communities that maintain advantageous outcomes may facilitate interventions that diffuse them throughout Hispanic communities. Second, despite an overall mortality advantage, Hispanic populations experience off-setting health disadvantages that are associated with their minority and disadvantaged economic status. Third, national incidence and mortality rates average conditions that vary across local settings. To understand and redress health inequalities affecting Hispanic populations, we have to understand the diversity of mechanisms affecting health outcomes in different environments.
ARTHHRITIS IMPACT ON THE HEALTH-RELATED QUALITY OF LIFE AMONG OLDER MEXICAN-AMERICANS

Arthritis is a major and growing public health problem, prevalent among older Hispanics, with a sizeable impact on their health-related quality of life (HRQoL). Arthritis is the most common cause of disability in the U.S. and it has been estimated that about 67 million adults will have arthritis by 2030, and older adults will be the most affected (50%). Older adults, represent the fastest growing segment of the U.S. population. The older Hispanic population is projected to grow faster than all groups from just over 2 million in 2003 to 15 million in 2050, and approximately two-thirds of Hispanics are Mexican-Americans.

While age is a universal risk factor for arthritis and disability, older Mexican-Americans have more functional limitations than other race/ethnic groups. Older Mexican-Americans are characterized by low income, low levels of formal education, and high rates of arthritis, type 2 diabetes mellitus, obesity, disability, and low physical activity. They also have relatively low rates of health insurance coverage.

Little is known about the effect of arthritis on the physical function, disability, and HRQoL in older Mexican-Americans, a population that suffers high rates of arthritis and disability. Therefore, we examined the impact of arthritis among older Mexican-Americans over 6 years of follow-up by using a conceptual model that mimics the disablement process model. This conceptual model describes a pathway leading from arthritis (pathology) to impairment, to functional limitations, and to disability; which ultimately is associated with poorer HRQoL. The result of this research will increase our understanding regarding arthritis and disability, 2 focus areas in the Healthy People 2010 initiative.

The Department of Health and Human Services (DHHS) started the Healthy People 2010 initiative in 2000 to achieve 2 major goals: (1) to increase years and quality of healthy life; (2) to eliminate disparities in health between racial and ethnic groups. Likewise, the National Arthritis Action Plan (NAAP), a public health strategy, was developed in 1999 to reduce the burden of arthritis and to improve HRQoL for arthritic subjects. Findings from this dissertation project would provide valuable information for the Healthy People 2010 initiative, the National Arthritis Action Plan, policy makers, researchers, and clinicians regarding the impact of arthritis on physical function, disability, and HRQoL among older Mexican-Americans.

THE INFLUENCE OF ARTHRITIS ON THE HEALTH-RELATED QUALITY OF LIFE AMONG OLDER MEXICAN-AMERICANS

The current paper, entitled “The Influence of Arthritis on the Health-Related Quality of Life among Older Mexican-Americans,” is one essential part from my dissertation’s conceptual model. We examined cross-sectionally the association between arthritis and health-related quality of life among older Mexican-Americans, aged 75 years and older from the Hispanic Established Populations for Epidemiologic Study of the Elderly (EPESE).

The population of Mexican-American older adults will consume an increasing proportion of health-related services and resources in the coming decades. Accordingly, it is important that we increase our understanding of how HRQoL is affected by a highly prevalent chronic condition such as arthritis. Ultimately, state and local health agencies can benefit from this research in planning programs to meet the Healthy People 2010 goal of increasing the quality of life and years of healthy life for persons with arthritis. For example, state health departments that organize physical activity programs, such as the “Buenos Días, Arthritis” need to consider including the older arthritic Hispanic population, along with those aged 45 to 64 years, since arthritis is highly prevalent in older Hispanics.

In conclusion, we found arthritis to be a highly prevalent medical condition in this subset of older Mexican-Americans. Older Mexican-Americans with arthritis in this sample have poorer HRQoL than those without arthritis. Arthritis also was significantly associated with low physical and mental health. Future population-based longitudinal research is necessary to examine how HRQoL measures in people with arthritis change over time. This research is particularly important in underserved groups such as Mexican-Americans with a high prevalence of arthritis.

RESOURCES AND LINKS RELEVANT TO THE POSTER TOPIC

UTMB- The Center for Population Health and Health Disparities
http://www.utmb.edu/scoa/Research/CPHHD/index.html

UTMB – The Sealy Center on Aging
http://www.utmb.edu/scoa/index.html

UTMB – The Center to Eliminate Health Disparities
http://www.utmb.edu/cehd/

UTMB- The Hispanic EPESE
http://www.utmb.edu/pmch/hepese/default.htm

Saad Bindawas is a physical therapist from Saudi Arabia and he just received his PhD in Rehabilitation Sciences from the Department of Preventive Medicine and Community Health, at the University of Texas Medical Branch, in May 2009. His dissertation, titled “Arthritis Impact on the Physical Function, Disability, and Health-Related Quality of Life among Older Mexican-Americans,” was completed under the mentorship of Elizabeth J. Protas, PT, PhD, FACSM, FAPTA. Also serving on Saad’s dissertation committee were Kenneth Ottenbacher, OTR, PhD; Dennis Hart, PT, PhD; Soham Al Snih, MD, PhD; Yong-fang Kuo, PhD; and Anita Mecado, MD.
The 8th International Symposium on Osteoporosis: Translating Research into Clinical Practice, April 1-5, was attended by more than 14 physical therapists from the United States and Canada, many of them Section on Geriatrics members. Physical therapists joined several hundred health care professionals in Washington, DC, for 4 days of scientific programming. SOG member, Karen Kemmis, PT, DPT, served as a member of the symposium planning committee. She also presented at a plenary session on Nonpharmacologic Issues in Osteoporosis Management on the topic of Exercise Prescription for Osteoporosis. Her session focused on the risks, prevention, and management of vertebral compression fracture. She reported on the results of her own pilot study on a biomechanical intervention after acute vertebral fracture.

We were pleased to have physical therapy content in the program and also to see increased recognition of the role of physical therapy in the prevention and management of osteoporosis. Physical therapists participated in the Q and A that followed each session, bringing the physical therapist’s perspective to the topics. We learned about areas where research is needed to show the benefits of physical therapy, such as falls prevention in nursing homes.

Research on space travel and new diagnostic imaging raised provocative questions about the special characteristics of bone and its response to mechanical loading. We learned about limitations in current bone density measurement and the effects of the size, shape, and material properties of bone. FRAX, the new multifactor guidelines for estimating absolute fracture risk, allows clinicians to estimate absolute 10-year risk of hip and other fractures.

The reports on Vitamin D deficiency and SSRIs as secondary causes of osteoporosis were of great interests to therapists. Vitamin D intake was associated with calcium absorption, bone remodeling, bone loss, muscle strength, fall risk, and fractures. Intakes of 800 to 1000 IU/d or more are now advised for seniors. Several studies were cited on the role of SSRIs among older populations in bone loss and fracture, suggesting that these widely used antidepressant medications are as significant as corticosteroids in their skeletal effects.

Other sessions of interest included ones on secondary causes of osteoporosis, benefits and risks of current medications, and new pharmacology. Presentations on Denosumab, a human antibody to RANKL, reported its relationship to bone turnover and reduced fractures in postmenopausal women with and without osteoporosis. It is not yet approved but appears to be the most effective anti-resorptive medication yet.

In several sessions we were reminded of the significant cuts in reimbursement for DXA bone density studies, an important part of osteoporosis diagnosis and treatment. Since 2006, reimbursement rates for DXA have been reduced by 50%, with more cuts expected in 2010. Current reimbursement levels do not cover the costs, and many physicians have reduced the number of tests and discontinued bone density testing. We were all urged to contact our congress people to reverse this.

The highlight of the symposium was the report on the National Action Plan, built on the findings and recommendations of the 2004 Surgeon General’s Report on Bone Health and Osteoporosis and the European Action Plan for Osteoporosis. APTA was among more than 150 stakeholders attending the Summit for a National Action Plan for Bone Health, June 2008 in Washington, D.C. The Plan outlines 4 priority areas that will be the focus of future bone health actions:

1. Development of a bone health alliance.
2. Promotion of bone health and prevention of disease.
4. Enhancement of research, surveillance, and evaluation.

Highlights and important new bone health information will be featured in at the Bone Health SIG Business Meeting at CSM 2010.

SECTION ON GERIATRICS 2009 SLATE AND CANDIDATE STATEMENTS

All Section on Geriatrics (SoG) Members will be able to vote online or through a paper ballot. An email will be going out to Section members in September with instructions for voting online. Those members without a valid email addresses will receive a paper ballot in the mail. Ballots are also posted online for you to print and mail in. Ballots must be returned to the Section Office by October 21, 2009 or earlier in order to be counted. We appreciate every member’s participation in this year’s election, and thank all of our candidates for their willingness to serve the SoG!

SLATE
Treasurer (Elect 1)
Don Backstrom, PT, MBA, GCS
Anne Coffman, PT, MS, GCS

Director (Elect 2)
Linda Eargle, PT, DPT, MIn Ed
Nora Francis, PT, DHS, OTR
Bob Thomas, PT, MSPT
Mary Thompson, PT, PhD, GCS

Nominating Committee (Elect 1)
Patrice Anthony, PT, GCS, CAPS
Kathy Brewer, PT, GCS, Med

Candidate Statements
The Section on Geriatrics (SoG) candidates for office were invited by the Nominating Committee to provide a candidate statement by answering several questions within an 850-word limit. Below are the candidate statements and biographical information provided by each of the candidates.

TREASURER
1. How do you view the role of the Treasurer and its interaction with the Section on Geriatrics Board and its membership?
2. What prior experience has prepared you for the role of Treasurer for the Section on Geriatrics?
3. How can the Section prioritize members’ services while maintaining a balanced budget?

DON BACKSTROM, PT
MBA, GCS
Residence: Ulster Street, CO
Credentials/Degrees: PT, MBA, GCS
Employment: Kaiser Permanente

Section Membership: 15 years
APTA Membership: 20 years
Activities, SoG: Geriatric Specialty Council Member; Chair of Geriatric Specialty Council; Participated in strategic planning process and represented the Geriatric Specialty Council as part of the ABPTS.

I embrace the spirit of volunteerism and am grateful to the APTA for the past experiences that I have had. I believe that my carrier experiences as a director and as a therapist with an advanced degree in business qualify me for consideration to the position of Treasurer of the Section. Since leaving the council, I have been looking for opportunities to share my strengths and benefit our great profession. Thank you for your consideration.

Role of the Treasurer: I view the role of Treasurer as a position of trust. Trust that members’ dues will be treated and used as if they were my own. Trust that I will manage members’ resources with a high degree of care and good judgment. Managing the budget allows the Section to serve members and provide a variety of services to members that result in success of our membership, our Section, our profession, and our patients. The role of Treasurer is to follow policy and procedure resulting in the assurance that more is coming in than going out. At the same time, the role of Treasurer is to assist the Section in the accomplishment of the strategic plan. In the last two years the role of Treasurer has been influential in expanding the creation of new knowledge areas of geriatrics. More funds have been allocated to the Geriatric Fund of the APTA Foundation.

Spending funds to advertise in external publications has increased awareness of the public to view physical therapists as the authority in geriatric rehabilitation, wellness, and prevention. Ensuring that members’ dues and investments are used to support the strategic plan and mission of the Section is a primary role of the Treasurer. In addition, growing our assets ensures the sustainability of our Section. In the last four years, our current Treasurer has doubled our Section assets. This was done by making wise decisions about short term and long term savings funds and using conservative approaches during a bear market. While most 401K plans lost money, our Section grew its savings. This is an excellent example of the role of the Treasurer. My goal as Treasurer would be to further this conservative approach and continue investing in educating the public, supporting member education, and increasing evidence-based research. Specifically, my personal experience has left me with a passion for the continuum of care of older adults. Acute care, SNF, acute rehabilitation, home health, out-

Nancy Abodeely, PT, MA, OCS is Vice Chair of the Bone Health and Chair of the SIG Practice Committee. She is a 1983 graduate of the University of California San Francisco Physical Therapy program. She is in current clinical practice at Kaiser Permanente in San Francisco. She is an outspoken advocate for bone health and fracture prevention for older adults.
patient, and wellness settings are all represented by our membership and are rolled into the strategic plan. Another relevant priority for the next Treasurer is to re-evaluate our portfolio of investments. Currently 80% of our assets are in low interest, conservative accounts. As the market improves, we may want to increase our risk slightly to keep up with inflation and increase income. The role of Treasurer is not only to balance the budget but to influence and guide the Section in making wise decisions that support the strategic plan to meet the needs of our Section.

Prior experience: My passion for excellent care for older adults, in many ways, prepares me to serve the Section on Geriatrics. In addition, I have over 10 years of experience managing budgets that range in scope from several hundred thousand dollars to my current position in which I manage over one-hundred million dollars. My educational background includes an MBA which provides a solid theoretical and educational background for financial management and accounting. I have four years of experience serving the Section as a member of the Geriatric Specialty Council, 2002-2004 as the chair. In this role I observed a variety of Section activities and participated in Section board meetings. My experience, my education, and my prior service to our Section prepares me for the position of Treasurer.

Maintaining a balanced budget: Many business leaders say that strategy is everything. Continually asking, how are we fulfilling our mission of “furthering our members’ ability to advocate and provide best practice physical therapy for optimal aging.” A clear example of strategy is the planning done by the Section every two or three years. Balancing the budget involves saying “no” when the request for funds does not align with the strategic plan. Balancing the budget also means saying “yes” to requests that further our mission and support our strategy. Whether it is creating new knowledge related to geriatric PT practice or advertising in external publications, the mantra is the same: what will give us the most bang for our buck. My goal as Treasurer would be to continue the progress and success of the Section and Dr. Staples as Treasurer. I will use the knowledge that I have of business as well as the interpersonal skills that I have for listening and reaching consensus. Thank you for your consideration. I humbly ask for your vote for Treasurer of the Geriatric Section.

ANNE COFFMAN, PT, MS, GCS
Residence: New Berlin, WI
Credentials/ Degrees: PT, MS, GCS
Employment:
Gentiva Healthcare Services

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years, I believe I am well prepared to lead the Section over the next three years as its Treasurer and I would appreciate your support. Thank you.

**DIRECTORS**

1. What experiences do you bring to the position of Director that makes you a strong candidate for this position?
2. What three activities would you like the Section to accomplish while you are on the Board of Directors?
3. What is the greatest challenge facing the geriatric practitioner and how can the Section help?

![Linda Eargle](image)

**LINDA EARGLE, PT, DPT, Min Ed**

**Residence:** Sun City Center, FL  
**Credentials/Degrees:** PT, DPT, Min Ed  

**Section**

**Membership:** 20+

**APTA Membership:** 43 years  
**Activities, SoG:** Wellness and Health Promotion Special Interest Group, Nominating Committee 2005-2007, liaison to EXPAC 2010 Steering Committee 2009, Committee on Cultural Diversity 2002-present


As a Section member, I’ve benefitted from the excellent Section leadership for a number of years. This nomination gives me the opportunity to give back. I just retired so have time to dedicate to the Section on Geriatrics position of Director. I now have the opportunity to practice in home health and outpatient settings in Sun City Center, FL, one of the early adult living communities, where I live.

**Prior Experience:** Directors have a responsibility to represent Section members. I feel the experiences of regularly attend the CSM business meetings, contributing to the work of the Health Promotion and Wellness SIG and participation on the Committee on Cultural Diversity have given me the experience to represent a broad spectrum of the Section members. I’ve been an active member of the Section for more than fifteen years and of APTA for more than 40 years.

APTA membership has afforded me leadership experience in a number of appointed positions such as the Commission on Accreditation for Physical Therapy Education, the Committee for Screening Proposals/Abstracts, and the Committee for Physical Therapist Assistant Recognition.

I have had the opportunity to practice, predominately in geriatric PT, but also I’ve also been involved in PT and PTA education. In 2008, I retired from full time practice. My most recent experiences are quite eclectic, adding to my strength should I be elected as a Director. I live in an adult retirement community, where I practice PRN in both private practice out patient and home health settings: teach online PT education courses and both the basic and Advanced Clinical Instructor Credentialing Courses. Currently, I am working with the Carolina Clinical Education Consortium (CCEC) in a part time executive director role. I previously served the CCEC as secretary and chair.

I am new to the Florida chapter, but have 25 years of experience as a member of the SC chapter board of directors, chief delegate, member of the nominating committee, and in multiple appointed positions.

I agreed to be slated for a director candidate because I feel a responsibility to the Section and I have both the time and energy to devote to the position. Being slated for Geriatric Section Director is an honor and privilege.

**Activities to Accomplish:** The Geriatric Section has been a leader in providing information to students at CSM to encourage practice in geriatrics, has made great strides in supporting diversity in Section leadership, and continues to provide excellent continuing education opportunities. I would like to continue these activities, which are directly related to Section Strategic Goals and the position statements on Cultural Diversity and the Geriatric Practitioner in 2020. Additionally, I see a need to search for innovative ways to encourage PTs and PTAs to utilize best practice for optimal aging, to inform PT and PTA program faculty about the wealth of Section resources available, and to make the public aware of Section consumer resources.

**Greatest Challenge:** I believe the greatest challenge is lack of public awareness of consumer resources and the advantages of direct access to physical therapy for health promotion and wellness as well as to improve impairments and functional limitations. I am very worried about Medicare reimbursement, both as a person on Medicare and as a PT clinician. My neighbors do not have a clear understanding of physical therapy, how PTs can help them prevent future limitations and disability, or how to self manage chronic impairments and functional limitations. The Section can help by enabling Section members to teach their patients and to reach to out in their community. I envision more in-
volvement among Section committees, such as the Section on Geriatrics Advocates to the States and Special Interest Groups to garner ideas and disseminate information.

NORA FRANCIS, PT, DHS, OTR
Residence: Evanston, IL
Credentials/ Degrees: PT, DHS, OTR
Employment: Northwestern University
Section Membership: 13 years
APTA Membership: 21 years

Activities, SoG: Member, GeriNotes Editorial Board; Member, Geriatrics Section, 1996 - present

Activities, other Sections: Best Poster - Health and Policy Administration Section Research Committee (Francis N, Sanders B. Intent and choice of female physical therapists’ employment before and after childbirth. Department of Physical Therapy and Human Movement Sciences, Northwestern University, Feinberg School of Medicine, Chicago, IL, American Physical Therapy Association, Combined Sections Meeting, February, 2009); Member, Section on Administration, 1988-1992; Member, Bylaws Committee, 1988-2000, Chairperson, Bylaws Committee, 1989-1990, Member, Publications Committee 1991-1992; Member Education Section, 1994 - present


I am honored to be asked to serve as Director and am excited about the possibility of serving the Geriatric Section. If elected, I would enthusiastically embrace my duties.

Prior Experience: I have many previous experiences that I believe help to make me a compelling candidate for Director in the Geriatrics Section. First, I have 29 years of experience as a physical therapist; 16 of those have been as an educator in physical therapist professional and physical therapist assistant education programs. In addition, because of my passion for geriatric clinical practice, for the past 11 years, I have served as the course coordinator for the Issues in Geriatrics course at Northwestern University Department of Physical Therapy and Human Movement Sciences. I have been a member of the APTA since 1978 and I have held a wide variety of leadership positions at the district, state, and national levels. I have also served as a member of the GeriNotes editorial board since 2008 and I am a member of the Section’s Bone Health Special Interest Group. Lastly, I believe I demonstrate effective organizational and verbal/written communication skills, I respond to requests in a timely manner, and I am a strong team player.

Activities to Accomplish:

a. Promote the type of research that may be funded by the Section on Geriatrics Fund and the Marilyn Moffat Endowment Fund for Geriatric Research provided by the Foundation for Physical Therapy. In addition, I would like to have the Section explore possible funding on smaller scale than the Foundation, such as $1,000-$10,000, for practicing clinician or academic faculty research.

b. Communicate to members the interdisciplinary outreach and engagement in which the Section is engaged. By promoting and evaluating the activities in which the Section is participating, we can ensure that physical therapists are well-positioned as leaders in the larger field of geriatric health care.

c. Develop a self-assessment guide for physical therapists who provide services for older adults to assist them in developing a plan for individual achievement of the Section on Geriatrics Position Statement - “2020 PT Practitioner for the Aging Population”. This self-assessment guide can assist each practicing geriatric physical therapist to determine the steps he or she specifically needs to take now so we can all meet the vision as delineated in the Geriatrics Position Statement.

Greatest Challenge: I believe that we as geriatric physical therapists have an amazing opportunity to promote and demonstrate our skills to the growing older adult population. Therefore, we must continuously advance our skills so we may meet the health promotion and movement function needs of older adults in the future. I think that one of the greatest challenges is keeping up to date with the professional literature and using appropriate outcome measures in geriatric practice. The Section can help by developing the self-assessment guide to which I referred in the second question above. Only by doing so will we achieve our vision of the “2020 PT Practitioner for the Aging Population”.

BOB THOMAS, PT, MSPT
Residence: Portland, OR
Credentials/ Degrees: PT, MSPT
Employment: Infinity Rehab, Merit Rehab
Section Membership: 14 years
APTA Membership: 19 years

Activities, SoG: Active Member - Section on Geriatrics (1995 to present); Oregon Liaison to Section on Geriatrics (1996 to 2000); SNF Committee, Section on Geriatrics (2001); Wrote “Reimbursement Issues in HealthCare: Understanding the Medicare and Medicaid Systems”, Section on Geriatrics, APTA, Home Study Series, Spring 2008; Wrote Medicare Medical Review: Changes and Updates’. GeriNotes, July 2005; Wrote “Supervision Requirements for the Physical Therapist”, GeriNotes, Section on Geriatrics, APTA, winter 2002

Activities, other Sections: Active member – Private Practice Section, (2009 –
In addition, I am a member of the Board of the Oregon Physical Therapy Association (OPTA) and the National Association of Rehab Providers and Agencies (NARA) organizations that serve therapists in various aspects of practice and profession. From these current as well as past board positions, I’ve been involved in collaborative decision making and committee work group oversight.

I believe my experience and skills will allow me to make a contribution to the Section but the driving force for my professional life is that I have a passion for our profession, for therapists, and for the geriatric client. I believe this passion coupled with my experience makes me a strong candidate for Director.

**Activities to Accomplish:** I would like to see the Section accomplish the following activities as part of the Strategic Plan:

- Increase collaboration with other Sections, other organizations, and potentially universities to enhance education on the physical therapy care and treatment of the older adult in all practice settings. Increasingly, the older adult is becoming a prominent patient type in more than just traditional settings. I would like the Section to look to facilitate the education of practitioners in a targeted, outcomes oriented, best practice approach to the older client in all settings.

- Increase training and education on impending changes to our health care system, Medicare, and other reimbursement systems that we are expected to experience in the next 10 years. I believe our Section can take a strong role in helping geriatric practitioners prepare for resulting practice changes to maintain professional viability and patient quality.

- Increase advocacy and promotion of Geriatric Practice as a prime choice specialty. In my experience teaching in our local university and around the country through continuing education courses, my impression is that geriatric practice, as in other health professions, is often perceived as a second or third choice to other practice settings and patient populations. With the aging population and a current shortage of physical therapists, it will be necessary for growth of a larger population of geriatric physical therapy practitioners who have a passion for the older adult.

**Greatest Challenge:** I believe the greatest challenge facing the geriatric practitioner is the coming Perfect Storm. In the next 10 years, we will see the confluence of 1) increasing demands for quality and outcome driven care and performance, 2) expedited decline in reimbursement, 3) an increasing shortage of geriatric practitioners, and 4) a substantially increasing geriatric patient population base. I see geriatric practitioners working harder to provide quality care, to more people, with less help and for less reimbursement. I see the Section on Geriatrics as being an organization that can bring not only clinical but practice solutions for these coming challenges through education, practical strategy development and advocacy.

**MARY THOMPSON, PT, PhD, GCS**

**Residence:** Celina, TX

**Credentials/Degrees:** PT, PhD, GCS

**Employment:** Texas Woman’s University, School of Physical Therapy

**Section Membership:** 29 years

**APTA Membership:** 29 years

**Activities, SoG:** APTA, Section on Geriatrics Home Study Co-Editor (2001), Editor (2002 – 2007); 2007 American Physical Therapy Association, Section on Geriatrics President’s Award for Exceptional Contributions to the Section on Geriatrics.; 2007 American Physical Therapy Association, Section on Geriatrics Distinguished Educator Award for Excellence as a Physical Therapy Educator

**Activities, other Sections:** 1996 American Physical Therapy Association, Section for Education Adopt-a-doc

**Activities, APTA Chapter(s):** Delegate for the North Texas District to the Texas Assembly of the Texas Physical Therapy Association (1996, 2001).

**Activities, National:** American Physical Therapy Association, Clinical Residency and Fellowship Program Credentialing, Reviewer Subcommittee Member (2007 – present); APTA Education Strategic Planning: Participant (August 21 - 22, 2005); American Board of Physical...

Prior Experience: My experiences related to geriatric practice, professional and postprofessional education, and professional organizational service make me well qualified for the responsibilities of a director. I have practiced in the area of geriatrics for 29 years and continue a practice part-time to maintain my specialization. I have extensive experience in various roles that help therapists develop professionally. I served as Co-editor of the Section’s home studies in 2001 and then as Editor from 2002-2007. I surveyed members to determine their professional development needs, and fostered the development of new authors and future editors. In that role, I also attended Section board meetings at CSM and became familiar with the activities of the Board. My knowledge of the specialization process comes from 4 years on the Geriatric Council and 4 years on the American Board of Physical Therapy Specialties where I was able to promote geriatric practice at the highest level. Since 2007, I have been involved in the APTA Clinical Residency and Fellowship Program Credentialing as a reviewer subcommittee member. As Chair of the Education Committee of the Texas State Board of Physical Therapy Examiners from 1999-2008, I was instrumental in modernizing the rules for continuing education requirements for licensure renewal. As a Foreign Education PT Standards Committee member and then as FCCPT board member, I understand the educational challenges of foreign educated therapists and the need to maintain integrity in the licensing process. In my role as coordinator of postprofessional programs at Texas Woman’s University, I advise physical therapists about paths that may lead to (1) ABPTS specialization, (2) contemporary practice in line with APTA’s Vision 2020 through a tDPT, and/or (3) filling our profession’s faculty shortage by preparing physical therapists to transitioning to the academic environment by earning a PhD in Physical Therapy. I teach geriatric content in the entry-level and postprofessional levels.

Activities to Accomplish: The first activity I would like the Section to accomplish while I am on the Board of Directors is better communication and coordination between the “parts.” I believe the Section provides a variety of quality professional development opportunities for members from face-to-face programming at CSM, and regional courses including the new Certified Exercise Expert for Aging Adults course series, to “distance education” in the broadest sense (eg, home studies, the Journal of Geriatric Physical Therapy, the listserv, GeriNotes, and mentoring). I believe the leaders involved in these individual efforts would benefit from periodic group communication/planning so that each aspect builds, reinforces, and supports the others and so that we do not compete with ourselves. Since each Section endeavor has different planning timelines, some years in advance, this is a long term goal.

The second activity I would like the Section to accomplish while I am on the Board of Directors is a better assessment of learner outcomes across the entire spectrum of professional development. Programming and publications are costly to produce. Are member learners getting the outcomes they expect? APTA is working on the development of evaluative methods for face-to-face CE offerings, but the Section could pilot ways to determine learner outcomes in other arenas. Do the Section’s home studies, the Journal of Geriatric Physical Therapy, the listserv, GeriNotes, and mentoring experience help you in your practice? Knowledge of outcomes will help us be fiscally responsible.

The third activity I would like the Section to accomplish while I am on the Board of Directors is to explore ways that the Section can better serve members who seek Board specialization and provide additional resources for members seeking to start geriatric residency programs.

Greatest Challenge: Physical therapists working with older adults across settings face a number of challenges that compound upon one another. Just as I rarely have a patient with a single problem, these challenges are not singular. Insufficient numbers of physical therapists committed to geriatric practice probably results from inadequate reimbursement, but it also fosters practice which does not meet current standards of being evidence-based and efficacious. Pressures on our day-to-day practice force us to be vulnerable to cutting corners in an ever changing health care environment, and make us neglect our own well being and professional development. We may feel isolated in our geriatric practice because of our affinity for older adults and our wish to be better at what we do. The Section plays a major role in combating our isolation in practice, responding to work force needs, providing models of practice that include balance in our personal lives, and providing resources in clinical and administrative areas. The Section is a virtual place where like-minded physical therapists can exchange ideas, experiences, and research evidence we can incorporate into practice.

NOMINATING COMMITTEE
1. Please describe what attributes you value in a candidate. How would you identify individuals who meet these qualifications?
2. How would you go about developing new leaders within the Section?
3. What skills and experience qualify you to serve on the Nominating Committee?

PATRICE ANTONY, PT, GCS, CAPS

Residence: Orlando, FL
Credentials/Degrees: PT, GCS, CAPS
Employment: Elder Advocates, Inc. and Adaptable Living Design LLC
Section Membership: 31 years
APTA Membership: 31 years
Activities, SoG: Nominating Committee Chair for the Section on Geriatrics, APTA, 1997-2000 and 2003-2005; Editorial Board for GeriNotes (Section on Geriatrics publication) current
Activities, other Sections: Nominating Committee, Educational Commit-
Activities, APTA Chapter(s): Florida Physical Therapy Association - member 09/1978 to present

Attributes in a candidate: I look for candidates who show initiative and a track record in attendance at conferences and SOG business meetings. I realize that the current economy may limit the ability of individuals to attend out of state conferences, but there are many ways to be involved with the Section including serving on a committee, participation with the list serv, publishing articles, serving on the editorial board of a journal, and becoming a certified specialist. The Section needs "new blood" to stay fresh and on the leading edge. It is important to recruit experienced leaders, but also to mentor new leadership for the future.

Developing new leaders: We need to encourage and recruit new/enthusiastic members to serve on committees and mentor them into leadership positions. I think that members need to know the value of networking with leaders across the country and the many ways that this network can enhance career opportunities and growth. The tremendous relationships that I have nurtured and relied upon throughout my career have sustained me in tough economic times and provided value added service to the patients that I work with. I don't think that newcomers realize how valuable that is. This is not something that happens with a couple of months of effort, but something that grows with years of investment.

Skills and experiences: I have been a member of this Section for over 25 years. I have served on the Nominating Committee twice for 3-year terms each time, and have chaired the committee through very big election periods. I am very familiar with the nominating committee process and its inherent deadlines, and I have a working knowledge of the leadership within the SOG. I currently have 2 growing businesses with a vast network of contacts and feel that my knowledge of “people” make me a good candidate for this position.

KATHRYN BREWER, PT, GCS, MEd
Residence: Phoenix, AZ
Credentials/Degrees: PT, GCS, MEd
Employment: Mayo Clinic

Section Membership: 20+ years
APTA Membership: 34 years

Activities, SoG: Joan Mills Award; GeriNotes editorial board (98 – current); Delegate (2 terms); CSM Program committee; previous nominating committee member

Activities, APTA Chapter(s): PT of the Year AZ – 2006; Nominating committee (current); Public Relations Committee (current); Community Advocacy Committee (current); district chair (past)

Activities, National: Steering committee reviewing the National Action Plan for Falls Prevention; APTA liaison to the National Council on Aging; APTA liaison to the American Geriatric Society; abstract/program review for annual meeting.

I feel that the Nominating Committee is an often overlooked, yet vital place to serve the association. Identifying, recruiting, mentoring, and retaining Section leadership is a year round task and deserves a dedicated effort. I have consistently made time in my professional life to participate within APTA at a state and Section level. I have always found the benefits to far exceed the costs and would look forward to this continued opportunity.

Attributes in a candidate: Though experience, collaboration, communication skills, diversity, accessibility, flexibility, and open mindedness are all great credentials—the greatest in my mind is passion. Individuals with passion for their work and their profession are transparent. Their enthusiasm, creativity, and dedication speak volumes about who they are as a professional. Through advocacy, education, and excellence in practice, they contribute to the efficacy of optimal physical therapy practice for the aging population. Identifying and recruiting candidates requires networking throughout the Section and being present at Section functions. Recommendation from faculty and managers, peers, and friends who see potential is the first step to identifying our future leaders. Working with candidates to match skills and interests to the right position, both now and in the future is the responsibility of the nominating committee members.

Developing new leaders: Leadership development is a process not a task. Mentoring committee members and volunteers, encouraging them to take on more responsibility, and celebrating their successes contributes to building of self confidence and the willingness to move to the next level. Maintaining existing leadership is also necessary, perhaps identifying fresh and challenging roles for them.

Skills and experiences: I have been an active member of the state association in Arizona since 1980, participating in leadership at a variety of levels including Public Relations and Community Advocacy committees, and current Nominating Committee. I have been involved with the Section on Geriatrics as Section Delegate and Board member 2002 - 2007, a member of the GeriNotes Editorial board since 1998, Nominating Committee member 1998-2000, CSM Program Committee since 2002 and CSM Preconference Program Chair, 2000-2002. At the national level, I have been involved with several committees, task forces, and projects which have allowed me to become familiar with the leaders, staff, and resources at APTA on a first hand basis. This experience across the organization has exposed me to many individuals who possess the qualities and characteristics needed to be a successful and effective leader. I believe that I am sufficiently networked throughout a variety of education and practice settings and professional communities across the country to help identify those who have passion for their profession and are ready for service at the Section leadership level.
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Please contact: Anna Charles, Regional Therapy Recruiter p: 866-667-1813 AICharles@SavaSC.com

NC & SC
Please contact: Tiffany Dawn Vinci, Regional Therapy Recruiter p: 877-517-8391 TDVinci@SavaSC.com

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*A Student Contest for PT and PTA Students: Creating Patients Handouts*

PT and PTA students throughout the nation are creating consumer/client instructional materials. Brochures created over the past 3 years are available on our Web site, and are a valuable resource to the clients we serve (see www.geriatricspt.org, Consumers, Patient Education Brochures).

Winning handouts will be displayed at the Section booth at APTA’s 2010 Combined Sections Meeting. Authors will be recognized through the display, in GeriNotes, and on the Section’s Web site. The handouts will be available for clinicians to download and print for client care and instruction.

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The years teach much
which the days never knew.

- Ralph Waldo Emerson
To members of the Bone Health Special Interest Group, Falls & Balance Special Interest Group, and the Health Promotion & Wellness Special Interest Group:

At the annual business meeting to be held in February 2010 at Combined Sections meeting, there will be a vote to modify the SIG's standing rules. At the same meeting, elections will be held for new officers:

- Bone Health SIG will elect a Vice-chair & 1 Nominating Committee member
- Balance & Falls SIG will elect a Chair, Vice-chair, Secretary, & 1 Nominating Committee member
- Health Promotion & Wellness SIG will elect a Vice-chair, Secretary, & 1 Nominating Committee member

If you are interested in serving in any of these roles, please contact the respective nominating committee members:

For HPW: Donna Bainbridge @ dbridge@montana.com
For Bone Health: Cindy Horn @ cindy1800@comcast.net
For Balance & Falls: Judy Daniel @ jdaniel@hcrhealth.com

The revised standing rules for each SIG as well as Candidate's statements will be posted on the SIG's respective pages on the Section on Geriatric’s Web site by November 1, 2009. Notification to members about the posting will be made via email.

Thank you!