GeriNotes

January 2021 • Vol. 28 No. 1

APTA Geriatrics
An Academy of the American Physical Therapy Association
Age on.™

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APTA Geriatrics
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Age on.

From the President

Greg Hartley
President,
APTA Geriatrics

As my tenure as President of APTA Geriatrics comes to an end, I find myself reflecting on the work of the Academy: its volunteer members (***you***), its staff, its SIG and committee leadership, and its Board over the past 3 years. I am proud of (and amazed by) the multitude of things we have accomplished in just a few years.

- We completed our brand alignment with APTA and successfully launched a rebranded Academy, reframing aging for the future. While much work remains to be done, we have already seen benefits from this new campaign. Concurrently, we updated and expanded our social media presence including Facebook, Instagram, Twitter, and (soon) YouTube and LinkedIn. We welcomed new staff in October of 2019 who have already improved operational and strategic efficiencies from top to bottom. Under the executive directorship of Christina McCoy, CAE, and the rest of our *amazing staff*, we are poised to accomplish even more extraordinary things in the coming years!
- Under the leadership of Editor-in-Chief Dr. Leslie Allison, the *Journal of Geriatric Physical Therapy* increased its impact factor and is now among the top ranked journals worldwide (#6 of 68 in the rehabilitation category).
- The Research Committee developed and published an updated Research Agenda which was shared with the Foundation for PT Research.
- Our online Journal Clubs have become very popular and now fill to capacity.
- *GeriNotes* successfully converted to a sleek digital format and is now a searchable/citable publication largely thanks to the work of Editor Dr. Michele Stanley and APTA Geriatrics staff.
- Though face-to-face course instruction paused in 2020 due to COVID, our Regional Courses (CEEAA, ACEEAA, and more) flourished in the 2 previous years. We look forward to resuming these courses in multiple formats, enabling us to expand their reach in the coming year. Participation in webinars and home study courses grew far beyond our projections, and we saw record attendance at CSM 2020 in Denver.
- All of our educational resources including certification courses, webinars, and home study courses, etc., are now housed in the new APTA Geriatrics Learning Center, a platform designed to streamline continuing professional development for all of our members.
- Our SIGs created some amazing resources, like the Falls Prevention Awareness Toolkit, the Outcome Measure Toolkit, Bone Health SIG Flash!, a Community Bone Health Presentation, a fact sheet on Delirium, a webinar on Encouraging Older Adults to be Physical Active While Sheltering in Place, and a PPT presentation intended for community audiences on Physical Activity: A Key to Successful Aging.
- We continue to provide funding to developing geriatric residency programs and residents.
- Our GCS Prep Committee has established a mentoring network, connecting PTs seeking Board Certification in Geriatrics to volunteer mentors from across the country. That program filled to capacity virtually overnight.
- We established the Carole B. Lewis Lecture, the Academy's flagship annual scholarly lecture award.
- We continue to develop clinical practice guidelines and other evidence-based documents that are made avail-

APTA Geriatrics, An Academy of the American Physical Therapy Association

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GeriNotes

Mission: To provide engaging content that empowers the community of physical therapy clinicians to build expertise and expand the delivery of evidence-informed care that promotes health and wellness in aging adults.

Vision: To create an evolving online community through which clinicians develop their knowledge and skills based in shared ideals that are person-centered; and promote a world where aging adults move, live, and age well.

able open-access when published.
- We moved to an online volunteer portal to manage all member engagement opportunities within the Academy.
- Our Delegate and others successfully lobbied for national APTA bylaw changes that resulted in Academy Delegates (2) getting a vote in the House of Delegates for the first time in the history of APTA.
- We've advocated on behalf of patients, caregivers, and our members for fall prevention coverage under Medicare, stopping planned CMS payment cuts, allowing PTAs to treat under TriCare, permitting the ability to provide telehealth services within Medicare during a pandemic, and building a framework for a unified post-acute payment system. And, we have written op-eds, letters to editors, or completed interviews in the *New York Times, Washington Post, Reader's Digest*, and the *New England Journal of Medicine* to name a few.
- We responded to the COVID-19 crisis by participating in the PACER Project and by quickly providing a dedicated webpage for resources and tools to help clinicians, patients, and caregivers in what have been unchartered waters for nearly all of us.
- We published a strong statement condemning racial injustice and formed a task force devoted entirely to diversity, equity, and inclusion. Their important work will impact *everything* we do going forward.
- We also created task forces for *Best Practice, Governance/Bylaw Review, Partnerships, Post-Acute Payment Reform*, and others. We forged new alliances with the National Senior Games Association and the National Council on Aging and developed consumer and clinician focused resources in partnership with them.
- We converted our annual student contest for patient education brochures to patient education videos which you will see this year.

In November, the Board spent several days developing what will become our new strategic plan, guiding the organization through the next several years [see page 30]. I am very much looking forward to even more exciting changes within the Academy; engaging and re-engaging our members, expanding our reach ***and*** our influence, and pushing all of us toward excellence in care of aging adults.

As I pass the gavel to President-Elect Dr. Cathy Ciolek, I won't be far away. I look forward to assisting in shepherding the Academy through the next 3 years as your Vice-President. Finally, 2021 is APTA's Centennial Celebration. *What an amazing journey we have had*. Happy 100th APTA! #AgeOn.

Incoming 2021 Academy Leadership *terms begin February 2021*

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Cathy Ciolek, PT, DPT, FAPTA
Board Certified Geriatric Clinical Specialist
Certified Exercise Expert for Aging Adults™
Elected Term Expires 2024

Vice President
Greg Hartley, PT, DPT, FNAP
Board Certified Geriatric Clinical Specialist
Certified Exercise Expert for Aging Adults™
Elected Term Expires 2024

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Certified Exercise Expert for Aging Adults™
Elected Term Expires 2024

From the Editor

Michele Stanley
Editor,
GeriNotes

Happy Birthday to us, Happy Birthday to us! Happy Birthday APTA . . . you get the picture.

Usually the January issue of *GeriNotes* is all about upcoming CSM excitement and plans, but, well you know. COVID. Dang it! I may now have transitioned chronologically into the category of "older adult," but I was really looking forward to celebrating at Disney World. True confession: I still believe in the "happiest place on earth" press and was, maybe, just as excited to think about the planned centennial hoop-la (can you imagine how FUN it would have been to have a whole park filled with ONLY the PT crowd for a night?) as the chance to immerse myself in stimulating presentations and discussion with colleagues as well as the Tai Chi 2 pre-con that I was looking forward to.

All is not lost. APTA Geriatrics has some pretty exciting presentations scheduled including the Carole Lewis Award presentation by rockstar Dr. Richard Bohannon on Thursday, Feb 4. The really cool advantage – even better than seeing Mickey and Minnie – this year is that you won't have to choose between competing sessions – you can see them all! See dates and times for all APTA Geriatrics programming on page 7. Check out the posters and platforms too. And see programming for other sections here. Then register at www.apta.org/csm/registration.

Make sure that you "attend" the APTA Geriatrics Member Meeting, as well.

While you are waiting for February 1 and the beginning of CSM, check out this issue for thoughts from some of the founders of "the Section on Geriatrics" on how they intentionally age: you might want to be like one of them. Their pictures are fun.

COVID-19 has changed more than just the CSM experience, the resident's corner explores observed effects of how isolation has affected some seniors.

The challenges of COVID sparked creativity for students of a tDPT program to create their own ways to brighten up the lives of patients: enjoy the Encouragement Calendar that resulted.

The really cool advantage this year is that you won't have to choose between competing sessions – you can see them all!

An entertaining but sobering read, a PT student shares his experience with the health care system, his mother, and the concept of return to prior level.

Learn about a test you may have never used (BOOMER: Balance Outcome Measure for Elder Rehabilitation) and the focus of this month's JClub [see page 22].

Balance is always on a PT's radar: Carole Lewis and Linda McAllister share some research thoughts about more commonly used tests in GetLIT.

A new year brings new beginnings. Congratulations to the newly elected officers of APTA Geriatrics Board of Directors and all the SIGs. Thank you to outgoing members for their service during this challenging time. Watch for upcoming meetings of the SIGs; the virtual format should make attending easier! #AgeOn

New! *register for the JClub discussions , now in a free webinar format and get 1.5 CEUs. Questions for presenters may be emailed to gerinoteseditor@gmail.com before or on day of webinar.*

GeriNotes

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Newsletter Deadlines:
February 1
April 1
July 1
September 1
November 1

Statement of Frequency
5x/year:
January
March
May
August
November

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

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APTA **Combined Sections Meeting**

Feb. 1-28, 2021

APTA members can register for APTA CSM for as little as $150.

- Choose from hundreds of cutting-edge on-demand sessions.
- Experience live content from all 18 specialty sections.
- View hundreds of digital posters featuring audio narration.
- Gain up to 2.0 CEUs (20 contact hours).
- Chat with speakers and poster presenters.
- Take a postconference course, available for an additional fee.

Registrants will have unlimited access through March 31, 2021!

APTA Geriatrics Member Meeting

Wednesday, February 24, 8:00-9:30 PM ET

- Annual Awards Celebration
- Presentation of New Leadership
- State of the Academy
- Recognition of the GSC Class of 2020
- Pass bylaws changes

Special Interest Group meetings are tentatively scheduled for the following dates and times and will be held via Zoom.

February 22	Global Health, 7:30-8:30 PM ET
February 23	Balance and Falls, 8:00-9:00 PM ET
March 1	Residency and Fellowship, 8:00-9:00 PM ET
March 2	Bone Health, 8:00-9:00 PM ET
March 3	Cognitive and Mental Health, 8:00-9:00 PM ET
March 4	Health Promotion and Wellness, 8:00-9:00 PM ET

PRE-REGISTRATION OPENS IN EARLY JANUARY AND IS REQUIRED FOR THESE MEETINGS
geriatricspt.org/events/csm/2021/

APTA Geriatrics Poster and Platform Abstracts for CSM 2021 have been published online-only in conjunction with the Journal of Geriatric Physical Therapy's first issue (44(1)) of 2021.

Stay up to date with current research in the field, and prepare for CSM 2021, by reviewing these Poster and Platform abstracts!

APTA Geriatrics

An Academy of the American Physical Therapy Association

Thursday, February 4, 2021

7:00 PM - 8:30 PM

GR-6076 Carole B. Lewis Lecture Award - Scholarship and Practice as Symbiotic Agonists

Richard W. Bohannon, PT, DPT, EdD, FAPTA

Thursday, February 11, 2021

7:00 PM - 8:30 PM

GR-7489 Get Your Foot in the Door With Competitive Aging Athletes: Developing an Engagement Strategy

Becca D. Jordre, PT, Mike T. Studer, PT, MHS, FAPTA and Kimberly Nowakowski

8:30 PM - 9:00 PM

GR-6133 Maintenance Therapy Jitters? Understanding Right Place, Right Time, and How To Document Maintenance Appropriately

Jaclyn Kay Warshauer, PT, Mary L. Saylor-Mumau, PT, MPT and Rebecca Setaro

9:00 PM - 9:30 PM

GR-6493 Assessing Cardiorespiratory Fitness for Exercise Prescription and Clinical Decision Making in Chronic Stroke and Frailty

Sherry Osborn Pinkstaff, PT, Chitra Lakshmi K Balasubramanian, PT, PhD and Carroll E. Robinson, PT, DPT

9:30 PM - 10:00 PM

GR-6473 Pills and Spills: An Assessment of Medications and Fall Risk in Older Patients

Kelly L. Covert and Courtney D. Hall, PT, PhD

Thursday, February 18, 2021

7:00 PM - 7:30 PM

GR-6014 The Older Adult With Limb Loss: Specialized Care for a Special Population

Daniel Joseph Lee, PT, DPT, PhD and Carol Ann Miller, PT, MSPT, PhD

7:30 PM - 8:00 PM

GR-7448 Getting Older Is Not for the Weak: Geriatric Rehabilitation for the 21st Century

Jennifer Elaine Stevens-Lapsley, PT, MPT, PhD, FAPTA, Daniel Joseph Malone, PT, PhD, Allison Gustavson, PT, DPT, PhD, Katie J. Seidler, PT, DPT, MSCI, Tyler Bjorhus, PT, DPT and Sara Ochoa, PT, MOMT

8:00 PM - 8:30 PM

GR-6046 Age-Friendly Health Care: We Can Help Make It Happen!

Cathy H. Ciolek, PT, DPT, FAPTA, David W. M. Taylor, PT, DPT and Rachael Walton-Mouw, PT, DPT

8:30 PM - 9:00 PM

GR-6471 Using Movement System to Manage Pain and Reduce Fall Risk in the Elderly

Pradip Kumar Ghosh, PT, PhD, Myla U. Quiben, PT, PhD, DPT, MS and Jill Elaine Heitzman, PT, DPT, PhD

8:30 PM - 10:00 PM

GR-7439 The Future Is Already Here: Super Aging Society in the Global Community

Soshi Samejima, PT, DPT, ATC, PhD, Yuri Yoshida, PT, PhD and Deborah L. Doerfler, PT, DPT, PhD

Thursday, February 25, 2021

7:00 PM - 8:30 PM

GR-6878 Why Words Matter: Facilitating Behavior Change Using Health Coaching in Older Adults

Catherine Frances Siengsukon, PT, PhD, Janet R. Bezner, PT, DPT, PhD, FAPTA and MarySue Ingman, PT, DSc

Tuesday, March 2, 2021

10:00 AM - 6:00 PM

GR-6062 Advanced Topics in Dementia

Cathy H. Ciolek, PT, DPT, FAPTA

GR-6130 Age on: Maximizing the Performance of the Geriathlete (2-day Post-conference Course)

Mike T. Studer, PT, MHS, FAPTA, Joel Sattgast, PT, DPT, Becca D. Jordre, PT, Peter C. Barusic, PT and Christopher Johnson, PT

Wednesday, March 3, 2021

10:00 AM - 6:00 PM

GR-5973 Tai Chi Fundamentals for Professional and Personal Wellness

Kristi Hallisy, PT, DSc

GR-6130 Age on: Maximizing the Performance of the Geriathlete (2-day Post-conference Course)

Mike T. Studer, PT, MHS, FAPTA, Joel Sattgast, PT, DPT, Becca D. Jordre, PT, Peter C. Barusic, PT and Christopher Johnson, PT

Register at
www.apta.org/csm/registration

Policy Snapshots for the New Year

by Ellen R. Strunk PT, MS

Nursing Home Resource Center

CMS has a one-stop shop for all things nursing home. There are pages dedicated to providers and other Centers for Medicare and Medicaid Services (CMS) partners, as well as patients and caregivers. On the Providers page, find quick links to regulations and guidance, training and resources, technical information, payment, policy and COVID-19 updates. On the Patient and Caregiver side, there are quick links to finding a nursing home, resident's rights, and COVID-19 information and resources. Bookmark it! https://www.cms.gov/nursing-homes

Is your state collecting SNF PDPM information for Medicaid?

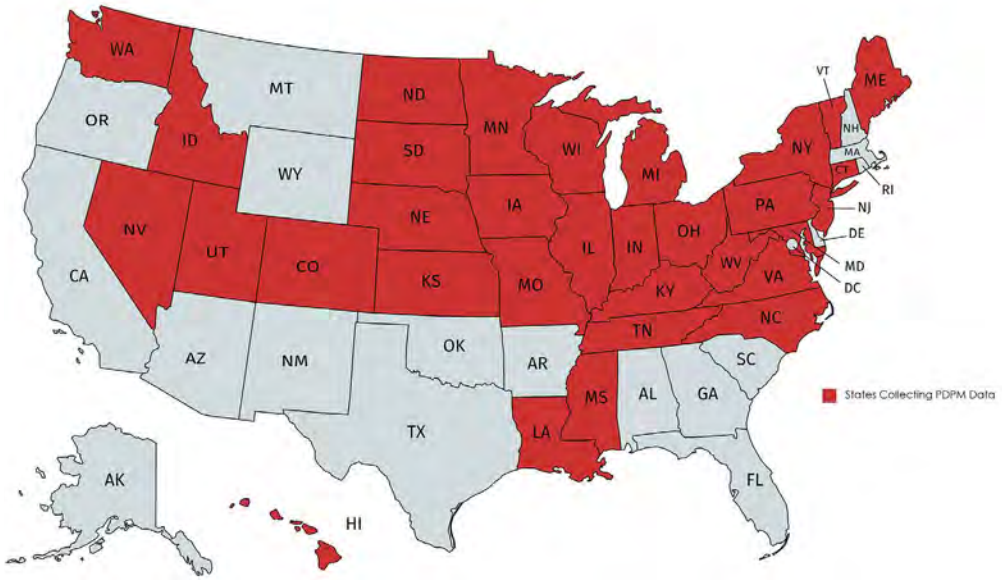
Effective Oct. 1, 2020, several states began collecting Minimum Data Set (MDS) items that contribute to a Patient Driven Payment Model (PDPM) payment category on the quarterly and annual assessments. As you may recall, CMS had originally said they would stop supporting all Resource Utilization Group (RUG) software once the PDPM was implemented. There was a fairly significant outcry from the provider community and state Medicaid agencies, since currently more than 35 states use a RUG-based case-mix methodology to determine their Medicaid daily rates for long term care. In fact, some states are still using the RUG-III-34 grouper. CMS acquiesced, but now many states are interested in collecting this data on their long-term care residents in order to begin modeling what their case-mix system might look like using PDPM. The states in red on the map are those that are collecting MDS data since Oct. 1,2020. The District of Columbia (DC) and Delaware (DE) were undetermined at the time of this writing. CMS has created a system where states can "elect" to begin collecting the data at any time. Once they elect to, their Omnibus Reconciliation Act (OBRA) regulatory assessments will be populated with these items.

What sections will be new? States will begin collecting new Section I and J information as well as Section GG. Its important for nursing homes to have a mechanism for monitoring whether their state elects to begin collecting this information, since it could occur at anytime during the year.

PTAs can now perform maintenance therapy under the Medicare Part B benefit

The Medicare Physician Fee Schedule (PFS) final rule for 2021 did not include a lot of "good" information. However, one piece of good news is that CMS finalized the decision to make permanent the policy for maintenance services when provided by a physical therapist assistant (PTA) or occupational therapist assistant (OTA).

While PTAs and OTAs have been able to perform maintenance services in the skilled nursing facility (SNF) under the Part A benefit, they were unable to provide this valuable service under the Part B benefit. That is, until the Public Health Emergency (PHE) related to COVID-19. This was one of the waivers CMS granted early on in the pandemic. In this final rule, they made the decision permanent. Therefore, once a physical therapist (PT) or occupational therapist (OT) establishes a maintenance



program, then the PTA or OTA (respectively) can perform that service, as clinically appropriate.

PT Codes on telehealth services will remain billable . . . at least for a while

The Medicare PFS also finalized the addition of some PT codes to the Medicare telehealth list, but only on a "Category 3" basis. That means some services provided using telehealth methods will be paid at the rate they would have been if they had been delivered one-to-one in person. The Category 3 status means this policy will stay in place until 12/31/XXXX of the year the COVID-19 PHE ends. For example, if the COVID-19 PHE ends on:

June 30, 2021	these services can be provided and billed using telehealth through	**Dec 31, 2021**
Feb 1, 2022	these services can be provided and billed using telehealth through	**Dec 31, 2022**

**NOTE: Telehealth means the services are provided by real-time, two-way audio/video technology.

What codes does this include?

97161	97162	97163	97164	97165	97166
97167	97168	97110	97112	97116	97535
97750	97755	97760	97761	92521	92522
92523	92524	92507			

VA confirmed PTs and PTAs can practice in any state

In November, the Department of Veteran's Affairs (VA) released an interim final rule (IFR) that confirms health care professionals may provide services in a state other than the health care professional's state of licensure. They can do this as long as they practice within their scope of practice and VA employment requirements. In other words, VA health care professionals don't have to be concerned about state regulatory boards alleging unlicensed practice against them.

The aim of the rule is to ensure consistency throughout the VA system, whether those services are provided in-person or via telehealth. Any health care professional employed by the VA system is covered under this rule. The rule does not apply to contractors working in VA medical facilities or the community. The VA plans to develop national practice standards through a subregulatory process.

HH final rule

The Home Health (HH) Prospective Payment System (PPS) final rule was released in November 2020. Overall, HH agencies are expected to see a 1.9% pay increase in calendar year 2021. Other than that, there was not a lot of "new" news. The rule did establish that HH Agencies can use telecommunication technologies or remote patient monitoring to provide care to its patients, as long as those services are included on the plan of care. The documentation should also support what services were delivered via these methods and why they are medically necessary. However, the services cannot substitute for in-person visits. Therefore, they will not count toward the Low Utilization Payment Amount (LUPA) threshold for that patient. CMS also stated that if a patient does not want to receive services through telecommunications technology, the HH must provide all services in person.

Have you heard?

The Office of Inspector General (OIG) announced in October that they were adding a new topic to their Work Plan: Medicare Telehealth Services During the COVID-19 Pandemic: Program Integrity Risks. Their review is going to look at Medicare Parts B and C data and will identify any potential program integrity risks associated with the numerous waivers and flexibilities CMS granted during the PHE (Public Health Emergency). Specifically they are going to look for provider billing patterns that may stand out. They expect the work to be completed in 2021.

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Ellen R. Strunk is President and Owner of Rehab Resources & Consulting, Inc., a company providing consulting services and training to providers in postacute care settings with a focus on helping customers understand the CMS prospective payment systems. She also lectures nationally on the topics of pharmacology for rehabilitation professionals, exercise and wellness for older adults, and coding/ billing/ documentation to meet medical necessity guidelines and payer regulations.

Age: The Passage of Time

Personal experiences and thoughts from some early Academy of Geriatrics leaders

by Tim Kauffman PT

Editor's Note: This is a special feature in observation of the APTA centennial. Special thanks to Tim Kauffman who organized the interviews with Steve Gudas, Fran Kern, Bette Horstman, Dale Avers, Neva Greenwalt, Osa Jackson-Schulte, Carole Lewis and Jennifer Bottomley. Answers published below are in random order for each question to preserve some privacy. Not all interviewees answered each question, answers were transcribed to preserve content while conserving space.

Chronological aging can't be stopped; healthy aging is what everyone wants. Life expectancy in the United States in 1920 was 53.22 years[1]; the American Physical Therapy Association was founded in 1921. In 1978, the year the Section on Geriatrics was founded, life expectancy had increased to 69.6 years for males and 77.3 years for females.[2] Today, the projected 2020 life expectancy in the United States is 79.11 years for men, 81.65 years for females based on 2019 United Nations data that did not reflect COVID-19 impact.[2]

Chang et al used the Global Burden of Diseases, Injuries and Risk Factors Study 2017 and determined the disability-adjusted life-years (DALYs) in 195 countries to compare changes in aging. They reported that people age 65 years had different health burdens based on DALYs and socio-demographic Index.[3]

Poor health in older age increases risk of death, but the tricky part is that problems of aging go beyond disease. Impairments in cognition, mood, and physical function are all relevant, even when not disabling.

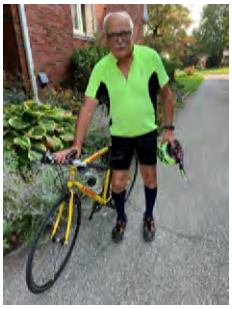
A broader approach to age-related health changes is the concept of frailty.[4] The frailty index score recognizes that health problems other than diseases are important and is useful in understanding the complexities of aging. Accumulation of age-related disease may be inevitable, although with variable extent. Physical therapists focus geriatric care as prevention of disease, more importantly, prevention of the accumulation patterns of loss of physical and medical function that often accompany disease burden.

How, then, do physical therapists themselves age? Do years of clinical patient care, observation of rehabilitation, continued learning through research, and continuing education courses change outcome?

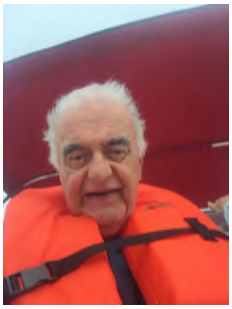
Herein are responses to questions about the personal aging of some of the early leaders and founders of the Academy of Geriatric Physical Therapy (APTA-Geriatrics). These people practiced, taught, wrote, and lived gerontology and geriatric health care. Many of their names are very familiar. Likely at least 1 was your professional role model. Four decades ago they built the foundation of our present Academy, starting as the Section on Geriatrics, and dedicated their professional lives to rehabilitation of older persons and making aging a wonderful and positive experience. How have these knowledgeable ones faired with the passage of time?

How do physical therapists themselves age? Do years of clinical patient care, observation of rehabilitation, continued learning through research, and continuing education courses change outcome?

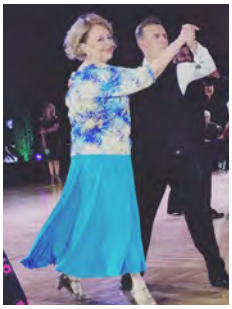
Early SOG leaders interviewed for this story



***Tim Kauffman** joined the APTA Geriatrics Board in 1978. He held positions as Research Committee Chair and Director and is ex officio the historian for the Academy.*



*At age 28, **Steve Gudas** was a charter member and served on the first Board of Directors of the Section on Geriatrics. He was Membership Chair and then Program Director for 2 years.*



***Fran Kern** was the Editor of Geritopics from 1981 to 1983. She also held positions on the Nominations Committee and Board of Trustees for the Foundation for Physical Therapy.*

Do you feel you have aged?

- Yes. It was nearly 45 years ago when I started my gerontology study. If I could stop physical aging I would.
- I have aged, but feel healthy for the most part at age 71. Getting up from the floor or ground is difficult. Balance has changed and one has to be careful.
- Yes, of course. Every day brings new challenges to maintain what's possible and substitute for failing abilities.
- Yes. I have severe decreased hearing and initially refused hearing aids. "It will make me feel and look old," I said. I am instantly aware of the need to hold a banister when descending stairs. I do not feel my age.
- No question. Despite daily exercise, continued work as a PT in clinical settings, good nutrition, and an optimistic attitude, the parts have succumbed to wear and tear. My agility and balance are affected, even when I focus on these during my exercise. Taking 1 day of exercise off results in a two-to-three day catch up to get back to my baseline! I've experienced the results of a fractured distal femur as a result of a fall. I have had a TKR and am currently dealing with advancing spinal stenosis.
- I have been a physical therapist for nearly 45 years. My physical body has aged, well, I hope. But I don't feel a lot different.
- Since the first time I became involved with [the study of aging] I have changed both in my ideas about aging and my attitude about aging. As a college student, I could not imagine being over 50 in a retirement setting and myself responding to physical therapy care. By the time I had been a practitioner for several years that had changed. I met Joan Mills and we established a clinical education affiliation for students in a county facility that only treated older adults. This association led to my becoming a founding member of SOG. Over the years I have changed in many ways and many would say that it is aging. I view it as changing some in physical and mental capabilities. From an intellectual perspective I have always seen myself as part of a community without a numerical age identification.
- I have aged in my physicality and yet I still explore walking, running, and hiking as favorite activities. I do not like some of the changes I have no control over and yet, as my mentor Dr. Feldenkrais pointed out, most high performers do not even use 15-20% of their brain capacity. I believe in exploring to have access to my reserves. I do not even know what I have hidden in my "blind spot" (all those decisions I made as a child or young adult not to use some strategy to avoid rocking the boat and to be accepted and feel safe). I must admit that I do not reflect on age and aging as much as I explore daily ways for maximizing my performance in life. I found that the more I studied gerontology, the documented aging trends can easily be interpreted as a story of decline. I began during my doctoral training to look for performance enhancement possibilities. The Norwegians were my inspiration as many could cross country ski at the age of 80 with heavy packs to finish a race called the Birkebeiner. So, I have become a "functionalist" as time has marched on, granting me many amazing experiences and much new learning.

I'm very aware of the need to be cautious, to live "carefully," and avoid foolish physical mistakes while continuing to live to the fullest.

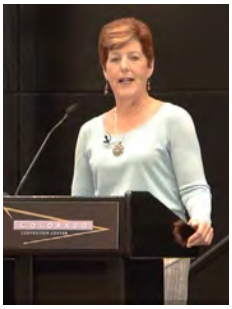
Consensus:
Yes, many feel they have aged.

In what way have you aged and how are you preventing it?

- I stayed active and worked until age 69. I walk frequently and stay active and involved.
- I'm very aware of the need to be cautious, to live "carefully," and avoid foolish physical mistakes while

Early SOG leaders interviewed for this story

Bette Horstman *is a chartner member and held several positions including Chair, Chief Delegate, and Vice President. She was the SOG representative to the White House Conference on Aging in 1981.*



Dale Avers *was Secretary, Director, Vice-president, and President of SOG. She has held multiple committee and task force positions. She presented the Carole B. Lewis Distinguished Lecture in 2020.*

Neva Greenwalt *was a charter member and Secretary of SOG. She presented the first statement on aging to the APTA HOD and organized the first international course on aging for PTs through the WHO.*

continuing to live to the fullest. Several times a week I get down on the floor and prove that I can get up again without any assistance of nearby structures.

- Swimming is a helpful activity. I love daily walks – though only going 2-3-mile bouts where I once would easily do 5 miles or more. My endurance is less despite my attention to staying fit. I do daily stretching/Yoga – a must to assist in balance and flexibility, proprioception, and kinematics.
- I notice a decrease in power, having to pause between repetitious jumps, not getting as high, not being able to go as long. It used to be easy to walk a 15-minute mile. Now I have to consciously push myself to keep that pace. I'm stiffer (joints) and I have an assortment

I exercise hard, weight lift and bike, which is magic for my joints. I really feel it when I don't get that 30-minute bike ride in.

of knee and hip pain at times, but a majority of the time I have no pain, in spite of bone-on-bone arthritis that the orthopedist said he would be happy to replace with a TKA. That will be the day! I exercise hard, weight lift, and bike, which is magic for my joints. I really feel it when I don't get that 30-minute bike ride in. I also find I can't garden for 8 hours straight (I'm down to six), and I"m really tired after. I have developed a concern about falling when negotiating certain obstacles – the concern comes from knowing that if I did break something, the long rehab road that might result.

- I gave in and accepted hearing aids, now I have an annual auditory checkup. I began simple balance exercises and try to do them daily. I stepped up physical activities (gardening, walking the dog) without success. I tried adding a third weekly bowling date.
- Taking advantage of new activities and challenges, while being committed in some way to previous interests is my way of changing over time. I try to change habits as more information is available on physical activities and the importance of nutrition needs. Years ago, I was not a very physically active person and my diet was rather limited. Now I walk and eat a wide variety of fruits and vegetables.
- I try to be willing to take risks. I try new ideas or ways of doing daily activities is a part of my continual change. Since retirement, I have continued several leisure activities that are not physically challenging, like knitting and reading while beginning several others like raising dogs and doing more gardening.
- I have gotten lost in my journey of self-care/personal growth and empowerment multiple times in my life. When my son was ready to be born, I did not speak up and plan to have a midwife along in the journey. I forgot to listen to my truth, I got injured; by the Grace of God my son was born healthy. The pelvic floor injury taught me so much about how injuries need to be maximally rehabilitated, if possible, as compensations that are not ideal will develop and need refinement in the compensation patterns to support ongoing performance enhancement. I need more learning time on the floor to keep growing functional balance reactions as life keeps giving me new challenges.
- I need more self-care time as I am aging. I have more injuries that need to be problem solved to manage powerful performance emotionally, physically, mentally, spiritually, and sensorially. The biggest thing for me about aging is that there is so much baggage that builds up to be released. My biggest gift was discovering ways to get complete and then file past experiences in the past where they belong. When I do not do that, I am not as effective in living my created life; I can become a knee jerk reaction waiting to happen. Wrinkles are there with aging: off and on I resist and give in to my "looking good conversation" and buy some new crème. I have racked up many small and big injuries running, skiing, and just plain having fun travelling and living life. I require more precise and regular

Early SOG leaders interviewed for this story

Osa Jackson *was a founding member of SOG and served as Chair and Vice President. She practiced in Norway and later lectured for PT associations in Australia, Canada, Sweden and Denmark.*

Carole Lewis *is a founding member of SOG. She held positions as Vice Chair, Chair, Secretary and Public Relations Chair. She is also a regular contributor to GeriNotes.*

Jennifer Bottomley *was Chair of SOG, Vice Chair, Treasurer, Director, Education Committee Chair, and Editor of Gerinotes from 1998-2000.*

maintenance or self-care as the years have gone by. I have a commitment to stay fit so I can travel, run, and play with my family. I take actions to remain my agent, the person in charge of me, not letting other peoples' drama take me over. My best prevention is growing my relationship with God every day.

- Why would I want to prevent aging? It is part of life.
- I would love to be able to run (glide) over the trails/ streets and play rugby, soccer, and climb mountains, but that is in the past and I have no regrets. I have bilateral patellofemoral knee pain. I use my arms when getting down and up from the floor and I have a full rotator cuff tear. But despite no surgical repair, it is totally functional except for doing push-ups.

Consensus:
Losses happen. Keep active. Adjust

Were there contributing factors to your feeling of aging?

- No contributing factors – I do not take medications. I am in perfect health and tend to be a minimalist when it comes to health care.
- I have osteoarthritis and have had both hips replaced.
- I had been a runner and played many contact sports which lead to 3 knee arthroscopies over the years.
- I have pigmented villonodular synovitis (PVNS) that was diagnosed at age 11 and resulted in 5 subsequent surgical interventions. I think I can do as much as I used to do and get in trouble due to fatigue and muscle cramps. There is wear and tear on joints from life-long preference to keep moving. Perhaps I do not get enough sleep or balance rest with exercise.
- I should have paid attention to my mother's and father's medical history (severe hearing loss and cardiac problems) and informed my medical provider of family problems for possible help. I should have begun balance exercises sooner.
- There were years of caring for others who are now gone; I lost time to concentrate on my personal health and intellectual activities.
- My changes would have been different if my lifestyle had always been one of more different physical and intellectual activities.
- Living life?
- Aging at the physical level happens and the question is what do I make it mean? I choose to make it mean time has passed by and there is a lot more to learn and discover to keep me passionately engaged in the life journey of discovery. The option I have seen is people make age-related losses mean all kinds of things that disempower them. Then they give up on the most important mission: create love while learning and discovering how to be a mature adult. Big factors that I have been touched by are caregiver fatigue, resisting reality versus accepting what happens, getting an attitude and then the injuries were more likely to happen. Life-long learning about how to be mentally, emotionally, spiritually, and physically in the present; having a purpose that carries my life is the antidote to suffering and upset. Then there are those things that happen, like the ski bindings do not let go and I get a knee injury. Or falling on ice covered with snow that I did not see and breaking my tailbone. Then comes the work of acceptance of myself and others (the person who did not shovel their sidewalk and who had an uneven sidewalk) and the fact I had to sit on a donut pillow for school. Yes. I watch out for being overtired. Don't drive after midnight if you can avoid it, as the risk of a car accidents goes way up — so say the majority of patients I have worked with who have severe motor vehicle trauma.

Consensus:
How you live life is a factor in how you age.

Did you practice any special habits to deny aging or age as best one can?

- Denying aging to me is not healthy. Accept it and enjoy.
- Exercise! Eat nutritiously. Stay mentally, socially and physically active. I ride my bike 3-5 times weekly for an average of 140 minutes. I walk several days and keep my METS up with household activities.
- I exercise, but not enough. I'm still involved in the PT profession and I attend CSM every year.
- I made changes to the standard American diet by removing red meat, dairy, imiting salt intake. I do physical exercise, which includes walking on level streets or on a treadmill and engaging in ballroom dancing which is great for balance and posture. Mental stimulation comes from the challenge of playing duplicate bridge and keeping up with changing technology.
- I have a daily practice of sit-to-stand and balance exercises, multiple times. I frequently use pliers for opening cans and jars. I volunteer weekly at the local VA hospital and actively participate or am involved in organizations like Moose, VFW, sorority, and VA. I keep current on my electronic devices, computer and smart phone. I let friends and acquaintances know I am ready to offer solutions to their physical problems and follow through. I bowl and go to casinos!
- I try to exercise and stay functionally active around my home. I mostly succeed in eating nutritious food and maintaining a healthy weight. I seek to stay mentally active through writing, playing games, and being socially engaged with friends, as well as social justice activities, and staying physically active. I ride a bike 3-4

times weekly for at least 30 minutes. I walk most days and engage in instrumental household activities.

- No way I'm denying aging – just aging intentionally. I love aging and all it allows me to see and do. I exercise at least 150 minutes/week at moderate-intensity. I teach an exercise class for 50+ (boot camp style). I travel a lot, keep a positive attitude, keep mentally stimulated, and eat well. I've always believed in "everything in moderation, nothing in excess."
- Having an idea of what activities are projected for the day and then, as circumstances change, being flexible makes life more interesting. Of course exercise of some sort daily, partaking of fresh fruits and vegetables, as well as having social contacts by text and in person are daily musts.
- I age as best I can and seek education about the human body and the human spirit and what emotions are meant to be used for. I set healthy boundaries, find fun ways to exercise, and avoid high-impact sports as the trauma invites life-long distortions in functional alignment that will need lots of selfcare and learning time once you get past 60. I explore exercise buddies who can also be people who speak to bring out the best in me and invite me to look at the workability of my actions, "Is this what you want or what is it you want to create?" Move in the direction of fun, fulfillment, and things that enhance sleep, flexibility, agility, and "yummy" breaths that can prepare you for sleep. The older I got, it became obvious that editing out the drama became necessary so I could sleep like a baby and my physical and mental self could be "fully alive." Life-long fitness and agility is the best antidote to the unexpected problems that can occur.

Consensus:

Exercise. Don't deny aging. Stay engaged with social and mental activities. Get good nutrition.

Do you have any recommendations?

- Appreciate every day. Exercise every day. Smile and give thanks every day.
- Stay engaged with life, family, friends. Keep moving and eat well. No one can stop the passage of time; we can choose what we do during the years of life.
- Stay positive and upbeat. Cherish the wisdom that comes with age. Stay in touch with loved ones. Have a mentor — everyone, no matter what your age, needs someone older, wiser to learn from. Volunteer. Offer your experiences to those younger.
- In addition to staying engaged with life, family, friends: functional activity, exercise, a healthy diet, I focus on my own personal growth, spiritual growth and engagement with socially conscious activities (e.g. food banks, meal preparation and delivery to underserved elderly, continued clinical work with homeless and formerly homeless elders on a pro bono basis). All very rewarding. Keeping a positive outlook is vital to staying active and maintaining health, despite the inevitability of physical aging. Also, maintaining a balance between rest and exercise – something I've needed to learn since retiring from my teaching position.
- Don't look back. Just be the best possible example of one's current age.
- Absolutely stay active. Listen to people when they mention their problems. Volunteer regularly in multiple areas. Think outside the box, "How can I help?" Do not feel sorry for yourself; everyone ages (consider the alternative). Do not be afraid to ask for help (climbing ladders, computer, home issues). Keep multiple flashlights and pliers around the house and garage.

Life is more fulfilling and fun if one is open to continual change and challenges.

Have your cell phone close by. Stay off ladders and step stools. Be more careful walking up or down stairs and the front door stoop. Know and share family medical history with younger family members. Continue to practice and preach therapy!

- Enjoy the aging journey – it is priceless. Embrace aging – learn as much as you can about it. I love being a student of it. Be intentional, especially after age 40.
- Life is more fulfilling and fun if one is open to continual change and challenges. Make an effort to do things differently rather than the same way from a physical, mental, and social perspective. Making new friends, exploring new hobbies, seeing new things, while not forgetting the familiar activities is a wonderful way of life. Some examples of common things to promote growth and change are finding a new route to a familiar place, listening to an unfamiliar type of music, looking up more information on a news item, exploring some new destination by air, land, or sea.
- My car insurance gives me a reward for practicing what works: accelerate smoothly so you have time to judge the situation and avoid having to brake so sharply and fast that it makes my heart race at the thought of a near collision. I see prevention as a key to having the clarity to create a life that includes what makes me happy. Sometimes I cannot change something; I can choose to accept that person or situation. I do meditation daily, sometimes many times in a day. I live by the Optimist Creed (look up Optimists International) and each day I create a possibility of being fully alive, compassionate to myself and others, making a positive difference, and leaning on God for guidance.

- I am starting a new project each year so that I hopefully leave the world in a better state. Two years ago I created a new CEU course about Healing Touch and its application for the frail adult (cancer recovery, severe trauma, etc., when other PT modalities are temporarily too strenuous). This past year I have been studying to be a chaplain. I completed in June 2020 despite the COVID-19 pandemic. My project this year is to finish my certification as a Healing Touch practitioner through the international organization called Healing Beyond Borders. The new skills that I am learning from this multidisciplinary group of physicians, nurses, PT, OT, and massage therapists are amazing. My new favorite concept is the ongoing development and editing of my personal self-care process and upgrading this process. I recently had a fall so my practice of getting 5-7,000 steps in per day has been cut back during my recovery. I have added more Zoom self-development classes and increased my rest breaks during the day to allow integration of the balance training, breathing facilitation, and very gentle agility training done in supine and sitting. My diet has been radically changed as the functional medicine specialist has recommended that I go completely vegetarian during my bone healing process. While I am on a ½ pound lifting restriction, I hired caregivers to come in 5 days a week for 2-4 hours to manage all the preparation it takes to be vegetarian and to drive me to appointments.
- As physical therapists, we have access to so much training. My goal is to keep being relevant and use my age and experience to be a powerful force for neurological facilitation/energy medicine and all the related functional problems related to this. The key is the integration of whole self-care training for both client and caregivers. Functional training must support the development of personal engagement or health care ends up accidentally enabling dependency as everything is done for the patient while in acute care/acute rehab. Then the person has not mastered the ability to generate their own daily living program to accomplish their own care through a whole day (waking, medication, grooming, dressing, hygiene, supply management, laundry, equipment use, developing a family, friend, and caregiver assist schedule.)
- Appreciate every day. Exercise every day. Smile and give thanks every day.

Consensus:
Exercise. Keep engaged.
Maintain a positive attitude.

Summary

Exercise and stay active physically, mentally, and socially. Aging and physical changes are part of the passage of time. Grow, continue to learn, and embrace the journey.

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Spreading Encouragement to Seniors In a Pandemic

by Bonnie L. Rogulj PT, DPT and Lashia Hicks PT, DPT

Editor's Note. A selection of calendar images accompanies this article. Some images are copyrighted elsewhere and not publishable in this domain. Special thanks to the students for the creative images shown. Please email Bonnie Roguli, broguli@usa.edu, for a complete copy of the calendar.

"Normal" daily life has become modified and a "new normal" has ensued in the COVID-19 global pandemic. In the midst of the "new normal," many older adults have experienced limited accessibility, social distancing, and enforced regulations. Community-dwelling seniors are restricted from participation such as leisure shopping, restaurant dining, traveling, and time spent with loved ones. The older adult population has reported increased loneliness and isolation, resulting in an increased risk for anxiety and depression.

Flex Doctor of Physical Therapy (DPT) students enrolled in the Geriatric Physical Therapy course at the University of St. Augustine for Health Sciences (USAHS) recognized the potential negative impact on health and wellness from COVID-19 restrictions. In the midst of this global pandemic, an opportunity was provided in the form of a virtual calendar to spread encouragement for community and institutionalized seniors. The calendar was created in Power Point presentation format and consisted of a total of 30 presentation slides, able to be repeated throughout the calendar year. Each calendar slide included a positive message for older adults.

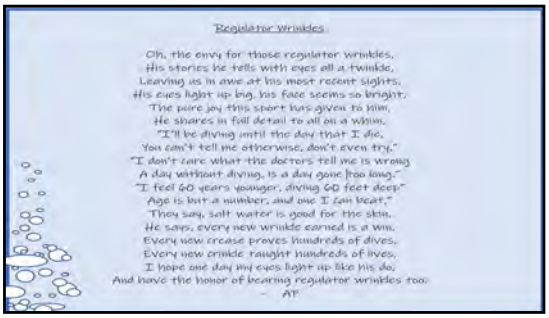
The virtual calendar allowed the students to be creative. Each of the 30 slides was filled with colorful images, positive quotes, or beautiful poetry. The completed calendar was shared virtually with older adults in the community including (but not limited to) the Council on Aging located in St. Johns, Florida.

In conclusion, students reported feeling grateful for the unique opportunity to promote health and wellness for seniors. A multitude of opportunities exist to overcome the challenges faced by seniors as a result of COVID-19. Current and future health care leaders must continue to prioritize health and wellness during (and beyond) the global pandemic.

Julian Zapata

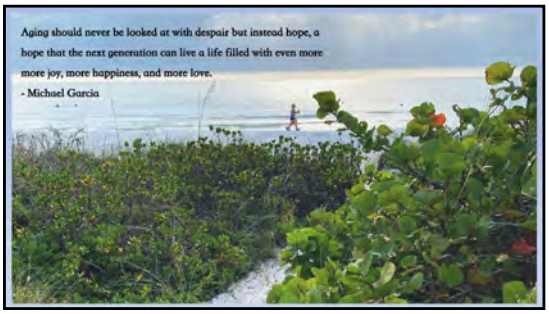
Mike McGettrick

Ryan Felder

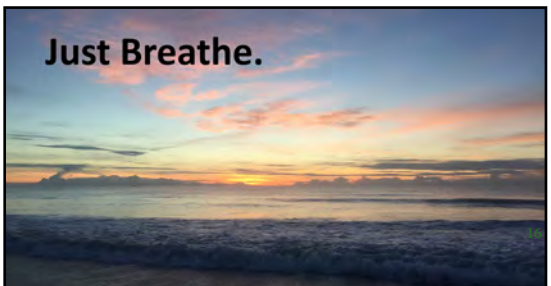


Alex Perez

Julianne Jones



Michael Garcia



Amanda Noto

Dr. Bonnie L. Rogulj completed her Doctor of Physical Therapy degree at Old Dominion University and completed a geriatric residency at Brooks Institute of Higher Learning. She is a board-certified geriatric clinical specialist (GCS), Stepping On Instructor, and Mental Health First Aid Instructor. She is a licensed Physical Therapist and Assistant Professor at the University of St. Augustine for Health Sciences in the Flex Doctor of Physical Therapy program.

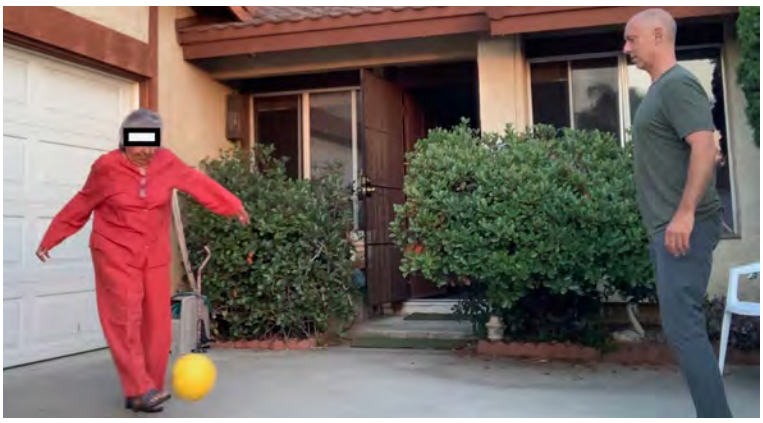
Dr. Lashia Hicks earned her Physical Therapist Assistant (PTA) degree from Florida State College and practiced for 3 years prior to beginning the Flex Doctor of Physical Therapy program at the University of St. Augustine for Health Sciences (USAHS). In 2016, she earned the Doctor of Physical Therapy (DPT) degree. Dr. Hicks completed a geriatric residency at Brooks Institute of Higher Learning and is a board-certified geriatric clinical specialist (GCS). Presently, Dr. Hicks is the lead orthopedic PT from Brooks University Crossing SNF.

Stronger, Faster, Better: A Son's Story of Wanting More Than a Return to Prior Level of Function

by Diego Schoch SPT, MFA, CPI

What you are about to read is a personal narrative from the perspective of a student physical therapist. It is my mother's journey through the health care system following a traumatic event. I hope it is relatable and, perhaps, even generalizable.

This story begins in September 2019. My mother (who I will refer to as Inez) and I have gone to a movie. The auditorium is quite full and the only 2 seats available are in the top row. As we ascend the stairs, I stand behind her and note that she is utilizing the handrail to haul herself up. I am in my fifth term of PT school and have been exposed to patient assessment and fall risk. It suddenly dawns on me: my mother is a fall risk. When we get to the top, I ask her how much she used the handrail and her reply is "a lot."



Inez is 76 years old and recently retired from teaching middle-school which had kept her mentally vigorous and feisty. Inez had little use for exercise and never developed a consistent practice of physical activity. She is a bit overweight, short and round with a classic endomorph physique.To my knowledge she has not been to a doctor's office in decades other than for 2 accidents. First, Inez tripped and fell sustaining a classic right Colles' fracture which was set, cast, and resulted in a few physical therapy sessions. Later she got tangled in the dog leash; she sustained a left comminuted Colles' fracture, requiring surgery, and a few PT sessions. Inez settled back into her usual routine including smoking 2 to 5 cigarettes per day (all windows must be open, otherwise the smell lingers!) with a few drinks each night to unwind.

In the 5 years since I lived with mom, I noticed she used momentum to stand up from the couch, free-fell into that same couch when sitting, and held onto the doorframe when navigating the step at the front door. In darkened theaters she was extra careful, often requesting my arm to navigate steps. Mom had plans for her retirement. She was going to finally get that membership to the YMCA and get more politically involved. None of that happened. In early January 2020, I departed for my first 6-week clinical internship. Inez promised to get that membership while I was gone,. That didn't happen either.

The fall and its prognosis

Inez, my daughter, her partner, and I go to a local winery 3 days after I return from that rotation. Inez enjoys herself a great deal and has too much to drink. Heading to the car, she requires my arm to steady herself. I am angry and resentful at what I consider her lack of restraint and reluctantly provide the aid she requests. Arriving home, I park on a slight decline. Somewhat sullen and unforgiving of her excess drinking, I move slowly. Inez, however, has unfastened her seatbelt, opened the car door, and is exiting while I am still unbuckling. I note a blur of movement, hear a cry of pain, and realize my mother has fallen.

Inez is lying on the cement on her left side. She indicates pain on the side of her hip and my hopes for something other than a hip fracture significantly decrease. She cannot flex her right hip without pain; she cannot bear weight on the right leg. We head to the emergency room. The radiograph shows a full, clean break at the neck of

the femur with 25% percent displacement. Inez is scheduled for a hemiarthroplasty the following day. On the advice of a friend, I ask the attending physician to initiate an alcohol withdrawal protocol. The surgery goes well, Inez is at the hospital for 3 days. I am present when the attending physician debriefs Inez, stating that they expect a good recovery, but lab tests of her liver indicate that she needs to stop drinking. Her vitals are within the good-to-excellent range and she is otherwise in very good health.

Despite a good prognosis, it is time for a reality check. Multiple studies state the prognosis for a senior to return to their prior level of function following a hip arthroplasty is not great. In 2017 Katsoulis et al. conclude elderly who have had a hip fracture have an increased risk of mortality compared to those who have not had a fracture and surgical repair.[1] A 2020 study by Parke et al states a population at high risk of perioperative complications, including death, are those seniors who are already frail with additional comorbidities and then suffer from a hip fracture.[2] The first sentence in Green et al's abstract, from their study of 2020, states hip fractures are a marker of existing frailty and further state this type of event can be life-changing, or even life-ending.[3]

If emojis were allowed in GeriNotes articles, insert a frowning face here. There's more: High risk of mortality, poor outcomes, and increased dependency in elderly patients suffering hip fractures.[4]

Several criteria are listed in a 2001 study with a definition of frail and Inez has 3 of them: decreased grip strength, slow walking speed, and low physical activity.[5]

Frailty increases with age and is more prevalent in women than men.[5]

This is all bad news. However, it doesn't have to be. All the authors agree there are ways to moderate and combat these grim statistics.

Back to the story. During the weekend of Inez' surgery, my classes resume, and I strategize my mother's recovery beginning with pushing for admission to an inpatient (IP) rehabilitation facility. I need her (want her?) to be ambulatory. I tell her she can recover from this surgery better and stronger than before. My second clinical rotation begins in September and my mother must be able to drive and go shopping for groceries by then. Thankfully, she qualified for IP acute rehabilitation and transfers to begin phase 2 of her recovery.

Recovery and independence for all

In 2 and a half weeks Inez makes good progress. She is ambulating with a front-wheeled walker, making 2 laps around the facility, and knows her hip precautions. She meets the discharge criteria and is sent home with home PT, OT, and a home health aide for bathing.

At this point, I will make a detour. This story is not only about my mother, but about me and my ability (or inability) to be a caretaker. In December of 2015 I found it necessary to move back and live with my mother. After 36 years, I was once again sleeping in my childhood bedroom. It is an understatement to state this scenario was deeply humbling. While my mother and I had generally been close, it took time to grow accustomed to the situation. Eventually an equilibrium was reached and some boundaries established. My desire for a good outcome concerning my mother's recovery is not solely based on a compassionate and altruistic desire for her to get better, but also on the realization I am in no way prepared emotionally, mentally, or financially to be her caretaker. I need her to be independent so I can continue the process of rebuilding my life, changing careers, and reestablishing my independence.

On with the main narrative. A week after coming home the occupational therapist visits and determines Inez does not require OT, but the home PT finds that Inez is a suitable candidate. In the meantime, I have given Inez exercises: supine pelvic bridges; step-ups onto a 1 ¾ inch box; standing heel raises at the kitchen counter; hamstring extenders in supine and, in preparation for sit-to-stands, standing hip-hinges with a flatback being aware of her hip precautions. Sean, her PT, prescribes short-arc quadricep sets with a foam roller under her knee in supine, bilateral hip abductions in supine, heel slides in supine, mini-knee bends at the kitchen counter, and forward and lateral side-stepping at the counter — all relatively simple considering her success during inpatient rehabilitation. He does, however, provide guidance and education in performing functional activities, specifically getting in and out of bed and walking outside with the walker.

Sean comes twice a week for 4 weeks as Inez progresses steadily, slowly. I frequently reiterate that she is not only recovering from the fall and surgery but also overcoming her prior deconditioned state. During these 4 weeks, Sean does not prescribe sit-to-stands. I teach them to Inez, using padding to elevate the chair to preserve hip precautions. I progress her to stepping onto a 3 ¼ inch box as she was doing well at the lower height. I am hoping to see Sean progress her off the front wheeled walker. That doesn't happen. At 4 weeks he proclaims she is ready for outpatient. Since the walker is facilitating a forward trunk lean and a forward shoulder posture, Inez does not seem ready for a cane. I order hiking poles. They have the desired effect; she feels stable and safe and walks with improved vertical alignment.

There is a 2-week lag between Sean's last visit and Inez' first outpatient PT appointment. During this time I seek new ways to challenge her. I add alternating marches to her pelvic bridge, standing marches to her gait training with the poles, and standing lateral leg lifts at the counter. I also nuance her sit-to-stands, eliminating momentum to stand up using her hip hinge to shift her weight (nose over toes!), and then stand up. In addition, I ask her to control her descent so it's slower and works the eccentric contraction more strongly.

It's been 7.5 weeks since the surgery and Inez' first outpatient visit goes well. Because the first visit has so many unknowns, she uses her walker even though she's been ambulating with the hiking poles for a week. She also uses the walker to the second appointment even though she is practicing in the driveway with the poles. By now I have increased the height of her step-ups to 5 inches, and she does a set in the sagittal plane and then a second set laterally in the frontal plane, going right then left.

Raising expectations and addressing fear

At the third outpatient visit, 10 weeks post-surgery, we dispense with the walker (now folded up in the garage) and bring the poles. Inez reports that the therapist is concerned about her balance and recommends going back to her walker. I am astounded. I understand I am still only a PT student, but I completely disagree with this assessment. From this point on, I begin to feel the therapists treating my mother lack urgency in their protocol, are not pushing her hard enough, and are not expecting enough of her physicality. My expectation is for my mother to emerge stronger and better than she was prior to her fall, something I've been saying to Inez as I praise and encourage her progress.

This point of view is confirmed by the professor teaching my Geriatrics course at school. My takeaway during the first 4 weeks of class is that our senior patients are more capable physically than many expect. Inspired by lessons to decrease repetitions and increase weight, as well as to make exercises more fun and functional, I have Inez hold 5-pound weights during her sit-to-stands and institute playing catch and kick ball with a deflated soccer ball. For the kick ball she uses her hiking poles, for the ball handling I have her throw it in different ways, such as stepping forward to throw, alternating feet, throwing underhand and overhand, and standing sideways to throw the ball across her body. My intention is to improve her reactive postural control in her ankles, knees, and hips. She responds well and after a few weeks I am challenging her by deliberately tossing the ball off target and forcing her to reach out in various directions.

I decide to introduce some measurements: the Senior Fitness Test (SFT) and the Dynamic Gait Index (DGI). I need objective measures to validate and support my mission and I am not certain the therapists performed outcome measures on my mother. This uncertainty is due to Inez' response of, "No, I don't think so," when asked if she remembers the therapists telling her they were going to do assessments or if she did anything that felt like a test.

My rationale for the 2 measurements were that falling results in a (reasonable) fear of falling again.[6] Fear of falling causes decreased confidence in one's physical ability which leads to decreased physical activity.[6,7] I chose the DGI because it is a good predictor of recurrent fallers.[6,7] Further, an improvement in DGI score has been shown to be a good indicator of increased feelings of self-efficacy regarding falls.[7] If falling results in decreased physical activity and decreased physical activity is a component of decreased self-efficacy, then increasing a person's fitness level should increase their self-efficacy regarding falling and their ability to participate in activities of daily living. Therefore, it is reasonable to say Inez' strength and general fitness is inversely proportional to her fear of falling and self-efficacy – the stronger she gets, the less fear she will have. The SFT is a both a criterion and normative reference measure that makes it appropriate to measure an increase or decrease in general fitness level. The first assessment was conducted with Inez using a wide base pivot style cane which she had started using. (See Table 1)

Performance outcomes

Since the initial assessment with the DGI and SFT, Inez has continued with outpatient physical therapy weekly and I have continued to challenge her. Interestingly, the outpatient therapy never sent home a printed exercise program. Even assuming that they knew her son was in PT school this would appear to be a critical oversight. By

Table 1. Results of Senior Fitness Test and Dynamic Gait Index testing

Test	**June 30, 2020**		**July 19, 2020**
DGI Stairs not tested so scored out of 20	15 (with cane)		18 (without cane)
SFT		**Normal ranges for 75-79 yr old**	
30 sec chair stand	12	10-15	12
30 sec arm curl	16	11-16	20
2 Minute step test (with cane)	45	68-100	60
Chair sit and reach	L (-)1.5 inches R (-)4 inches	(-) 1.5 – (+) 3.5 inches	L (-) 1 inch R (-) 2 inches
Back scratch	R high (-) 1.5 inch L high (-) 3 inches	(-) 5 – (+) 5 inches	R high (-) 2 inches L high (-) 2.5 inches
8 foot up and go	12.74 seconds (with cane)	7.4 – 5.2 seconds	11.2 seconds (without cane)

now Inez was regularly performing the exercises shown in Table 2. I continue to play catch and kick ball with her 1-2 times per week. She regularly walks 2 blocks, 3-4 times a day with her cane, which she frequently abandons around the house. She is independently bathing, has been to the grocery store with me several times, appearing confident. The goal is to have her driving to the grocery store and shopping by the end of July. Her discipline is a testament to her determination and motivation. To my knowledge she has not had any alcohol other than the small amount present in the non-alcoholic beer enjoyed, appropriately socially distanced, with our neighbors every Saturday evening in the driveway discussing politics. The smoking continues.

The results of her reassessment are shown in Table 1. The DGI increased by 3 points, performing the re-assessment without her cane. Based on the scores and the validity of the DGI, I now rate her as a safe ambulator.

Table 2. List of exercises performed

Activity	Sets, repetitions	# of times/week	Notes
Hamstring extensors	1 x 10 R/L	Almost everyday	In bed
Bilateral leg abductions	1 x 10-16	Almost everyday	In bed. We call these "snow angels"
Heel slides	1 x 10 R/L	Almost everyday	In bed. She adds hip external rotations for a stretch
Pelvic Bridges w/ alternating marches	1 x 20	Almost everyday	In bed
Standing squats to a chair, just touching the chair and then standing up	8-12x	Almost everyday	Performed w/ 2 5lb hand-weights and combined with alternating 1-arm shoulder press on each standing
Step-ups, alternating R and L	12-20x	Almost everyday	Box is approximately 7 inches Counter for support
Heel raises	1 x 20	Almost everyday	Counter for support
Step up and descend off other side	10-20x (point is to mimic descending down a low stair)	Almost everyday	Alternating R and L legs, completing 5-10 on each leg 3 ¼ inch box Counter for support
Single leg knee bends and heel taps off a box	Front 5x Side 5x R and L legs	Almost everyday	Counter for support
Toes taps onto the bottom of a paper cup	20x, alternating R and L legs (10 total each leg)	Almost everyday	Cup is placed on a 5" box Hiking poles for support She works on a light grip
Lateral crab walks	Back and forth 3m 3-4x	Almost everyday	Performed with a yellow theraband
Standing lateral hip abductions	2 x 10, R and L	Almost everyday	Performs 10 small, isometric "pulses" twice on each side

Scores also improved on the SFT, primarily in the 30-second Arm Curl Test, the 2-minute Step Test, the Chair Sit-and-Reach Test, and the 8-feet Up-and-Go Test without the cane. I was surprised her 30-second Chair Stand Test remained the same, however, prior to the re-assessment she indicated some soreness in the lateral hip potentially preventing her best effort.

The importance of geriatric specialists

It's been 20 weeks since my mother fell and broke her hip –just under 5 months. I am encouraged by the progress she has made, especially the progress between assessment dates. However, it does make me wonder – where would she be if I hadn't been there? I don't believe that her recovery would be as good if I had not been a PT student with knowledge to supplement her care or if she lived alone, solely reliant on the contact hours with her physical therapists. Based on this critique it appears that the PTs treating her seemed uncomfortable working with older adults. I never saw evidence of therapists pushing my mother hard enough nor the use of creative and fun interventions to engage an older adult.

After this experience, I understand the importance of geriatric specialists. The other issues are the systemic problems: a health care system run by a for-profit business beholden to third-party payers in which access to quality health care is not considered a basic human right. Insurers have an inordinate say in plans of care and treatment schedules, especially with their insistence that patients be returned only to their prior level of function. The big problem here is that my mother's prior level of function was not working, as evidenced by several falls, including one in which she fell and broke her hip. Hip fractures are a marker of existing frailty.[3] I ask my professor, "If my mother was previously deconditioned, why is the aim to merely get her back to that frail state?" As a son and soon-to-be physical therapist, I say returning Inez to her prior level of function is insufficient. In a shameless reference to the 70's TV show, The Six-Million Dollar Man, I want her to be stronger, faster, and better following this experience. I don't want her to fall again.

My final takeaway from this experience is a deep concern for other patients, like my mother who will fall, break a hip, and enter our health care system.

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Pain? Choose to BOOMER for Boomers?

by Kathlene Camp PT, DPT

Editor's Note: This clinical case commentary was part of content for the January 2021 Journal Club. These case studies are intended to demystify the more formal statistics and format of a peer-reviewed article and translate key concepts into clinically usable information. Join us for Journal Club on the third Tuesdays of January, March, May, July, September and November at 8 pm ET to discuss current concepts with a wide range of peers. Register to join us or view archived recordings at geriatricspt.org/journal-geriatric-physical-therapy.

Evelyn Smith, a 75-year old female, presented to her primary care geriatric physician for an annual wellness exam with a complaint of recent insidious onset R inguinal pain radiating to her anterior thigh. Medical imaging of hip/pelvis was ordered; results were pending.

PMH

- Chronic Obstructive Pulmonary Disease; quit tobacco use in 2011
- Osteoporosis (diagnosed in 2014); T score -2.7, no location specified. Failed use of Alendronate;
- Squamous cell carinoma- upper 1/3 of esophagus treated with chemotherapy, radiation, a gastrostomy tube for nutrition. Treatment completed 2 months ago, planned PET scan in 30 days. Allowed only sips of water for comfort.
- Insomnia
- Trunk brace, physical therapy for 1 year as child (suspected adolescent scoliosis)

Subjective examination:

Patient primary complaint: Mrs. Smith reports sharp pain in R groin and anterior thigh to knee which began about 3-4 weeks prior. She reports no known trauma or change in activity level. Pain is intermittent and provoked with sit to stand, initiation of gait, and stepping up on curb with R leg. She also reports new difficulty lifting her 17-lb dog. Relief of pain reported after walking several steps and with sitting. No pain reported with preferred sleeping pattern on R or L side. Pain with initial stance for night voiding.

Medications: Vitamin B-12, Ambien, Spiriva, ondansetron, olanzapine (last 2 meds during cancer treatments). No other report of supplements or OTC medications.

Social history: Lives with husband in single family home with no steps for entry. She enjoys walking with her dachshund in the mornings. Prior to cancer treatments she was walking 3 miles per day (about 1 hour) but can now only manage 1 block (about 20 minutes including standing breaks for dog) before fatigue. Several children and grandchildren live nearby. Hobbies include puzzles.

Patient goals: Be able to walk further, relief of pain, and hoping for a cancer-free report from PET scan.

Objective Examination

Cognitive screening: results available from social worker notes indicate recent GDS: 2/30, MMSE: 28/30

Pain survey: Hip Dysfunction and Osteoarthritis Outcome Score (HOOS) Jr: 6/24 (Interval Score: 70.426) with pain primarily impactful for stairs and rising from sitting.

Pain: 0/10 rest, 6/10 with sit to stand, initial steps + stepping onto 8" step. Pain sharp, only in groin area at this time; intermittent report of anterior thigh pain

Falls: Patient denies history or concern for falls; no AD used for indoor/outdoor ambulation

Vitals: rest- BP 128/85; HR 84 bpm, regular; RR- 14 breaths/min; SpO2 on room air 94%

Height/weight: 5'4", 127 lbs. (1 year prior: 5'4", 138 lbs.)

Posture: Thoracic kyphosis, forward head and rounded shoulders, wide BOS

Flexibility: Symmetrical mild tightness

in bilateral hamstrings at 75 degrees

Trunk screen: Mrs. Smith is able to perform trunk flexion without pain, mild L thoracic rib hump noted. No pain with extension. Symmetrical side-bending and rotation, without pain or provocation of leg symptom.

Hip ROM: L hip WNL throughout. R hip WNL except limited by pain at soft to firm end-range with ER at 45 deg and ABD at 50 deg.

MMT: WNL except for pain reported with resisted R hip flexion and ABD in supine

Palpation: no tenderness in bilateral pelvic or hip regions

Special tests: FABER R (+), Fulcrum test R (+)

DTRs: symmetrical results- patellar (2/4), Achilles (1/4); no report of tingling or numbness in LEs

Outcome Measures:

- Occiput to Wall Difference (OWD): normal posture= 8 cm; best posture = 5.2 cm
- BOOMER score:
  - Step test: 8 reps, R/L- score 2 or 3 (score criteria does not differentiate with 8 reps)
  - TUG: 12.75 sec - score 3
  - Functional Reach: 11.5 in (29.2 cm)- score 3
  - Timed stance: 62 seconds - score 3
    - total score: 11 or 12/16 (note: final score dependent on step test)
- Short Performance Physical Battery (SPPB)
  - Balance test: Semi-tandem = 10 sec, Tandem 2 sec; score 2
  - Gait: 8-foot gait speed 2.5 sec, score 4
  - Repeated STS: 12.5 sec; score 3
    - Total score 9/12
- Single Leg Stance (SLS): R= 2 seconds, L = 3 seconds (no pain either limb)
- 6-minute walk test:
  - 295 meters
  - post vitals:
    - 1 minute: BP 170/90, HR 96 bpm, RR 20 breaths/min, O2 78%
    - 3-minute: BP 134/82, HR 78 bpm, RR 14 breaths/min, O2 97%
    - RPE: "fairly light" - 12-13 on Borg scale 6-20

Assessment: Mrs. Smith presents with pain influencing transfers, initiation of gait, and management of steps/curbs. She has impaired posture with normal OWD >6.5 cm, suggestive of hyper-kyphosis which can impact fracture and fall risk. Decreased aerobic capacity as compared to persons with COPD (<380 m). She has impaired balance, with SLS < 5 sec and tandem stance <10 sec, which places her at risk for falls especially when relying on narrow or single limb support. BOOMER battery was used to assess performance due to multiple components associated with fall risk but did not reveal significant risk based on individual components and did not reveal pertinent areas for intervention. The SPPB was found only to be significant for decreased stability in tandem stance as suggested above. Her medical history, lifestyle, smoking history, decreased persistence for osteoporosis management recommendations, weight loss, and current presentation of symptoms raises concerns for bone integrity, especially in R hip. Mrs. Smith has maintained her independence with ADLs and is performing limited walking aerobic activity to tolerance of fatigue without limitations due to pain. Mrs. Smith would benefit from skilled physical therapy to provide education and therapeutic intervention for factors related to osteoporosis management including proper body mechanics, strengthening, and balance. Mrs. Smith would also benefit from collaboration with care team to address nutrition and considerations for pharmacotherapy management

Plan: Mrs. Smith will attend outpatient physical therapy once every 2 weeks for 12 weeks, 6 visits total, to address goals for progressive strengthening, balance, postural correction and education on osteoporosis management and bone protection. Plan to follow-up with physician's group to attain results of recent X-ray. Will recommend collaboration to address additional factors for nutrition and medical management.

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The APTA Geriatrics Journal Club is a free, facilitated webinar-based discussion about a Journal article where you interact directly with the author and a clinician with a relevant case study that demonstrates how that information could be used. It's a fun way to move yourself in the direction of life learning and beef up your evidence- based practice.

The next APTA Geriatrics Journal Club will be held **January 19, 2021** at 8 pm ET.

We will discuss **Score Distributions of the Balance Outcome Measure in Elder Rehabilitation (BOOMER) in Community-Dwelling Older Adults with Vertebral Fractures**; *Journal of Geriatric Physical Therapy*: 42(3):E87-E93, July/September 2019.

Registration is now required:
www.geriatricspt.org/events/webinars

Goals

Short-term goals (2-6 weeks)

1. Patient to verbalize and demonstrate understanding for proper body mechanics to reduce torque forces on R lower extremity during ADLs.
2. Patient will be able to perform with repeated 5-time sit to stand without pain and <12 seconds to decrease fall risk and improve functional strength based on cut-off risk for falls[1]
3. Patient will demonstrate improved control with transfers and initiation of gait to perform TUG in <12 seconds based on cut-off score of 12 seconds for increased risk of falls.[2]

Long-term goals (12 weeks)

1. Patient to demonstrate proper body mechanics using hip-hinge while performing desirable tasks such as puzzles and ability to lift >17 lbs pet.
2. Patient to improve functional balance and mobility with increase in BOOMER score to ≥15 points based on MCID change of 3 points[3]
3. Patient to improve normal postural alignment with OWD to <6.5 cm to decrease risk of VCF due to hyperkyphosis based on 6.5 cm cut-off[4]
4. Patient to commit to 2 appropriate behavioral action steps to address modifiable risk factors and interventions associated with osteoporosis management.

Clinical interventions

Mrs. Smith will be provided with educational materials from reliable resources such as the National Osteoporosis Foundation and the American Bone Health organization to enhance her understanding for osteoporosis management considerations. This education will be reinforced during her therapy sessions and utilized to influence behavioral change towards actions steps to improve her osteoporosis management.

Physical therapy intervention will be directed toward progressive strengthening with bilateral to unilateral body-weight support functional training. Additional resistance with use of free weights to increase loading forces as appropriate for motor control and symptoms. Strengthening resistance for the lower extremities will be maintained in alignment with vertical forces through femur to reduce proximal torque stress at femoral neck, especially until X-ray clearance.

Additional intervention to address postural alignment will be considered with manual intervention, self-mobilization techniques, and/or trunk extension strengthening to decrease kyphotic posture. Functional movement training with use of hip hinge will be performed with carryover to tasks such as lifting, reaching, and household tasks. Exercises for balance training will be incorporated to address static and dynamic balance to reduce fall risk.

Mrs. Smith will be provided with written HEP illustrations to reinforce exercises, mechanics, and management of osteoporosis.

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Submit questions for Kathlene Camp (case report) or Jenna Gibbs (researcher) to gerinoteseditor@gmail.com

For My Own Good? How Isolation and Quarantine are Devastating the Aging Adult

by Matthew Sahhar PT, DPT

The COVID 19 pandemic has revealed major fault lines in the health care delivery system in America and abroad. These fault lines are present in our ability to screen, test, contain, and provide adequate care for those infected with the virus. Systems have become more streamlined and adapted as months of the pandemic roll on. Pending pharmacological treatment of the virus, the primary prophylactic measure is a blanket prescription of social distancing, wearing a mask, and isolation. This prescription comes with side effects not unlike pharmacological interventions. The aging adult is simultaneously highly susceptible to the most debilitating symptoms of the virus, as well as the negative psychological and physiologic impact of social isolation and quarantine. Social isolation, while highly effective in reducing transmission, results in downstream issues in the aging adult of psychological distress and expediting functional decline.

Isolation

The manifestation of isolation during the pandemic has been multimodal. It can occur as a result of physician recommendations for aging adults to stay home, quarantine from virus exposure, and government mandates to stay-at-home or shelter-in-place. Isolation is different in acute and skilled nursing settings in that patients suspected or infected with the virus are separated into cohort floors, have visitation restricted, and providers and visitors are also subjected to strict PPE measures to enter. The impact of these restrictions are widespread and variable based upon temporal and adherence components.

Stigma

Isolation as a means of reducing the spread of a viral agent is effective in limiting overall transmission. However, this can result in undesirable effects on an individual's psyche. One notable outcome is stigmatization. While medicine is constantly advancing the way we view and treat viruses, the use of isolation remains unchanged from the SARS pandemic of the early turn of the century. Qualitative research performed during the SARS pandemic (in which individuals were subject to similar isolation precautions) found that stigma in relation to a disease or infection is linked to feelings of depression, anxiety, and anger.[1,2] Health care workers, who were either treating patients with SARS, or had contracted it themselves, were interviewed for these studies. Interviewees reported psychological distress over family members being afraid to be near them, as well as guilt regarding the increased burden their quarantine was placing upon family and friends.

Clinical Correlation

"I woke up with a cough, and by the end of the day the hospital had convinced both my family and me that I was an alien. To touch me or even be close to me was a threat that, you, too, would become alien" is the way that a 78-year-old recovering male patient described his experience to me recently. The stigma felt by community-

dwelling adults is significant as well. An 81-year-old woman that I interviewed reported that she felt ostracized by the other residents at her independent living facility. It was well known that this woman volunteered weekly at a local hospital. Early in the pandemic she was notified by the hospital that she had been exposed to an individual who later tested positive for COVID-19. Instructed to remain within her apartment for the next 14 days, it became obvious to other residents of the building that she was absent. Rumors began to stir, and although she never tested positive, she was credited with "spreading the virus" at the independent living facility. This woman reported feeling both extreme guilt and anger with fellow residents. Her guilt was associated with the nagging feeling that maybe she could have been a vector for the virus. Conversely her anger was directed at individuals who seemed to seize upon her vulnerable state.

While both situations find individuals isolated in different capacities, they are similar in the degree to which the people felt stigmatized as a result of virus exposure.

Cognitive function

Many of the activities that bring joy to older people involve social engagement — taking part in a book club, meeting friends weekly for lunch. These and other simple pleasures are critical for the cognitive well-being of aging adults. Increased social isolation later in life (>65 years old) is suggested to be associated with poor cognitive function in healthy individuals.[3] The mechanism behind this relationship is hypothesized that with lower levels of social interaction, the mind is not challenged and neuronal growth slows, and neuroplastic changes do not take place at the same rate.[3,4] As individuals age, their relative risk of developing Alzheimer's disease (AD) increases exponentially, affecting nearly 50% of individuals over 85 years old.[3,4] Many of these individuals reside within memory care facilities in which daily routines are entirely centered on social and group interactions. Research suggests that social interaction presents itself as both an upstream protection against development of cognitive impairment and a downstream dimmer switch on the exacerbation of preexisting cognitive impairment [4,5,6]. One of the first routine social activities eliminated from memory care, skilled nursing, assisted, and independent living facilities was shared mealtime when social distance and quarantine policies were implemented. Many facilities tout the dining room and quality of food as the most attractive aspects of residency. Shared mealtimes improve socialization as well as the ability to eat, 2 factors that present as barriers with those in moderate-late stage dementia and may contribute significantly to functional decline.[4] It can be assumed that many residents forced to eat alone in their own rooms are feeling more isolated and lonely than ever. Research aimed at investigating the link between cognition, mental health, social interaction, and physical activity found that a "use it or lose it" phenomenon is present in relationship with social interaction. The findings of this study suggested that day-to-day interactions with others serve as a form of mental exercise and allows some individuals to cope with cognitive pathology more readily than others.[7] Group meals aren't the only social events cancelled within facilities: card clubs, manicures, Bingo, support groups, and pet therapy have also been subjected to cancellation.

Another clinical example

"Turned upside down" is the way one 91-year-old physical therapy participant described her world post cancellation of social activities at her assisted living facility (ALF). She had been a regular attendee of the bi-weekly support group for bereaved spouses. A year prior to the acute stay, her husband of 68 years had passed away. She reported that this support group was enough to "keep her head above water." Since cancellation of the support group, she reports that she has declined significantly in regard to her emotional and mental status. "I cry all day now. I feel like I am back to day one after his passing. I can't watch TV. I can't seem to hold conversations without drifting out. My mind has turned to mush." This woman has gone from being active in her ALF to feeling that she can't keep-up with the social pace due to her vulnerable state. Confidence in social interaction shrinking, she is at risk of falling into the vicious cycle of reducing further social interactions, thus feeding her declining mental and emotional state.

Cognitive health is also impacted by isolation policies that limit physical activity. Pre-COVID 19, 15-20 people in a room performing aerobic exercise or taking part in a walking group was not unusual. Gym closures occurring within communities nationwide and elimination of adapted fitness groups within ALF and senior centers leave many with no opportunity for activity or limited resources to exercise themselves. The relationship between cognitive and physical fitness is well-established. Similar to socialization, physical activity provides upstream protection and downstream mitigation of cognitive decline.[6,7,8,9] A meta-analysis of randomized control trials investigating the relationship of physical activity level and cognitive ability displayed broad spectrum improvements in function (processing, memory, attention, executive function) as cardiovascular fitness improved.[8,9] When restrictions are lifted and individuals again feel safe to interact within the community and return to therapy, therapists should be alert for signs of exacerbation or onset of cognitive impairment. Given the uncertainty that we face as to when all restrictions will be lifted, our role to promote community wellness and create novel ways to reach individuals, especially those in senior-geared facilities is more important than ever.

Phsyiologic implications

Individuals suffering from multiple comorbidities may constantly be walking a tight rope in which a small per-

turbation could have their physical function crumbling. It is not uncommon for patients to display steady continued progress in therapy and then have a major setback due to a secondary system undergoing stress, dysfunction or illness. Isolation restrictions have been a perturbation to progress for many.

Clinical correlation

A woman with chronic dizziness, neck pain, anxiety, and hypertension was displaying continued progress in outpatient neurology clinic. After 3 weeks of treatment, social distancing guidelines, mask use, and quarantine were implemented. Given the newly prescribed restrictions to social interaction, this 72-year-old was unable to continue to babysit her grandchildren 3 days a week, an event she took great joy and excitement in. She became far less social in the clinic and increasingly irritable as the weeks of restriction progressed. Gains made regarding calming her dizziness began to reverse course and she was very frustrated. Although previously managed well with pharmaceuticals, both her hypertension and anxiety worsened. In brainstorming reasons for her functional decline and exacerbation of symptoms, the patient reported that she had nothing joyful to look forward to with her days of babysitting being taken away. Further, her husband was so terrified of contracting the virus that he would not drive anywhere that was not absolutely necessary. She arrived to her last visit reporting that she slept exceptionally poorly, had a nagging unilateral headache, and a visibly bloodshot left eye. Blood pressure was found to be within normal limits. She had an abnormal test of smooth pursuit. With prompted abduction of her left eye she reported exquisite exacerbation of her headache with no visible abduction. Immediate follow-up and imaging from a neurologist determined that she had a small pontine hemorrhage isolating function of cranial nerve VI. As it relates to stroke in particular, social isolation increases risk factor for stroke by 32%.[9] While many other risk factors for stroke were in place prior to implementation of social isolation measures, the exacerbation of anxiety and psychologic distress coupled with pre-existing hypertension cannot be overlooked as possible factor contributing to this stroke.

Although it is an unfortunate event that this patient sustained a stroke, it is fortunate that she was continuing to go to physical therapy and was able to be screened. As fears of leaving the house arise, many individuals are electing to remain at home even in the face of serious medical events. Comprehensive research carried out in both China and Spain, 2 areas subjected to exceptionally strict lockdown measures, analyzed the admission rates for stroke during the pandemic compared to data from the same time a year prior. In some primary stroke centers, admission for stroke during the pandemic was down 40%.[10] Authors of the study attributed this massive decrease in stroke admission to several factors. The primary factor hypothesized is that individuals who were under lockdown or strict recommendations from physicians remained at home and elected to not receive medical care. If true, this explanation can likely be extrapolated to a myriad of other medical crises that individuals are simply too afraid to leave their home for. Another explanation is that given the reduced social interaction between the victims of stroke and their family, the tell-tale signs of stroke are missed and the individual may attribute them to a variety of other factors deemed non-emergent. Regardless of the reasons why, it is frightening that stroke, one of the most devastating events to happen to the aging adult, is being experienced without rapid medical care or not treated at all.

Life space

The magnitude of the world we occupy with our day-to-day routine is paramount to longevity and risk of mortality. Individuals relegated to staying at home as a result of quarantine minimize the footprint that they create in the world around them. Individuals who live within an independent living or ALF may be confined to living space that is <400 sq ft. Individuals who reside in skilled nursing facilities, may be confined to their rooms at all times which may be <175 sq ft. Community dwelling adults may fair a bit better with access to homes >1000 sq ft. Despite differences in space available, the life space that they occupy is diminished. Life space is defined as "a novel and integrated measure of mobility that assesses the extent, frequency and independence of individuals' movement within their environment."[11] The calculation of one's life space is impacted by the frequency and radius in which they travel beyond their bedroom and what level of assistance is needed to do so. It measures ability to go from the bedroom to the porch/yard, all the way to the ability to leave the surrounding town if they so choose.[11] Comorbidities and subsequent disabilities can impact longevity; the measure of life space is found to be an independent risk factor for increased mortality and frailty.[11,12] A leading hypothesis for this relationship is that as individuals spend more time within the home without venturing beyond its borders, the physical activity and subsequent cardiovascular fitness they would garner are significantly blunted.[11,12] Research currently suggests that men who are unable to venture outside their neighborhood are at a 28% increased risk of mortality over 2.7 years.[12] Most COVID-19 recommendations have, to one degree or another, relegated aging adults to home bound status. Further clarity will need to be established into whether the external mandate of staying home has the same impact on mortality as the biological and physical barriers that limit ones excursions. Therapists should anticipate that as the world around our patients shrinks, so does their longevity.

Frailty

A cluster of characteristics that is most attributed to the aging adult is that of frailty. Countless definitions

exist to describe frailty; a simple definition is "late life vulnerability to adverse health outcomes."[13] Imagining how a physically frail individual looks is no challenge. Quantifying frailty is more difficult. Fried et al established the quantitative components of frailty as well as the frail phenotype. The frail phenotype has several components including weight loss, weakness, poor endurance, and low activity.[14] These descriptors are powerful in capturing the physical well-being markers that can result in consequences related to poor mobility and falls. Similarly, the idea of social frailty exists and encapsulates those factors that capture mental and social well-being. Social frailty is defined as "a continuum of being at risk of losing, or having lost, resources that are important for fulfilling one or more basic social needs during the life span."[15] Components that contribute to the perception of social wellbeing progress from more basic aspects of owning a home and having the ability to mobilize within it, to having a social network that you are able to interact with and feel cohesion within.[15] Isolation restrictions related to the pandemic appear to create a perfect union of the exacerbating physical elements of frailty as well as the limiting the social aspects. Social isolation can have exceptionally devastating impacts on cardiovascular fitness, physical well-being, routine social interactions, life space, and cognitive well-being. Each of these factors are independent predictors of frailty. Ultimately the question now becomes, as aging adults are continuing to be isolated across the spectrum of community dwelling to skilled nursing homes, is this creating a situation of forced frailty?

Conclusion

As physical therapists, time spent getting to know a patient is critical. Deleterious effects are now shown to contact isolation measures; it is likely that because of the ongoing pandemic such restrictions will continue. However, given that physical therapists spend more time with patients than most other clinical professions, our ability to anticipate the aforementioned impact of social isolation, serve as source of social interaction, and screen for possible exacerbation of physiologic and psychologic dysfunction is more important than ever. It is paramount to avoid assumptions that if a patient appears friendly and happy that they aren't experiencing anxiety, depression, or loneliness as these can be experienced silently. Therapists must be sensitive to recognize developing mental as well as physical illness. "It wasn't all sadness. People laughed a lot. Or perhaps I should say that sadness has many faces, and laughter is one of them."[16] This quote highlights the importance of garnering rapport in order to ask difficult questions that may reveal sadness behind a well-placed smile. In summary, never again should it be assumed that homebound status will occur without negative impact. "So this is for my own good?" should always be followed by an interactive discussion.

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Balancing Our Measures

by Carole Lewis PT, DPT, PhD, FAPTA and Linda McAllister PT, DPT

Standing balance is an essential component of mobility and a frequent target of physical therapy interventions for the older adult. While we may be familiar with many of the standardized measures of balance, evidence is constantly evolving. In this article we will review the evidence surrounding a few commonly used balance assessment measures, with a focus on lower level balance tests.

The Berg Balance Scale (BBS) is a well-known, well-validated measure, studied in many older adult sub-populations, and is highly correlated with function.[1] Multiple fall cut-off scores have been suggested in the literature, ranging from 45-51 points.[1] A recent study examined the use of the BBS with older adults residing in nursing homes, which demonstrated excellent ability to identify fall status with a cut off score of 47.[2]

Muir et al suggested that the BBS is better used as indicating risk gradients for multiple falls, rather than dichotomous cut-off point, and found that scores below 40 showed a significant risk of multiple falls.[3] Throughout the literature, it is noted that no single performance measure is adequate to accurately predict falls, including the BBS. A recent meta-analyses by Lusardi et al studied the predictive properties of a constellation of measures (history, self-report and performance) and recommended including the BBS as one performance test in a cumulative measure. In this meta-analysis, a BBS score of 50 or less contributed to an increased post-test probability of fall risk of 59%, more than any other performance measure.[4]

Tinetti's Performance Oriented Mobility Assessment (Tinetti, POMA), another popular measure, has been used widely in the clinic since it's development in 1986. While an established reliable and valid tool, the POMA has demonstrated lower sensitivity and specificity than the BBS in identifying older people at risk for falling.[5,6] Lusardi et al's meta-analysis found the POMA demonstrated lower post test probability than the BBS and appeared less useful in evaluating the risk of future falls.[4]

One disadvantage of both of these measures, especially the BBS, is the time required to administer the test. The four-stage balance test is a shorter alternative and used as a screening tool in the STEADI toolkit.[7] The test measures the ability of the participant to independently hold postures for 10 seconds with a progressively smaller base of support: feet together, semi-tandem, tandem and single - leg standing. *The participant may not hold onto support while assuming the posture but can receive steadying support from the tester while moving into the position.* The inability to maintain a tandem stand for 10 seconds is associated with an increased risk of falling.[8]

Another salient, high-merit test within the four-stage balance test is the single-leg stand (SLS) test. A score of less than 5 seconds has demonstrated increased risk of injurious falls, of ultimate importance for prevention.[9] A recent study demonstrated that the single leg stand test along with 3 screening questions (How old are you? Do you live with someone? Do you need assistance with IADLs? See article for details) constitutes a promising tool for screening older adults to predict first-time injurious falls.[10] The single leg stand test has demonstrated robust capacity to identify risk of falling comparable to more comprehensive measures of balance such as the Brief BESTest.[11]

Timed Up and Go (TUG) is another well-studied, widely used testing measure which assesses static and dynamic balance components as well as general mobility. Cut-off scores have been reported for fall detection in various populations which range from 10 seconds to 13.5 seconds.[12] Lusardi et al's meta-analysis found that a cut off score of 12 seconds demonstrated increased post- test probability for falls of 47%; [4] this is best administered in a battery of performance measures. Barry et al noted in a systematic review that the TUG has limited predictive ability for community dwelling older adults; it is better at ruling falls in than excluding falls risk.[12] These studies underscore the importance of using the TUG in combination with multiple tools [and not in isolation] which reflects the multifactorial nature of balance.

Clinicians must weigh the psychometric merits of each balance measure or combination of measures while considering time constraints in busy setting. In our next column, we will explore clinically feasible, evidence-based interventions for balance with a focus on patients that function at lower levels.

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Lifelong Learning	Identify target audiences and their education needs, to expand our reach with diverse learning formats.	• Deploy survey to understand knowledge gaps and content opportunities • Develop hybridized Certification Courses • Define the value proposition of an Academy-hosted standalone conference
Advocacy	Develop an advocacy agenda, to raise awareness of geriatric physical therapy.	• Identify engagement and partnership opportunities that drive our agenda • Prioritize issues for geriatric PTs/PTAs and students • Research opportunities to develop a student outreach program