

Gerinotes

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APTA Geriatrics.

An Academy of the American
Physical Therapy Association

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GeriatricNotes

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APTA Geriatrics

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From the President



*Cathy Ciolek
President,
APTA Geriatrics*

The “dog days of summer” are here; I hope you are finding a way to stay cool. While the term comes from the rising of Sirius, the “dog star,” it coincides with the time of heat and humidity, a time where relaxing with lemonade and a hammock are welcome. What you should know is that your Board of Directors and leadership have been active and busy this summer.

In June, the Board of Directors conducted a strategic planning session utilizing the information you provided in a survey earlier this year. As a board, we each read “MemberShift” by Sarah Sladek, a non-profit organization membership professional who focuses on the changing needs of members. The retreat is the start of our process to update the strategic plan for 2025-2028, and we will continue to develop it and share it with you at or before CSM 2025.

At that meeting, we were also provided with an update about the APTA House of Delegates by our Chief Delegate, Beth Black. Beth has been coordinating the APTA Geriatrics delegation, including Amy Smith Hamel as delegate, and the president as Alternate this year. She has also taken the lead to invite our Student Caucus rep Faith Majors-Culp, a student at the University of Maryland Eastern Shore PT Program, along with several other interested students and other section delegates to have a broader group for discussions in preparation for this year's HOD in July. Voting for national elections will take place later this year.

Earlier this summer, Balance and Falls SIG Chair Heidi Moyer coordinated with other Balance and Falls SIGs in APTA sections to kick off planning for Falls Awareness

Prevention Day which is annually on September 22. The SIGs efforts have gathered notice, and we are delighted to now be coordinating with APTA to have falls be a feature for PT Month in October. So, now is a great time to consider how you can plan events for this fall either for Falls Prevention Awareness Day and/or PT Month Falls Awareness Activities. If you need resources, check out the [Balance and Falls Prevention Toolkit](#).

This summer has also been very active in the work of adapting the CEEAA program to a hybrid format. Hybrid CEEAA co-chairs Robin Schroeder and Jackie Osborne have worked extensively with course faculty and our education consultant to design and launch the new hybrid format. If you haven't taken the course previously we invite you to check it out [here](#).

Additionally, the Nominating Committee has been actively interviewing candidates for our next elections APTA Geriatrics offices. This election will take place in October, you will be mailed information on the candidates and how to access the ballot. Thank you to the committee led by Minnie Rafael, for their work to provide a slate of the best qualified candidates for the open positions this year.

As you can see, this has been a busy summer, and this is just a small example of the activities that are currently underway. Did you know we have over 370 members who serve the Academy on a committee, task force, SIG, editorial board, advocacy or other role? If you want to join us in this work, consider updating your profile with [APTA Engage](#), where we post openings on a fairly regular basis and they will be shared with you via email.

Grab a drink and find a place to keep you cool this summer while we work to serve you!

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From the Editor



Michele Stanley
Editor,
GeriNotes

Happy Summer! There are good things to note in this issue, peruse it while sipping a beverage of choice in the shade. Meet the leaders of the newest SIG *Where Do You Work?* as they share their motivations for starting the new SIG, goals, and some personal history. Read the guest Policy Talk column on Documentation written by SNF

gurus Jaclyn Warshauer and Mary Saylor-Mumau; information that is necessary for all practitioners but especially germane to those in SNF and LTC settings. Get the tools for expanding the way that you visualize the functional limitations for people with Parkinson's (read *GetLit* and then congratulate me on a fine pun). Enjoy catching up on Journal Clubs – both May and July case presentations are in this issue. Hear from colleagues making decisions about pathways to GCS *Resident's Corner* and from *PTA to PT*. World Day of Service is always on the horizon, Twilight Reflections provides another opportunity to engage.

I am a sucker for trying new gadgets, technology, and techniques but frequently don't have the administrative, time, or financial resources to test them out myself. My clinician's heart is always so happy when a fellow

PT does the informed testing – and then shares that information. If you don't already, please follow Dr. Dustin Jones' or Dr. Jeff Musgraves' podcasts called *Fitness for 55+*. They are always a mini trove of good information and knowledge translation. It was very handy to refer to and to refer a client to who had heard about vibration plates and was convinced that it was a better treatment alternative to her creeping osteopenia/osteoporosis than "drugs or exercise." If you are not familiar with vibration plates, they are often hyped by the "research" of the companies that manufacture them as a magic and essential bullet for building bone density and circulation. While this isn't supported by strong RCT science, they do look like fun and it is easy to see the consumer appeal. Also, way less sweat involved so you don't stain your Lululemons. Thanks to Dustin Jones and StrongerLife for permitting us to share! Check out this podcast and see for yourself: <https://www.strongerlifehq.com/blog/vibration-plates>

Mark Your Calendars for the 2024 NFPAW Kick-Off Call: July 10th, 7 pm CST

The APTA Geriatrics BF SIG will be hosting our Annual NFPAW Kick Off Call on Wednesday, July 10th at 7pm CST! This year, we will be using the Geriatric 5M's Framework to encourage our members to comprehensively address falls prevention and preparedness. We have an amazing line up including other SIGs, Task Force representatives, and more! [Join us!](#)



Register for the free **Journal Club** discussion webinars and earn 1.5 contact hours. Questions for presenters may be emailed to gerinoteseditor@gmail.com before or on the day of the webinar. See what's coming up at <https://aptageriatrics.thinkific.com/collections>.

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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.



Progressing From Treatment Plan to Payment Via Informed Decisions and Effective Documentation

by Jaclyn Warshauer, PT, CRC and Mary Saylor-Mumau, PT, RAC-CT

Medicare coverage is limited to items and services that are reasonable and necessary for the diagnosis or treatment of an illness or injury. Reasonable and necessary (R&N) guidelines require that the service is safe and effective:

- is furnished in a setting appropriate for the beneficiary's medical needs and conditions;
- is appropriate, including frequency and duration;
- and the service meets,
- but does not exceed their medical need.¹

Therapists must consider these R&N guidelines when developing the treatment plan at the time of the initial evaluation and reassessing it throughout the episode of care.

Therapy treatment plans must be R&N and provide value. Creating R&N and valuable treatment plans takes thoughtfulness: *Why THIS therapy? This plan of care? This intervention? This amount, frequency, and duration? These goals and this prognosis? It's wise to consider these questions and to document the clinical reasoning behind your treatment plan.*

Beyond Diagnosis

A teenager with a growth plate fracture, a school-teacher with a pathologic fracture, and an elderly patient who rolled out of bed may all have femur fractures. They each have a unique history and presentation that will dictate the course of treatment and need for therapist

skill. To effectively assess an individual's needs and establish an appropriate treatment plan, therapists must look beyond the patient's diagnosis or injury and see them as a whole person with unique complexities and document those details.

Reason for Referral (RFR)

Appropriate treatment planning begins with a clear understanding of the events that led to the decline in function and their specific concerns. Your RFR is like an opening statement in a trial. It outlines the facts and frames the evidence to set the scene in a favorable way – explaining what changed and why and making the case for why therapy services are needed. The RFR gives a glimpse of the past, the present, and the future. This is a good place to add assessment or analysis statements about the factors that might influence the amount of therapy services needed.

Requirements and Challenges of Home Environment

Therapists should document specific details of the person's home and routines. A rural home might have a long walk to the mailbox, uneven terrain between the door and the driveway, or few to no options for meal delivery. Conversely, urban settings may be apartments with or without elevator access, laundry facilities, and tight spaces. These details impact functional success after

therapy, so they should be documented and considered during treatment and discharge planning.

Functional Skills Assessment

Objective measures of functional abilities are essential to communicate the patient's abilities and challenges. Include the Current Level of Function (CLOF) as well as the Prior Level of Function (PLOF) for each functional area that will be addressed in treatment. The PLOF should reflect the status just prior to the onset of the decline that is now necessitating therapy services.

Measured Underlying Impairments

Patient conditions are communicated as medical diagnoses, treatment diagnoses, listed in the RFR, reported as relevant comorbidities, and noted through functional skills assessments. Some conditions and functional deficits prompt certain impairment assessments. For example, a recent TKA might prompt measures of pain, ROM, strength, balance, and edema. On the other hand, a noted diagnosis of GERD would not prompt the need for underlying impairment measurements.

Long-Term Goals (LTGs)

LTGs should relate to the meaningful activities that the patient cannot perform at this time, or has more difficulty performing, as the result of their illness or injury, but hope to be able to perform again as a result of the therapy intervention. The goals, when achieved, will make a difference in the patient's and/or caregiver's life. The LTGs established should reflect the criteria for discharge from PT services in your setting.

Short-Term Goals (STGs)

STGs should be patient and point-in-time specific, aligned with patient's goals and the clinical assessment, and set for a performance target that will be achieved within 2 weeks. They should be steppingstones that progress toward the LTGs. When writing goals with performance targets, choose a performance "ruler" that has as many measuring points as possible with increased sensitivity to change. The GG rating scale used in SNF documents bundle multiple assistance levels into single ratings. Using this scale, a patient would have to progress from contact guard assistance to standby, to supervision, and again to set-up/clean-up assistance before earning a new assessment rating. As such, this scale may not readily show the benefit of treatment.

Therapists should think about the anticipated gains for the patient and ensure that the assessment tool selected will appropriately reflect those changes. For example, if balance is impaired, specifically balance with trunk rotation and floor-level item retrieval, using the Berg Balance Scale would be a better choice than the Tinetti Performance Oriented Balance Assessment which

doesn't address those performance areas.

Your intensity, frequency, and duration treatment plan must be individualized and based on identified and MEASURED problems. Just saying something is "impaired" isn't enough. It must be measured to communicate the extent of the impairment.

Intensity

The number of interventions needed each session and the number of impairments or body parts that must be addressed will influence how many minutes it will take to deliver the treatment. In addition, some comorbidities and complexities may impact the need for higher or lower anticipated treatment minutes.

Pain, treatment tolerance, mental health, or cognitive deficits may impact treatment time, depending on the person and their current situation. Someone in a significant amount of pain might only tolerate a pain reducing modality and instructions for positioning to reduce pain, leading to a shorter session, with the plan to add additional treatment interventions as the pain reduces. Other patients with pain might tolerate multiple treatment interventions, but because they move slowly and cautiously, and frequent analysis and adjustments are needed to ensure the activities are performed safely, it may lead to a longer treatment. Unfamiliarity with task concepts, or mental health or cognitive deficits which require additional direction, instruction and cueing may lead to an increase in treatment session minutes for some but might be a limiting factor for others if the longer session becomes overwhelming.

These patient-specific characteristics that lead to longer or shorter than typical treatment intensities should be documented as they influence the medical necessity of the services.

While underlying impairments are not the only consideration influencing intensity decisions, they are a key consideration. Therefore, comprehensive underlying impairment assessments are necessary to ensure the development of the most appropriate treatment plan. One other clarifying point...only measured underlying impairments that are causing an identified and measured functional deficit should be a focus of treatment.

Frequency

As with intensity, many factors influence treatment frequency. The type of interventions required, certain medical conditions, the acuity of the conditions, and patient comorbidities, complexities and risk factors must be considered when determining frequency.

Decisions for frequency are not exclusively based on the considerations in Table 1, which is not all-inclusive. This table is meant to demonstrate that there is a continuum of frequencies, and many clinical factors are considered when determining the appropriate frequency.

Duration

The treatment duration is based upon clinical reasoning and explains how long therapy will be needed in your setting to meet the LTG(s). Key factors that influence duration include the events and/or conditions that caused the functional decline to occur, the amount of functional decline experienced, and the functional level that is expected to be regained that requires your skill in your setting. How you explain the events causing the decline in the RFR will play a significant role in justifying the duration of treatment planned.

Consider how long it might take to regain a PLOF of independence for a patient that requires moderate assistance for mobility after a THA versus a patient that requires moderate assistance for mobility after a CVA with hemiplegia. The plans of care will be different for

learning a new skill or HEP, then the assessment should reflect a cognitive level consistent with the ability to improve or learn in time (e.g., Allen Cognitive Level 3).³ Document the cognitive level but also include an explanation of what that level means such as “the patient has potential to learn but will require several weeks of repetition” to learn the necessary tasks or program. This shows the treatment plan is being customized to be successful despite the cognitive deficits.

Components such as cognition, pain, medical stability, or physician protocols or restrictions could be a strike against you if you haven’t documented how you’re going to adapt around them and why your services should continue and be beneficial despite them.

A rehab potential of “fair” does not strongly support the need for services because it suggests that the goals and/or plan are not appropriate for the patient, and it is likely

Table 1:

← FREQUENCY →	
Exacerbation of a chronic condition	Acute loss of function due to a new illness or injury
No need for modalities	Need for modalities (i.e., for pain or wounds)
No cognitive issues	Dementia or cognitive issues in need of frequent interaction and repetition to learn
Potential for decline in function without intervention	Likely rapid decline/loss of functional skills without daily interaction

both patients, including duration, in part, because of the events that caused the change in function.

In addition, the difference between the PLOF and the CLOF and the number of underlying impairments that must be addressed to regain the functional level needed to transition to the next setting (or to a HEP/FMP) will also play a significant role in determining the duration of treatment expected in your setting.

Influencing Factors/Barriers

If there are factors or barriers that impact intensity or frequency or duration, EXPLAIN IT. Especially if the services are expected to be more than typical. If factoring one or more conditions or physician ordered restrictions into treatment plan decisions, DOCUMENT IT. As the Centers for Medicare and Medicaid Services (CMS) indicates, “Documentation should establish the variables that influence the patient’s condition, especially those factors that influence the clinician’s decision to provide more services than are typical for the individual’s condition.”²

Reporting barriers without a paired plan or strategy to overcome them doesn’t necessarily support more time and in some cases has the opposite effect. For example, reporting cognitive deficits as a reason for lack of progress, without explanation about how treatment will be adapted around the cognitive deficit to facilitate treatment effectiveness, is not going to buy more time. Treatment plans should be effective despite the cognitive deficits. If cognition is impacting the rate of progress, and goals focus on functional improvement or the patient

to raise medical necessity concerns. Reviewers also expect that patients will participate in therapy to the degree that they are able. Therefore, stating that the patient is cooperative and participatory isn’t a strong prognostic indicator.

Skilled Services

CMS has many references to therapist skill in their Medicare manuals. They talk about services that are complex and sophisticated, that require the judgment, knowledge, and skills of a therapist, that are necessary for improvement, maintenance, or prevention of decline, among other details.² The concept of “skill” is so heavily emphasized in medical review because CMS has established that level of importance, and many other payors follow the Medicare coverage guidelines for therapy.

Unfortunately, there is no defined list of skilled tasks. Sometimes tasks are skilled, but sometimes they’re teachable. It depends on the circumstances. Impaired function with ambulation, strength, and balance probably requires skilled interventions from a therapist when the therapeutic task is new, the patient’s performance is being analyzed, and modifications are being implemented. But that need for therapist skill will likely diminish as the patient improves. As such, skill isn’t defined by the task itself but rather the complexity of the task or the complexity of the person’s clinical presentation.

Medical reviewers and prior authorization entities make coverage decisions based on what is written in

the medical record, but the content of the written notes doesn't always project the same picture as the one that exists in the therapist's memory. Therapists tend to be patient-focused and document what the individual can or can't do, how much help they need, their rehab potential, and their goals. Therapists often forget to look inward and document the details of what they as the therapists contributed to the interventions. How did the therapist use their hands, what were they thinking, analyzing, planning? These details support therapist skill, and they are just as important as the patient-centered details that support medical necessity.

The distinction of therapist skill lies in the presence of 4 therapeutic components: Assess, Develop, Analyze, and Modify/Progress. Therapists should ask themselves if their skills as a therapist are required to safely:

Assess the patient's underlying impairments and functional deficits?

Develop a patient and point-in-time specific treatment plan for medically necessary services?

Analyze performance during interventions?

Modify and/or **Progress** the interventions in response to the analysis?

If the answer is "yes" for all four components, the service is likely skilled. If those 4 components are clearly documented, the medical record should support the need for therapist skill.

CMS specifically states that the unavailability of a caregiver will not make an otherwise unskilled service skilled.² Therefore, if a patient and/or caregiver has a

THE FOUR COMPONENTS OF SKILL	
ASSESS	Underlying Impairments and Functional Deficits
DEVELOP	Customized Treatment Plan
ANALYZE	Performance during Interventions
MODIFY/PROGRESS	Interventions in Response to Analysis

history of non-compliance or if the therapist has concerns that they will not comply with a soon to be established program, this would not give cause to continue to deliver the service after it is no longer skilled. Also, while the patient's diagnosis may contribute to their complexity and may impact their need for our skill, the diagnosis in and of itself, does not justify skill.

Consider a treatment note that states, "Patient ambulated 50' feet with walker, minimal assistance, and verbal cues for foot clearance." These details report what the patient did but they don't describe the inherent components of skill. The medical record should highlight the treatment components that an aide couldn't do (e.g., stabilizing the hips during a specific phase of gait, timing and grading verbal cues needed for foot clearance during another phase of gait, and identifying the limiting factor(s) for distance walked).

Admittedly, therapists must also be efficient with their time. Perhaps not every CPT code can be documented with this degree of detail every day for every patient. If therapists committed to including one extra detail of skill on each daily note written on one day and then the next day, committed to documenting one different detail of skill for those same patients, it would be very impactful.

Reassessment

The individualized treatment plan for the patient today might not be the same treatment plan for the person tomorrow, or next week, or next month. Treatment plans over an episode of care are not static because patient levels of functional deficits and measures of related underlying impairments are not static as the patient responds to our treatment interventions. Because people are always changing, our individualized treatment interventions, intensities, frequencies, and duration must always be reviewed and updated to meet the current needs of the patient effectively and efficiently.

Teaching What is Teachable

Many believe that interventions learned in a PT/PTA program must be skilled. But many of these techniques can also be taught to patients or their caregivers. So, when is something teachable and when is it not? If each of the 4 components of skill were present, an intervention would not be teachable because it still requires the therapist's active presence and participation. But if one or more of the skilled components were not present, it is likely that it is teachable. Interventions that are skilled today may be teachable tomorrow, so therapists should assess for the required skilled components initially and then continue reassessing thereafter. Effective transitioning of interventions that no longer require therapist skill to the patient and/or caregiver will allow therapists to emphasize those things that only they can do. It's good for the patient, it's good for the therapist, and if it's documented well, the medical record will support the need for skill.

Repetitive exercises or tasks could be a possible indicator of lack of skill. If an intervention is repetitive by design (e.g., pendulum exercises for 4 weeks) or repetitive due to patient refusal or non-compliance, it would most likely NOT include those 4 required components of skill. Some repetitive tasks are challenging at first, but become easier over time (e.g., lymphedema wrapping). Initially, the patient likely requires therapist monitoring, assessing, and intermittent participation, but this need will fade over time and the task can and should be taught.

In some cases, the technique isn't changing, but the patient is at such a level of complexity that analysis of their condition and their response to the repetitive task requires therapist skill. If therapists are performing categorically similar interventions (balance training,

cognitive training, etc.) but each day they are reassessing, adjusting, and progressing as able, it will be important to document those not so obvious considerations, observations, analysis, and modification details. If progression is attempted, but the patient wasn't successful with the task, this should be documented because it is evidence of analysis and adjustments, even if the final decision was that the progression wasn't yet appropriate.

Prevent Unintended Misinterpretation

Consider the unintended optics of your documented narratives. If a note says that the patient "performed" exercises, it suggests that the patient didn't need the skills of a therapist. The note should report the skilled techniques, strategies, and dosing methodology that were utilized during the treatment. Similarly, when addressing gait quality, therapists should highlight the skilled components and use the term "gait training" versus walking or ambulating.

A therapist's documentation is their opportunity to give insight into their assessment and analysis when reporting patient and point-in-time specific details. Documentation software systems ease documentation burden by offering a collection of details selected through a series of mouse clicks, but this can result in non-compelling narratives. There should be a balance between the prefabricated non-specific sentences and the skilled, analytical, patient specific components which will likely require manually filled-in or add-in details.

Ignoring little to no progress, or situations in which the person declines, will suggest that the patient has plateaued, or achieved the maximum benefit from the therapy, and may not be supportive of further therapy. If they have not achieved maximum benefit and are not being discharged, explain why the patient is not progressing right now. Generally, the reason why the person is not progressing should be a transient issue such as a new onset of an illness, new pain, new exacerbation of a condition, or new onset of undue stress, such as a family issue. These would suggest plateau or set back is temporary.

Relating lack of progress to the impairments currently addressed in treatment such as weakness or balance deficits would suggest that the treatment is not effective and not R&N. It is expected that impairments will respond positively to treatment. Lack of progress will be evident to a reviewer when comparing goal status over time. Acknowledge it, explain it, and report how treatment will be modified to jumpstart progress.

Justifying Further Care

Many readers of medical records (e.g., medical reviewers, prior authorization entities) will not read between the lines of the documentation. TELL them what remains to be achieved and why this is important to the patient.

When insurance coverage is in question, therapists should participate in peer-to-peer discussions with payors if available. These discussions, if navigated appropriately, can be very impactful because they allow the therapist to talk about the whole patient and their real person challenges thereby giving the person a voice, a face, and a story that is relevant to the treatment plan. Therapists should take advantage of their opportunity to advocate by referencing notable challenges, gains, and other details from the medical record.

Payors are frequently asking for therapy medical records to determine if past services should be reimbursed or to authorize future services. Our records must convincingly demonstrate that this patient needs our skilled services at this specific point in time and for the treatment plan set forth. Documenting in a clinically persuasive manner (comprehensive and accurate clinical details with a clear connection to real life circumstances) will enhance documentation quality and will better support medical necessity and reimbursement for our services.

[This article was prepared by the authors in their personal capacity and based on their program presentation at CSM 2024. The opinions expressed in this article are the authors' own and do not necessarily reflect the views of Aegis Therapies, Inc nor those of APTA Geriatrics]

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Jaclyn Warshauer, PT, CRC is the National Director of Medical Review & Quality Services as Aegis Therapies where she monitors and trains on regulatory affairs, documentation, and coding. Jaclyn has worked as a Medicare medical reviewer and has served as a resource to CMS on subjects related to coverage and documentation of therapy services.



Mary Saylor-Mumau, MPT, RAC-CT is a Medical Review and Denials Manager at Aegis Therapies where she provides training and support on documentation, billing, compliance, medical review, denial, and appeal issues. As an MDS Coding Consultant for Post Acute Care Solutions (PACS) Consulting, she reviews medical records and provides education and recommendations for MDS coding accuracy.



Where Do You Work?

by Michele Stanley, Editor

“APTA Geriatrics has a significant portion of its members who practice and work in SNFs, and we recognize that their issues and areas of interest are often unique. This new SIG is very much needed and will spotlight member voices to intentionally bring attention to this large practice setting. I am very happy to see this energetic group get started and look forward to the massive potential it has to influence physical therapy and patient outcomes.” Greg Hartley, past President and Vice President of APT–Geriatrics, commenting on the formation of the newest Special Interest Group (SIG).

Adding a new SIG is a welcomed benefit and opportunity for those who work within that area of expertise and interest. From personal experience as a founding member of other recently founded SIGs (Global Health and Cognitive Mental Health), I can also attest that it takes a fair amount of administrative work and energy to make the new SIG come together and thrive. Like with most tasks, many hands lighten the load and speed the process, and the new leaders of the Skilled Nursing Facility (SNF) SIG welcome all interested parties to join in. During the 2024 issue year, GeriNotes will feature articles

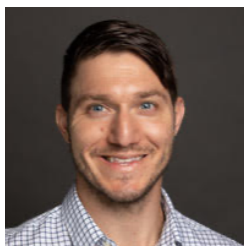
about this SIG as well as articles of special interest to those therapists who practice in the SNF or Long-Term Care (LTC) setting. This issue will introduce two of the new officers who agreed to answer some questions about themselves and the ideas that they bring to forming the new SIG.



Chair Richard White, PT, DPT

Richard White is the Corporate Rehabilitation Director of Education and Clinical Practice for Sigma Health Rehab. Additionally, he proudly chairs the APTA’s Academy of Geriatrics Skilled Nursing Facility Special Interest Group. Based in Utica,

NY, Richard guides and educates the Sigma Health Rehabilitation team across New York State and New Jersey, focusing on best practices within Skilled Nursing Facilities. He has been an APTA Geriatrics member for several years.



Vice Chair Kevin Cezat, PT, DPT, GCS

Kevin Cezat graduated from the University of Central Florida Physical Therapy program in 2011 and have been working in long term care within central Florida for the past 14 years as a staff therapist, a rehab director and currently as the

Director of Clinical Excellence for Therapy Management Corporation. He is interested in professional advocacy, promotion of interdisciplinary team development, and implementation of dosing methodologies. He has a wife who is also a Physical Therapist who currently serves on the APTA SCI SIG; they are parents of 2 young boys. He has been an APTA Geriatrics member for most of his professional career and has been a member of other SIGs.

What motivated you to start a SNF SIG?

Richard: While working in skilled nursing we were faced with a lot of challenges and questions that we just couldn't find great resources for. Our leadership team at Sigma started to create the resources and implement practices to best address these challenges we were faced with. We wanted to advocate for more help, more ideas, more resources for those practicing in skilled nursing so that they don't feel like they are alone on an island.

Kevin: I have always been eager to implement best practice and consistently attended Combined Sections Meetings and APTA Geriatric programming in an effort to better my practice. I became aware of a current disparity in resources and support for clinicians working specifically in long term care and was eager to find a way to bridge this gap.

What would you envision as goals for a SNF SIG?

Richard: Our goals are the goals of our constituency. We have provided our SIG members a 2 question form to send their responses to us and tell us what they want. Our interests often mimic their responses

- Maintenance therapy
- Navigating Managed Payers / Authorizations
- Advocacy for delivering more treatment
- Documentation

Kevin: Initially we are trying to get a good handle on what resources are the priority for our stakeholders. Each of us have different ideas about what tools, resources and trainings would be most useful. Ideally, we are hoping to become one of the largest SIGs and create tools and guidance that directly and immediately impacts the quality of care in SNFs.

Do you have thoughts on new grads vs experienced therapists for first time jobs in a SNF?

Richard: I think, at this time, most skilled nursing facilities are seeing a wide spectrum of patients with a myriad of diagnoses and acuities. Gone are the days of seeing Mrs Smith for 2 weeks post a hip or knee replacement. You're more apt to see Mrs Smith who sustained a fall at home and suffered head trauma affecting her cognition, was on the floor for too long and developed a wound, and her managed insurance is only giving her 7 approved days before discharge back home. The therapist has responsibility to coordinate with multiple members of the IDT (inter-disciplinary team) on top of managing their schedule of other residents and documentation. That being said, I think the SNF is a great place for a new grad to see a lot and learn a lot in a short amount of time. Sigma had assigned a Clinical Coordinator position to Jocelyn Nackley OTD to work on, amongst other things, student orientation to SNF. Experienced therapists have their place in SNF as well. Physical therapy and practice is ever evolving. As long as those with experience are willing to pivot and willing to learn, SNF therapy is a welcome home.

Kevin: I think it is an intimidating setting for new grads due to highly complicated and frail patients, patients with cognitive impairments, the concept of treating someone towards the end of their life, and the environment being so heavily regulated. I think they can thrive with the right mentorship, but it can be an environment where new clinicians can easily fail.

What do you think was your formative clinical experience or training for becoming a SNF therapist? What needs to be taught as part of DPT programs to make this successful?

Richard: I worked in customer service ever since I could work. I believe that as therapists, we are in the customer service business, and we have a product we need to get out there. The good news is, we know our product works! We need to serve those in our skilled nursing facilities – the residents, the over worked nursing staff. We have to...

Kevin: Personally, I had moments in CSM presentations over the years where my approach clinically has been challenged and I was forced to continue to up my game with evolving best practice. I think an understanding that you will always need to work hard to stay up to date is key to being successful.

What 3 things do you think that EVERY physical therapist needs to understand about skilled nursing rehab?

Richard:

- It's not a cookie cutter arena.
- It requires a versatile clinician.
- We shouldn't be afraid to treat and deliver best practice to residents in a skilled nursing facility.

Kevin:

- This population is one of the most at risk and complicated populations in terms of health outcomes and quality of life; clinician's skillsets need to match those challenges to be successful.
- The concept of this setting is challenging to the mindset of most Physical Therapists because we are so focused on improvement and return to PLOF, where often in these settings we play a major role in slowing declines and maintaining function.
- Many clinicians who currently work in SNFs are providing excellent evidence-based care, despite SNFs often having a negative stigma associated with clinical quality.

What excites you about rehab in a SNF or LTC setting?

Richard: No one is paying attention to it. I think we are truly on the cusp of giving something back to those, as I said before, who feel like they're on an island alone out there.

Kevin: Our interventions directly and immediately impact someone's quality of life and we often serve as the last line of defense in whether these individuals return home or continue into a downward decline. You also get a chance to connect with amazing people who have lived rich and full lives and are ready to share their lessons learned.

What do you see as the biggest challenges to rehab in SNF/LTC?

Richard: Documentation. I hear more and more about audits and 3rd party requests for documentation in which entire cases are being denied due to documentation issues. This is an area of opportunity we need to address

Kevin: Clinicians have found themselves in the middle of a tug of war between increasingly complicated regulations and diminishing reimbursement which has created a perpetual "do more with less" scenario. This is likely an impossible task unless we lean into best practice guidance to ensure we are providing the highest value interventions that are dosed at the optimum intensity. We also need to be prepared to advocate both through our documentation and our conversations to ensure we can continue to survive with further intrusion of Medicare Advantage plans and other value-based care programming.

You appear to work for a contract company, can you address pros and cons of working for a company vs in-house?

Richard: Speaking for myself, Sigma Health Rehab was born out of Centers Healthcare. Our same leadership team has been working together for quite some time now and we don't see much of a separation between the two, it's more like a brother-sister relationship.

Kevin: I have worked for several contract companies, but no in house companies. I think the challenge with contract companies is true when working for any company where the quality and mission can vary greatly depending on the leadership and financial goals. It is important for clinicians to ensure these values align with their own.

Join the Discussion!

Join the APTA Geriatrics **Forums** discussion group for intellectual exchange on clinical, regulatory, and other professional topics related to geriatric physical therapy.

See you there!



<https://forums.aptageriatrics.org>





Twilight Reflections

by Julie Hartmann, PT, DSc

Starting a nonprofit organization that focuses on older adults has been a transformative and rewarding journey for me. As I reflect on the 10 years that I was the Erie County Chapter Director for the Twilight Wish Foundation, I am reminded of the motivations and inspirations that led me to this organization.

Twilight Wish Foundation¹ (TWF) is a 501(c)(3) nonprofit organization that grants the wishes of seniors sixty-five and older across the U.S. Founded in 2003 by Cass Forkin, TWF has granted over 5,000 wishes facilitated by seventeen chapters nationally. Forkin, who is currently Chairperson of the Board, strongly felt that older adults deserve to be recognized for all they have done for others throughout their lives. This inspired her to found TWF, the first national organization to focus on granting wishes to seniors. Wishes granted range from simple needs such as lift chairs or dinner out at Red Lobster to larger, “living life to the fullest” wishes such as a ride in a Harley sidecar or driving cross-country in a big rig. To qualify for a wish, individuals must be 65 years old or a permanent resident of a nursing facility and have an income of less than 200% of poverty level. For 2023, that income amount is less than \$29,160. Applicants should

also have a demonstrated a history of giving to others.

The inspiration for my journey stemmed from a combination of personal experiences, a sense of responsibility for the aging community, and a desire to make a meaningful contribution. There is also a natural fit with the core values of the American Physical Therapy Association — altruism, compassion/caring and social responsibility.²

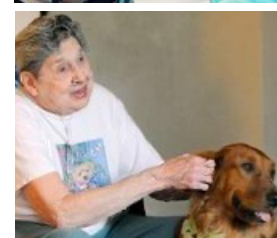
I graduated from Marquette University's Physical Therapy program in 1985 and the majority of my career has been spent working with older adults in my hometown of Erie, Pennsylvania. In 1993, my work focus shifted to the home care setting and knew I had found my passion. My territory was initially quite large. In the course of one day, I might be out in the country treating a client on his family farm and next be center city treating a grandparent who was responsible for raising her grandchildren. Home care allowed me to spend more time with patients in a comfortable and familiar setting. I also realized how the social determinants of health impacted the lives of my patients as well as my ability to provide the best care for them. I wanted to do more for these older adults and began to investigate other opportunities that focused

specifically on older adults. I transitioned to the academic setting in 2004 and was drawn to service learning and community engagement. During an internet search in 2009, I discovered the Twilight Wish Foundation. This was an opportunity for me to give back in a meaningful way to a population who had shared their lives with me and allowed me to provide care for them or their family members. It was also the perfect opportunity to increase student engagement with older adults. I had the privilege of spending 10 years as the Chapter Director for the Erie, Pennsylvania chapter of the Twilight Wish Foundation.

Given my transition to the academic setting, I was able to offer service opportunities for all levels of student involvement. The initial contact was with the graduate and undergraduate business programs. The graduate students assisted in the development of the TWF chapter governance as a final project. The undergraduate business students implemented the governance plans which included fundraising, scheduling of speaking engagements and development of media/marketing. Doctor of Physical Therapy students were also involved as part of the service-learning component of the physical therapy curriculum. They participated in fundraising, wish selection and wish granting, and community presentations (senior centers, booths at senior expos). For example, one group of students wrote and presented a grant proposal for floatable beach wheelchairs to allow older adults access to the beaches and lake. Students appreciated the value of collaboration with other community partners.

What Did I Learn?

Developing and maintaining a nonprofit was not easy and pushed me outside my comfort zone. Navigating the complexities of fundraising, legal requirements and the ever-changing landscape of the non-profit world demanded a continual learning process. I felt confident in my collaboration and communication skills given my background as a physical therapist and physical therapist educator. Although I had worked with older adults for the majority of my career, I was surprised by potential wish recipients' response to the question, "If you could wish for anything, what would you wish for?" Many replied, "I have everything I need." Nominations from family members or caregivers were heartwarming. Requests were simple yet meaningful: time with a therapy dog, hearing aids to be able to hear a sick wife call for help, visiting graves of children who had passed, meals with friends or family, a flagpole to symbolize strength in an individual battling cancer. I made new friends and developed new contacts in the community through these wish granting efforts. This experience made me rethink what was most important in my own life.



Three wishes: a flagpole to demonstrate strength for an individual with cancer; time with a therapy dog; a celebration of life.

I relocated in January 2020 with the intent of looking into creating a chapter in Louisville, Kentucky and then COVID-19 happened. As of June 2023, I am proud to say that I am now the Director of the Louisville Chapter of the Twilight Wish Foundation. I am looking forward to developing and growing this chapter in order to serve the older adults in Louisville.

References

1. Twilight Wish Foundation. Accessed Dec. 1, 2023. www.twilightwish.org.
2. American Physical Therapy Association. Core Values for the Physical Therapist and Physical Therapist Assistant. Updated Dec. 14, 2021. Accessed Dec. 1, 2023. <https://www.apta.org/apta-and-you/leadership-and-governance/policies/core-values-for-the-physical-therapist-and-physical-therapist-assistant>.



Dr. Julie Hartmann is an Assistant Professor in the Doctor of Physical Therapy program at Bellarmine University located in Louisville, Kentucky. She is also the Director of the Bellarmine University Geriatric Residency. She has been a physical therapist for 38 years with a primary focus in geriatrics for the past 25 years. She is a board-certified clinical specialist in Geriatric physical therapy through the American Physical Therapy Association.



PTA to PT Journey

by Zachary Hughes, PT, DPT

The journey of a Physical Therapist Assistant (PTA) to a Physical Therapist (PT) makes for a clinician with excellent skills, interpersonal efficiencies, and high-class critical thinking skills. Physical therapist assistants have a drive, a motivation, and a passion for the field. Every PTA that wants to make the journey has their own unique reason. Mine was one of autonomy; I have a driving force that pushes me in the profession. I was happy as a PTA, it afforded me a lot of joy and financial stability, however I always wanted more. I wanted to treat patients without restrictions, without needing supervision, and without confinement. I always felt that I had my hands tied and needed approval to provide care.

I believe that a physical therapist assistant needs to have an educational shift. I believe that our discipline has enough knowledge and treatment concepts that warrant a bachelor's degree as entry level degrees for physical therapy assistants. Diagnostic testing based on signs, symptoms, and clinical diagnostics has justified a shift to Doctorate level degrees and practice patterns for a

PT. Physical therapist assistants should be taught how and when to advance treatment techniques; PTA need to recognize signs and symptoms that assist the physical therapist in making accurate diagnostics and preparing thorough care plans. The field has grown to be both holistic and all-encompassing; a PT can and should develop a plan of care for illness, disease, and dysfunctions from head to toe, ortho to neuro, rehab to wellness. PTAs should have a knowledge base that allows for accurate assessment of progression and regressions. This will allow PTAs to assist the PT in differential diagnostics, increase PTA efficiency, reduce burn-out and enhance care.

The physical therapy profession has seen numerous changes; these changes are a result of the industry driving reimbursement, school tuition costs, and technology making access more accepting. Advancing one's professional skills through education, evidence, and training will increase an individual clinician's happiness. Arguably, this also requires increased individual effort and

commitment. However, there will always be the PTA that wants to make the journey. No matter the reason or goals, the decision to make the PTA – PT journey should not be taken hastily. It should be well thought out with full preparation.

The journey that I am writing about today is uniquely my own; it is one that I have a passion for. Since I made this personal transition, I now teach others who also seek to make this journey. My bias is less than encompassing, as I have grown to also teach in other curricular settings and programs. I am now more open to other options to increase the growth of physical therapy disciplines. The field has a current shortage of therapists; any PTA that wishes to become a PT should be encouraged to do so.

The journey to advance a career from a physical therapy assistant to a physical therapist is not a linear track. It is not a charity drive. It is not a participation trophy. It is a mountain, a marathon, and an earned award. The journey to becoming a Physical Therapist has had a few toll roads. First, a person can be accepted and complete a traditional tract. A person can complete a hybrid accelerated tract. Lastly, a person can attain an undergraduate degree, and transition into a graduate tract.

The journey to become a PT is challenging. It requires numerous degrees, high costs, and dedication. To become a PT from a PTA, you must have an associate degree with classes that meet a relevance requirement. Most programs require the classes to be within 5 years of acceptance. You also must have pre-requisites that fit acceptance. Most programs require statistics, anatomy and physiology, chemistry, and physics; these requirements are subject to the admitting program. Each program has its own grade point average standards; most require completion of a bachelor's degree. Completion of all requirements make the journey a lengthy challenge.

For me, the journey to become a PT was 11 years in total length. Fortunately, I had taken post-secondary classes in high school to complete some prerequisite undergraduate classes. My associate degree was completed in 3 years, of which 2 years was in the dedicated PTA program. Completing the bachelor's degree took another 3 years of actual time. Chemistry and Physics were not offered concurrently. My chosen PTA -> PT bridge program required fully attaining that bachelor's degree prior to application. My assumption is that most graduate programs require a minimum of a prior bachelor's degree, but I can only speak definitively to my graduate program. I learned during the application process of the journey that undergraduates at the same university are often seen as more favorable candidates to that institution's graduate program.

I was, fortunately, accepted into my graduate program on the first application. I only applied to the one program as I fully knew the requirements and geared my undergraduate studies toward that program. In addition, my graduate bridge program was close to home, and met the

needs of myself and my family. I knew it would be challenging to both work and complete my degrees. I needed to select a program that would allow financial stability, by physical proximity to home to be able to continue at a job that ensured steady income to support myself and my wife. My graduate bridge program met that need.

I have had open discussions with other PTAs who indicated that they applied to 4 or 5 programs, never got accepted, or were only accepted as an alternate. The competitive nature of admissions makes academic performance rigorous for a candidate to be accepted. In addition, the increasing multitude of programs available may make application and admission more challenging for a potential candidate. Once a PTA selects a program, they must meet those requirements and then be selected. Even if a candidate meets the listed requirements, they may be denied based on competition from other qualified candidates with a higher GPA, more logged volunteer hours, or a better essay (requirements in most programs). I knew that volunteer opportunities would likely be regarded critically. Thus, I ensured that I had a good mix of volunteer hours and opportunities on my application. I also assumed that a committee of professionals would be reviewing my application, so I highlighted completed volunteer opportunities, and spoke heavily on diversity in my required essay. I expounded on my work experiences as a PTA and explained how volunteering in low income urban and rural settings with a wide variety of socioeconomic factors had influenced me. Explaining an ability to treat all people without bias is a key factor that can set one candidate apart from another.

Once you have been accepted into a program the journey is still just beginning. The 3 years enrolled as a graduate student were the most challenging aspect for me. The workload is immense and rigorous. There was also a work requirement; I had to maintain employment as a PTA for 20 hours a week. I was able to work 40 hours a week in the first year, and then decrease my hours to 32 a week in the second and third years. All curricular courses are stair stepped in the hierarchy of learning. Each class builds upon the last, so the workload and study habits have to shift to accommodate the change in time demand.

A strong support system is integral but not imperative. A student without strong external supports system can be successful if they develop and maintain strong study habits with good practice patterns. I was fortunate to have a strong support system. My wife picked up all the slack, maintained a clean house, and was understanding of my time burdens. I also had a strong support system of other family and friends who would volunteer as patients for application practice. My work setting was flexible enough to allow me to meet the time demands of group projects, examinations, and in class sessions. I believe that without the support of my family, employer,

and work environments, I would not have been as successful.

The final hurdle is passing the national licensure. This was a very nerve-racking process. It's a cumulation of all the hard work, studies, and years of perseverance. It is one snapshot, one test that can determine the rest of your life. Candidates need to be reminded that it is a test that can be taken multiple times, however its very expensive and is only offered 4 times a year.

I took multiple practice exams, studied a review book, and put in solid time with material review. No matter how much you study, the pressure feels overwhelming. I left the exam feeling defeated and mentally drained. I thought that there was no way I passed the exam, after 10 long days, the passing result was received. I was finally a Physical Therapist.

I sometimes wish that becoming a PT was the end of the journey, but to be honest the adventure was just beginning. Becoming a physical therapist opened numerous doors and afforded many opportunities. Since the PTA to PT transition, I have returned to teaching, shifted into middle management in clinical practice setting, developed a private practice, and started to work on a specialty certification. Becoming a PT allows a person greater opportunities to be valued, to be trusted, and to be financially solvent. For this reason, I opened a private practice. I wanted to treat patients with autonomy and with minimal restrictions; private practice has afforded me these opportunities.

Starting a private practice, alone, did not provide enough financial support. Working as a full-time staff PT, and mixing private practice into my days, I moved into middle management as a Rehabilitation Director. I hoped that having control as a rehab director would allow for more autonomy of practice. This was partly true, as I could control the schedule, however some insurance restrictions present insurmountable barriers. I continue to grow as a clinician and work to lobby for professional freedoms and advancements of practice. When I was invited back to be a teaching lab assist, I found a passion that I did not know existed. I now believe that I can have the most impact on the profession by guiding and teaching clinicians of the future. My views and careers goals

have shifted slightly; I will work to grow in the academic world. The first step is specialty certification. Graduate programs value specialty certifications, and terminal doctorate degrees. I know this after experiences applying for full time faculty positions. My first goal is to obtain my Geriatric Specialty Certification, then work on my Doctorate in Education. For now, the journey continues. I have become a life long learner.

Although there are many days in which health care politics are bothersome, helping people is very rewarding. A previous professor told me one, "I get up every morning to help those that cannot get up every morning". It has been a quote that drives me forward. The most rewarding part of the job is the genuine thank you that is received from a patient at discharge. Those moments are the justification of years spent on the journey and the milestones achieved along the way.

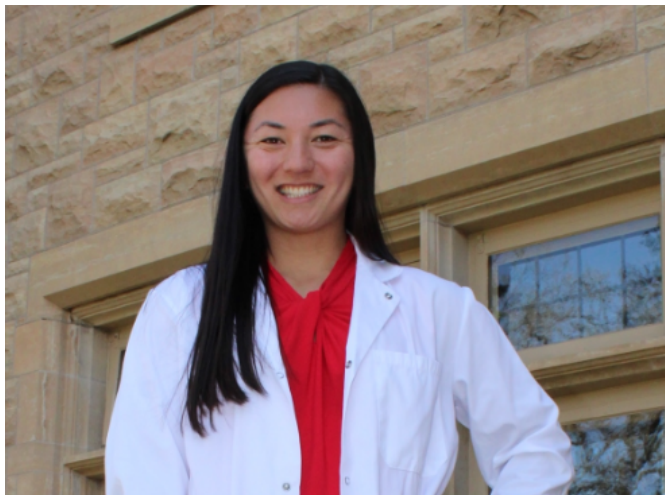


Zachary Hughes PT, DPT obtained an Associates of Applied Sciences as Physical Therapist Assistant in 2009, from James A. Rhodes State College, in Lima Ohio. He served 8 years as a Physical Therapist Assistant for St. Rita's Home Health. During those 8 years, he completed a Bachelor of Science in Healthcare Administration from the University of Northwestern

Ohio (2012), as well as a Doctor of Physical Therapy from the University of Findlay (2017). Dr. Hughes is the Full-Time lead Physical Therapist for The Spring, Synchrony Rehab, and works as a Part-Time Lab Assistant at the University of Findlay and Bowling Green State University. He also serves as the Clinical Education Partner for the University of Findlay. Dr. Hughes has ventured into the Cash-Based Model as the Owner and Lead PT of Unbroken Physical Therapy LLC, and thoroughly enjoys working with patients of various backgrounds, socioeconomic statures, and complexities of medical conditions. He loves to teach and hopes that one day a Full-Time teaching career will develop. He is a member of the American Physical Therapy Association, and a Credentialed APTA Clinical Instructor.

From Classroom to Residency: Navigating the Path to Geriatric Specialty

by Sarah Roberts, SPT



It all began during my first year of PT school. As part of Mayo Clinic's curriculum, we discussed the power of advocacy for our profession. Initially, when I heard the term "advocacy," my mind immediately jumped to politics—a realm I had little interest in. In fact, when the opportunity arose to participate in "PT Day on the Hill" at the capital, I envisioned my classmates and me marching around with picket signs that read, "Choose PT!" The mental image of this scenario led to laughter among my peers and faculty. However, my perspective on advocacy soon evolved. I realized that it wasn't solely about politics; it was about channeling passion into physical therapy. Our professors introduced us to various sections within the APTA, and I found myself drawn to the Geriatrics Academy. Why geriatrics? I can't pinpoint an exact reason, but perhaps it was influenced by my upbringing. Growing up, I frequently visited my grandma and great grandparents in Japan; these experiences instilled in me a deep appreciation for the importance of caring for the older adult population. In Japanese culture, there is a strong emphasis on the younger generation looking after their elders, and being raised within this cultural context could have ignited my passion for serving this demographic. Regardless, I knew deep down that this was the population I wanted to serve. My path to the Minneapolis Veteran Affairs Geriatric Residency was anything but straightforward.

I discovered many special interest groups within the APTA Geriatrics web page. At that time, I had a general interest in working with older adult patients, but I lacked clarity on what that truly entailed. The abundance of options left me in a state of analysis paralysis—a

common predicament for many of us. We all share an innate desire to help, yet often struggle with knowing how or whom to approach. In a personal challenge to myself, I decided to reach out. I composed an email to the chair of the balance and falls SIG. Little did I know that this simple act would alter the trajectory of my career.

After sending that initial email, I became the third ever student liaison for the APTA Geriatrics Balance and Falls Special Interest Group (BF SIG). This role involved contributing to balance and falls projects, offering a student perspective, and organizing a meet-and-greet event at the Combined Sections Meeting (CSM) for fellow SIG-involved students. Over the past 2 years, I've had the privilege of meeting APTA Geriatrics leaders, presenting on student-focused topics during the annual National Prevention Awareness Week call in June of 2023, and even embarked on research related to DPT and PTA Student Perspectives on Professional Preparedness for Managing the Clinical Needs of Older Adults. All this because I mustered the courage to reach out to one person, and that single connection opened a world of opportunities.

As I progressed through PT school, the inevitable question loomed: "What comes next after graduation?" Honestly, I often replied with uncertainty, acknowledging only that I was passionate about working with the geriatric population. I contemplated various paths—residency, staying at Mayo Clinic, or working at a skilled nursing facility or long-term care setting. Ultimately, I decided that pursuing residency was the path I wanted to take. Opting for a geriatric residency aligns perfectly with my goal of becoming the best possible physical therapist for older adults. It provides a specialized platform for honing my skills and knowledge in geriatric care. Additionally, a residency program allows me to explore teaching—an avenue through which I can give back and potentially consider further down the road.

I received acceptance into the Minneapolis VA Geriatric Residency to my pleasant surprise. As the program's inaugural geriatric resident, I owe it all to that leap of faith—the email I sent to someone I didn't know. My message to fellow aspiring geriatric clinicians is simple: Act. Often, we are our own limiting factor. Don't be the reason you look back and say, "I wish I had done more." After all, that drive to make a difference is what led many of us into this profession in the first place.

[Editor's note: Congratulations! We look forward to a progress report and your evaluation of your professional progress as you complete this residency]



Congratulations to the 2023 Credentialed Balance & Falls Prevention Professionals!

Congratulations to the following physical therapists for achieving their Credential as a Balance & Falls Prevention

Professional! And a special thanks to Lebanon Valley College (Annville, PA) for hosting everyone!

2023 APTA Geriatrics Credentialed Balance and Falls Professionals

James Aquino
Stephanie Baker
Maria Braxmeier
Marie Rose Campana
Amy Cerney
Madeline Cervini
Lynda Devlin
Adrianna Ellis

Russell Garrison
Kelsey Harrison
Christine Hobbs
Anna Hocker
Adrienne Jackson Hall
Andrew Johnston
Amber Kilgore
Deborah Koval

Brian NcLean
Justin Mierzwicki
Melissa Moore
Gerald Morigerato
Christopher Nugent
Paul O'Brien
Emma Peters
Nicole Pressner

Marangela Prysiazny Obispo
Sandra Rende
Bonnie Rogulj
Donald Russ
Rebecca Topping
Brian Trang

My Action Plan: An Interprofessional Event to Celebrate National Falls Prevention Awareness Week

Bonnie Rogulj, PT, DPT

At the conclusion of the March 2023 APTA Geriatric's Balance and Fall Prevention in Community-Dwelling Adults credentialing course, attendees were encouraged by workshop instructor and developer Dr. Lori Schrodt, PT, MS, PhD to further reflect on existing gaps in community partnerships. The attendees were then directed to develop a "My Action Plan", an activity with the purpose of implementing knowledge and skills gained from participation in the credentialing workshop. For the activity, an interprofessional event in the community of St. Augustine, Florida was chosen to celebrate the upcoming national Falls Prevention Awareness Week.

Development of the action plan began with sharing the idea of an interprofessional falls prevention awareness event with fellow professional colleagues and members of the interdisciplinary team. In my dual professional roles, as both a licensed physical therapist and full-time faculty member in the Flex Doctor of Physical Therapy (DPT) program at the University of St. Augustine for Health Sciences (USAHS), I was able to collaborate with graduate students, staff, faculty members, and licensed medical professionals including nursing, occupational therapy, pharmacy, and low vision. The event was scheduled on September 29, 2023, at the St. Augustine location of the University of St. Augustine for Health Sciences (USAHS). The site was selected for reasons including no cost, accessibility by interprofessional volunteers and community-dwelling older adult participants, and close proximity to nearby medical facilities.

The "Falls Prevention Awareness 2023 @ USAHS" event was based on the STEADI Initiative developed by the Centers for Disease Control and Prevention (CDC). The event incorporated the following stations: Station 1: Check-in for participants to register, enter a raffle prize drawing, complete the required consent forms in order to participate in the event, and be provided an event folder with STEADI resources; Station 2: Participants complete the STEADI's Stay Independent brochure; Station 3: Vital assessments, such as blood pressure and heart rate, and screening for orthostatic hypotension; Station 4, 5, & 6: Screening for mobility by using the Timed Up and Go, leg strength and endurance by using the 30-Second Chair Stand Test, and balance by using the 4-Stage Balance Test; Station 7: Vision assessment, as performed by a Low Vision Specialist, and including (but not limited to) visual acuity with a Snellen chart; Station 8: Medication review and referral to

local Pharmacist; Station 9: Assessment of adaptive medical equipment and proper footwear; Station 10: Check-out station for participants to be provided education related to fall risk, community resources including evidence-based programs (e.g., Tai Chi), local programs (e.g., Meals on Wheels), and opportunities for participation in health/wellness activities (e.g., Pro Bono Clinic located at the event site and offering physical and occupational therapy services), and also a nutritious snack.

Approximately 30 community-dwelling older adults participated in the interprofessional falls prevention awareness event. Pat, an 80-year-old community resident and event participant reported, "This afternoon I learned a couple of new things, like medications that may contribute to overall fall risk and about my vision. I learned that my peripheral vision is better on my right side, compared to my left side. Also, it is nice to come to a place in the community that has a comprehensive screening for falls and be provided education...I got a lot out of this event!".

In final reflection, I am very grateful to the APTA Geriatric's Balance and Fall Prevention in Community Dwelling Adults credentialing course and the University of St. Augustine for Health Sciences for providing an opportunity to further develop partnerships in my community, implement knowledge and skills to promote fall prevention among community-dwelling older adults, and to celebrate the national Falls Prevention Awareness Week for Professionals!

Dr. Rogulj gratefully acknowledges the following for assistance with writing, advising, and executing "My Action Plan"

Gerald Morigerato, PT, DPT
Margaret Wicinski, PT, DPT, EdD
Heather Bushnell, PT, DPT, EdD

About the Author: See Bonnie's photo and bio on page 27.

Community Transitions Made Easy

by Shelene Thomas, PT, DPT, EdD, GCS, FNAP

Editor’s Note: This clinical case commentary was part of content for the July 2024 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.

Case study presentation based on the research article from *Journal of Geriatric Physical Therapy*: Brach JS, Schrodt LA, Vincenzo JL, et al. Knowledge and Use of Evidence-Based Programs for Older Adults in the Community: A Survey of Physical Therapy Professionals. *J Geriatr Phys Ther.* 2023; 46(4):196-206.¹

An aging adult is referred to you for fall prevention. What clinical aspects would influence your decision to incorporate a community fall prevention program in your plan of care? If it is appropriate to incorporate a public health resource, which one? Two figures have been created to assist in problem solving which program to refer to categorized by impairment [Figure 1] and timeline of resource desired [Figure 2]. Additionally, the following vignette serves as an application to the study which investigated differences between practicing PTs who use the National Council On Aging (NCOA)² programs by applying the concept to 2 distinctly different cases to highlight aspects in the clinical reasoning process as to why PTs might refer to these community fall prevention programs.

Participant 1

Amy Keiffer is a 45-year-old female referred for a fall prevention program after her daughters’ report of increased unsteadiness in the community. Ms. Keiffer currently works full-time in retail and spends most of her time standing on her feet. She lives alone at home with 2 dogs, which she takes on daily two-block walks. She does not participate in resistance or balance training.

Ms. Keiffer’s medical history includes mitral valve regurgitation, intermittent low back pain, and

osteoarthritis. She reports occasional pain in both feet from swelling, knees with stairs, and lumbar spine for which she is undergoing further testing. Patient Health Questionnaire (PHQ-2) was positive for depression; she did not present with suicidal ideations.

She is independent in all ADLs and IADLs and notes moderate restrictions in mobility. She has reported one fall last year that did not result in injury nor require medical attention. She is starting to feel unsteady with standing and walking, reporting increasing shoe size, bilaterally. She enjoyed country line dancing in the past but has been unable to participate in the last 2 years due to work and family demands, as her children are both in college. Her stated health goals are to improve her overall wellness and aerobic endurance.

Participant 2

Dennis Shepard is an 80-year-old male, post weight loss from chemotherapy with increased frailty, who self-referred to a fall prevention program. Mr. Shepard expressed his desires to be compliant with his geriatrician who diagnosed the frailty from Dennis’ report of decreased ability in distant ambulation, general unsteadiness, and overall low endurance. The stated goals are to improve overall walking distance and steadiness to improve confidence and ability to go on vacations with family.

Table 1. Participant Demographics

Baseline Information	Score	
	Amy Keiffer	Dennis Shepard
Age (years)	52	76
BMI	19.2	16.5
Resting HR (bpm)	62	74
Resting BP (mmHg)	110/72	146/84
Resting SpO2 (%)	98%	96%
Resting RR (breath/min)	12	14
STEADI:	Yes – (Falls & Worry)	Yes – (Falls)

Medical History includes kidney cancer with removal of one kidney in 2020, CABG x 4 in 2000, hypertension, hypercholesterolemia, and benign prostate hypertrophy (BPH). Patient Health Questionnaire (PHQ-2) was positive for depression, which he and his geriatrician attribute to recent death of spouse that is not improving with time; he did not present with suicidal ideations. He is not currently reporting pain.

Mr. Shepard is a widow who lives in a two-story home, with 3 steps to enter and no handrails; he usually enters through the garage where there is only one step with no handrails. He is independent with all ADLs and driving, receives some assistance with grocery shopping and yardwork from his nearby 2 daughters and 4 grandchildren. Dennis does not require a walking aid and states that he ventures outside his home 4 times per week on average. He reports one fall to the ground in the past year that did not require medical attention. Mr. Shepard reports 4 instances of near falls that were either a slip, trip, or loss of balance but he did not hit the floor. He does not participate in regular aerobic, resistance, or balance training.

Assessment:

Participant 1:

Ms. Keiffer's increased swelling, pitting edema, diminished balance, and decreased power correlates with a higher risk for falls in multiple testing areas. However, her higher level of depression and perseverance on what she cannot do demonstrates she is in the precontemplation phase of

change. She classifies herself as lacking internal motivation. The measured deficit in dynamic balance correlates with her fall history. The evaluating PT desires to work on fall prevention strategies in person, prioritizing safety, education, and starting a home exercise program. She was scheduled for a follow-up visit to formally review the results and provide guidance on her exercise routine.

At her follow-up visit motivational interviewing techniques were used to assess her motivation, which was her son's upcoming wedding. In addition, questions about her home environment were asked to discover more about potential hazards in the home. Amy reported keeping her home clutter free, but admitted to having some home project needs secondary to residing in her home for over 30 years without anyone near to help repair things, such as the banister to her bedroom upstairs. Finally, she shared how social she is but lacks comfort with technology. Because of her self-reported lack of home hazards, yet need for a handyman, she was referred to the CAPABLE³ program in her area. The CAPABLE program, over the span of 5 months, is designed to assist with home falls by including the use of an OT for 6 visits, an RN for 4 visits, and a one-day visit by a handyman to assess and address the needs of the person's environment. Concurrently, she was referred to a NCOA fall prevention group program called A Matter of Balance⁴ that met at her local recreation center. Both these community-based approaches were referred, initiated, and incorporated into her PT sessions prior to her discharge as recommended by the insurance to

Table 2. Objective Data

	Test	Score	
		Amy Keiffer	Dennis Shepard
Posture			
	Wall to Occiput	0 cm	3 cm
	Rib to Pelvis	3 fingers	3 fingers
Circumference			
	Ankle figure 8	+2 inches R>L	Equal B
	Edema	1+pitting edema	None present
Balance			
	One Leg Stand Test (s)	L: 20 R: 27	L: 6 R: 8
	Tandem Walk – eyes open	0 errors	2 errors
	Tandem Walk – eyes closed	2 steps	Unable
Mobility			
	Timed Up and Go	20.25 sec	14.8 sec
Endurance			
	2 Minute Step Test	70 steps	62 steps
Strength			
	Grip Dynamometer (lbs)	R: 41.2 L: 36.8	R: 65.0 L: 55.7
	30s Sit to Stand (reps)	8	10

Figure 1. NCOA Fall Prevention Community Resource Algorithm

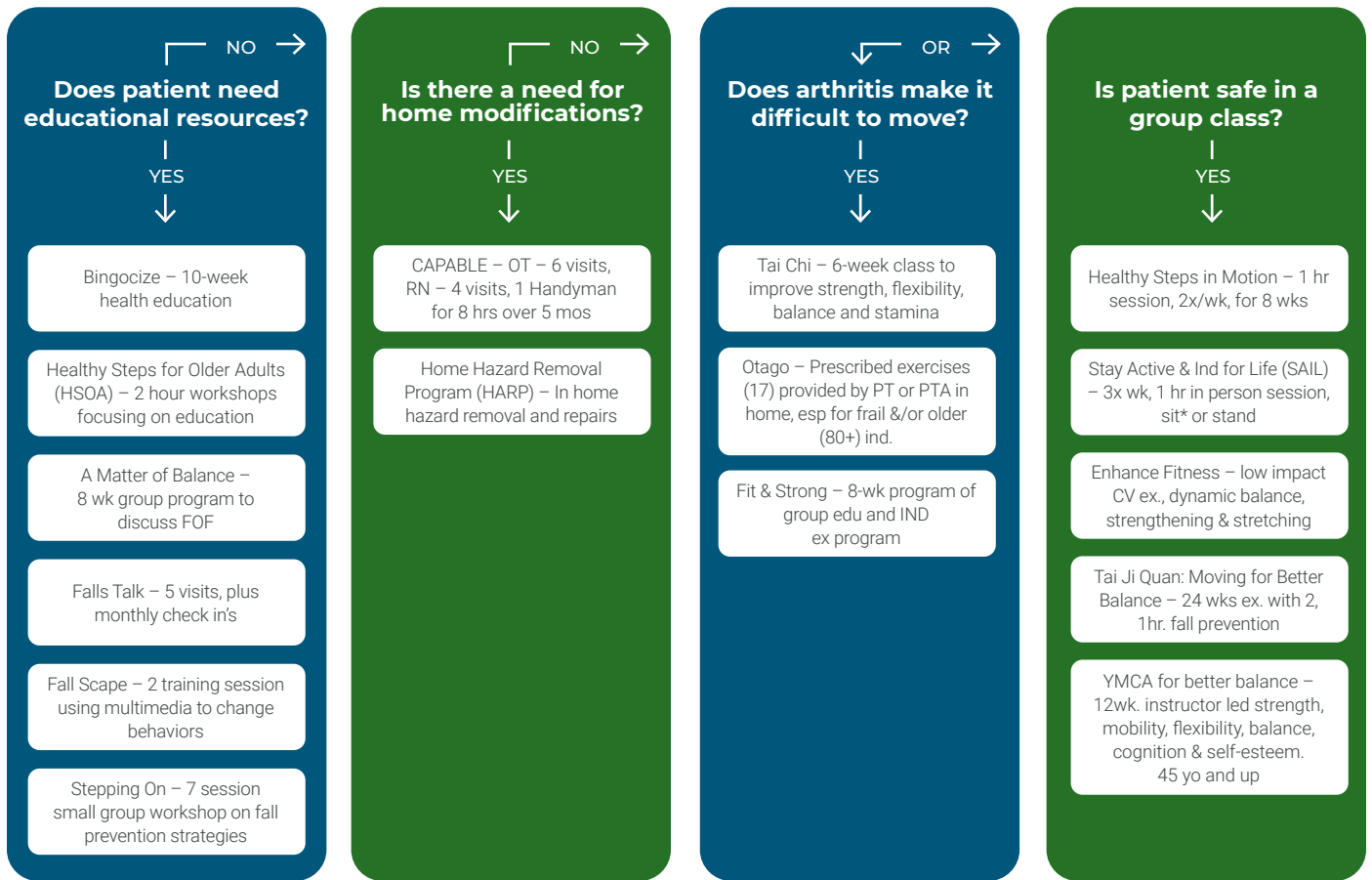
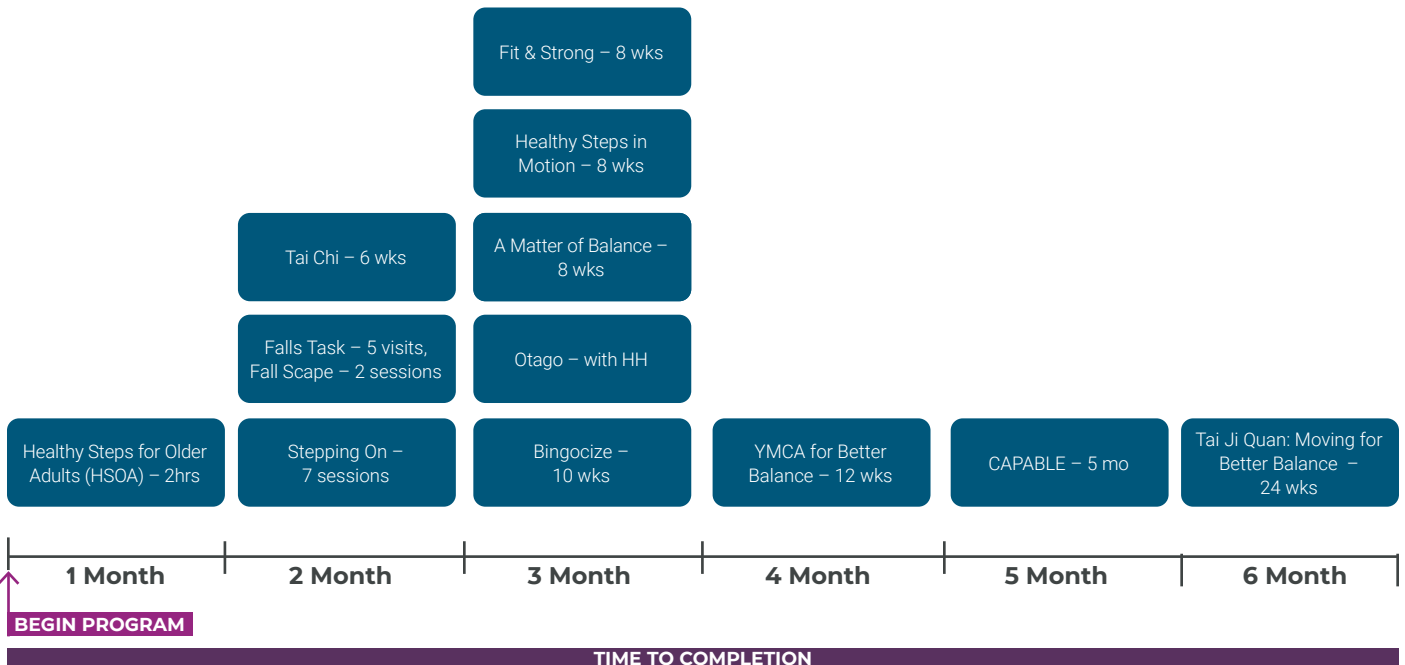


Figure 2. Visual Timeline for NCOA Fall Prevention Resources



A visual reference from NCOA Fall Prevention Community Resources for APTA Geriatric Section, placing Community Fall Prevention Resources on a timeline.
*HH=home health, wks=weeks, mo=months

assure a strong transition out of formalized healthcare to a community approach. For Ms. Keiffer's deficits, the PT plan of care combined traditional PT services with initiating and transitioning to community fall prevention approaches to effectively prevent future problems.

Participant 2:

The objective assessment for Mr. Shepard identified deficits in static and dynamic balance, aerobic endurance, and strength compared to his age-related norms. Upon further discussion, he expressed high motivation to take an active approach to his health and reported interest in complying with all his healthcare providers. Deficits in static and dynamic balance, as well as aerobic endurance correlated to below community-ambulator gait speed and a fall risk. The plan of care for him included interventions for balance, strength, and discussions around nutrition. The physiological needs required for strength and endurance training resulted in the physical therapist assisting him in initiating the Otago⁵ program. The Otago Exercise Program (OEP) is a two-part intervention. The initial 8-week portion is performed with a PT or a PTA and consists of 17 strength and balance exercises and a walking program, performed 3x/week by the older adult in the home, outpatient, or community setting⁵ Then the program transitions to a self-management phase for 4-10 months. During the self-management phase, the participant continues to independently do the exercises and can check in with their program provider via monthly phone calls and an optional face-to-face check-in at 6 months with a connection to a community exercise-based program to prevent further decline and future falls. Mr. Shepard was connected with a PT at his local rec center that could be available for the self-management phase. Studies demonstrate that OEP participants experience a 35 - 40% reduction in falls.⁵

Discussion:

Physical therapists often identify and treat issues related to fall risk, decreased physical activity, and chronic conditions and therefore should integrate various community-based resources into their plan of care to assist in transitioning the continuum of care to the community.¹ These 2 distinctly different cases highlight some of the variety of community-based fall prevention programs outlined by the NCOA which can improve a variety of issues for those in the mid to late phase of life. The systemic issues of Ms Kieffer were the primary source of her balance impairment yet her internal motivation and living situation amplified some of her inability to progress. Ms. Keiffer's lack of awareness of her deficits required increased time to provide motivational support for change and to educate on discrepancies in her current behavior as compared to her overall goals. For Mr. Shepard, the impairments of frailty and balance lead him to benefit from different NCOA community-based

programs. While the definition of frailty is not clear, the result includes a slowing of movement, fatigue and decreased muscle mass, strength, and physical activity.⁶ When referring to a community-based program, consideration should be given to the amount of time for completion. A participant similar to Mr. Shepard will likely require increased time for the effects of the Otago exercise program to result in improvements in static and dynamic balance, muscle mass and strength, muscle mass.

Overall, physical therapists should consider recommending community-based activities when treating fall prevention in the aging adult population as a way to extend the intervention timeline and address certain attributes that may be contributing to the fall risk. When selecting the community-based fall prevention activity, consideration should be given to individual's personal factors that may impact fall risk and the time commitment available to appropriately match the patient to the correct community activity. In the article,¹ the majority of PT practitioners knew of the NCOA² programs, yet data revealed both referrals to and location of these activities in their community occurred, were limiting factors. Future areas of opportunity could be for PTs to attend local conferences or investigate local recreation centers to garner specific details to resources in the area. Ultimately, using community resources by referring to and initiating prior to discharge appears to be a healthy way to transition from the clinic to the community.

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Perceived Neighborhood Walkability

by Bonnie Rogulj, PT, DPT

Editor's Note: This clinical case commentary was part of content for the May 2024 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.

Case study presentation based on the research article from *Journal of Geriatric Physical Therapy*: Blackwood J, Suzuki R, Karzewski H. Perceived Walkability is Associated with Recent Falls in Urban Dwelling Older Adults. *J Geriatr Phys Ther.* 2022;45(1): E8-E15.¹

"If I have to stay inside, especially as the weather is getting nice and warm, then I will just go stir-crazy!" exclaimed Cathy, as she sat in her living room recliner chair with both lower extremities elevated while



donning a left-sided compression hose. Cathy, a 78-year-old Caucasian female, is 3-weeks status-post recovery from an osteotomy procedure on the second and fourth phalanges of her left lower extremity. The surgery was performed in an effort to reshape abnormal bone growth

resulting from arthritic changes. She resides with her 79-year-old spouse in a two-story home within a middle-class suburban neighborhood located on the outskirts of Washington, D.C. While traveling to the surrounding areas, I had the pleasure of being introduced to Cathy, a friend of a family member. Cathy provided her consent to participate in an informal interview and screening. A licensed Physical Therapist, I have often found that my path will unexpectedly cross with individuals who need physical therapy services. This provides an excellent opportunity to advocate for the physical therapy profession.

Although Cathy appeared eager to return to her prior level of function as an independent community ambulator, she also demonstrated a heightened awareness of her increased fall risk. She reported a fear of falling (FOF), which she mostly attributed to a fall that occurred in the previous year. She discussed having been educated by a past physical therapist on various factors, both intrinsic and extrinsic, that may have contributed to her falling. The factors included her older age, vision impairments (e.g., left eye cataract and donning glasses due to farsightedness), chronic lower back pain, abnormal foot posture (e.g., hammer toes of the 2nd phalange on the left lower extremity and 4th phalange on the right lower extremity), and self-diagnosed cervicalgia that she blamed for occasional headaches and dizziness. (See Table 1.)

Table 1. Past Medical History

<p>Osteotomy in October 2023</p> <ul style="list-style-type: none"> · Second and fourth phalanges of left lower extremity · Abnormal foot posture · Hammer toes of the 2nd phalange on the left lower extremity and 4th phalange on the right lower extremity
<p>Fall 2022</p> <ul style="list-style-type: none"> · Fear of falling (FOF) · Left-sided bruising (mid-axillary region) · Right upper extremity rotator cuff tear · Increased lower back pain
<p>Multi-level Spinal Fusion</p> <ul style="list-style-type: none"> · L4-5 in 2022 · L3-4 in 2019 · Chronic lower back pain (LBP)
<p>Left Total Knee Replacement (TKR) 2020</p>
<p>Bunionectomy Left foot Great Hallux</p>
<p>Cervicalgia</p> <ul style="list-style-type: none"> · Headaches · Dizziness
<p>Cataract Surgery Left Eye</p> <ul style="list-style-type: none"> · Farsightedness · Glasses
<p>Osteopenia</p>
<p>Osteoarthritis</p>
<p>Memory Loss (Self-Reported)</p>
<p>Polypharmacy</p> <ul style="list-style-type: none"> · 18 medications · 3 separate prescriptions for elevated blood pressure (the names of which she was unable to recall) · Rosuvastatin · Ibuprofen · TheraTears · OTC Supplements: Vitamins (Turmeric, Calcium Magnesium,) Bio Complete 3 (pre-biotic, probiotic, and post-biotic), Foraspring, Heart Zest, Ubiquinol, Immutol, Vitamin D3, a Youngevity brand supplement packet, and Biofreeze (as needed)

Cathy described her fall from the previous year as “traumatic.” She reported the fall occurred in the evening while walking from her kitchen into the living room with only a night light to illuminate the pathway. She was donning bedroom slippers and carrying a glass of water. Cathy stated, “I tripped over my own self!” Her left side landed against an antique coffee table positioned in the living area. Cathy attempted to call her spouse for help; he was asleep on the lower level of their two-story home and unable to hear her. She was able to transfer herself from the living room floor onto the sofa eventually, and later was transported to the local emergency department. The incident resulted in significant left-sided bruising to her mid-axillary region, a rotator cuff tear of her dominant right upper extremity, and increased lower back pain. Cathy reported her rotator cuff tear was managed with physical therapy services over the course of several months.

Following her left lower extremity osteotomy, Cathy reported that she felt highly motivated to resume physical therapy. She stated her motivation was based on the positive results that were achieved in the aftermath of her fall, as well as her personal goals. Cathy’s short-term goals include an improved ability to navigate the 15 stairs (with bilateral railings) that separate the entry and second level living spaces of her home, and to resume her daily physical activity of leisurely walking a half-mile in her yard and the surrounding neighborhood. She discussed how daily walking enabled her to “not feel as isolated” and also maintain a healthier weight (i.e., 147 lbs.) for her height of 5 feet and 3 inches. However, she is now more sedentary due to her left lower extremity surgery, the inclement weather, and passing of her miniature terrier. She stated her long-term goal is to safely age-in-place at her current residence.

Cathy also volunteers as a caregiver for her senior neighbor currently. The primary responsibilities of her caregiver role include (but are not limited to) running errands in her neighborhood, such as to the grocery store and hospital for scheduled medical appointments. The errands range in frequency and duration, lasting approximately ten minutes to several hours. For assistance during community navigation, she reported the use of a right-sided walking stick. Cathy stated, “I have to be extra cautious, as the area traffic is very busy and expanding all the time!” She was employed full-time as an elementary school teacher until retirement.

At this point in our meeting, I was provided with an opportunity to gather additional findings related to Cathy’s status. (Table 2)

Since Cathy’s self-reported goals require daily physical activity acquired from walking for both transportation and leisure, it was imperative to gain insight into the walkability of her surrounding environment. For this purpose, the Neighborhood Environment Walkability Scale-Abbreviated

Table 2. Screening

<p>Mini-Cog®</p> <ul style="list-style-type: none"> · Able to recall only 1 item of the 3-item recall · Clock drawing test was normal
<p>10-Meter Walk Test (10MWT)</p> <ul style="list-style-type: none"> · Preferred walking speed of .84 meters/second demonstrated · Observed gait impairments included forward posture, increased sway from a straight path, decreased right lower extremity step length (as compared to left), decreased left lower extremity terminal stance, and decreased velocity
<p>Timed Up & Go test (TUG)</p> <ul style="list-style-type: none"> · Completed in 21.06 seconds with supervision · Performance required bilateral upper extremity assistance to assume standing position · Observed delay in standing prior to initiating ambulation · Decreased speed in turning toward the left side
<p>Single Leg Stance (SLS)</p> <ul style="list-style-type: none"> · Able to maintain balance for 11 seconds while positioned on the right lower extremity and 10 seconds on the left lower extremity · Stand by assistance was provided during the static balance assessment due to observed instability and reported fear of falling

(NEWS-A) was incorporated to assess her perceptions of neighborhood walkability.² A 4-point Likert scale (1 being “strongly disagree” to 4 being “strongly agree”) was used to answer NEWS-A items from 5 of 6 sub-scales. The subscale items used and the corresponding rating in parenthesis are located in Table 3.

Additional insight was provided by Cathy related to her perceived neighborhood walkability. She described having to “move slowly and watch my steps for loose bricks and tree stumps on my path.” Cathy reported there is limited parking available, so at times she must “walk uphill on the main street.” She mentioned a particular parking location for her vehicle that, if available, will allow for improved access and “not having to walk across the busy street.” She stated, “There are no benches (located at my routine destinations), ...and very narrow spacing on the sidewalks.” Cathy reported she avoids walking the neighborhood in the evening for her own safety based on her fear of falling, vision impairment, and concern for the increased risk of crime. Finally, Cathy denied being aware of any walking programs located in her neighborhood or surrounding areas but expressed interest in learning more about these if available.

At the conclusion of our meeting, I educated Cathy on being at a high fall risk based on her current performance findings and medical history. I emphasized the importance of Cathy participating in physical therapy

to progress toward achieving her self-reported goals and improving her overall health. Additionally, I shared previous research that has revealed participation in physical activity may be influenced by factors such as perceptions of neighborhood walkability.¹ I encouraged Cathy to share with her future physical therapist her perceived neighborhood walkability. For example, the barrier of uneven walking surfaces in her neighborhood that increases her fear of falling and the lack of benches that make it challenging for her to engage in prolonged physical activity outside of home.

Meeting with Cathy offered an excellent opportunity to trial the Neighborhood Environment Walkability Scale-Abbreviated version (NEWS-A) and advocate for the physical therapy profession. The NEWS-A provided a more in-depth assessment of perceived neighborhood walkability and was easy to incorporate due to requiring minimal time, equipment, and training. In future practice, I will continue to utilize the abbreviated scale to assess perception of neighborhood walkability, especially for older adults who present at an increased risk of falling, and generate further discussion related to the topic of physical activity. Physical therapists have an opportunity to increase the overall physical activity of patients and clients by promoting neighborhood walkability. Examples may include incorporating the perceived walkability of neighborhoods into routine practice, developing patient-specific goals based on neighborhood walkability, providing education on activity modification such as recommendations for how to manage identified barriers in the neighborhood, prescribing structured walking programs to achieve physical activity recommendations, distributing information based on available neighborhood resources, and participating in an local and national advocacy efforts to develop a more walkable neighborhood.¹

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Table 3. Neighborhood Environment Walkability Scale-Abbreviated (NEWS-A) Subscales and Items with Cathy’s Scoring

<p>Land use mix</p> <ul style="list-style-type: none"> · I can do most of my shopping at local stores. (4) · Stores are within easy walking distance of my home. (1) · There are many places to go within easy walking distance from my home. (1) · It is easy to walk to a transit stop (bus, train) from my home. (1) · The streets in my neighborhood are hilly, making my neighborhood difficult to walk in. (4) · There are many canyons/hillsides in my neighborhood that limit the number of routes for getting from place to place. (4)
<p>Street connectivity</p> <ul style="list-style-type: none"> · The distance between intersections in my neighborhood is usually short (< 100 y; the length of a football field or less). (1) · There are many 4-way intersections in my neighborhood. (2) · There are many alternate routes for getting from place to place in my neighborhood (I don't have to go the same way every time). (3)
<p>Walking/cycling facilities</p> <ul style="list-style-type: none"> · There are sidewalks on most of the streets in my neighborhood. (1) · The sidewalks in my neighborhood are well maintained (paved, even, and not a lot of cracks). (1) · There are bicycle or pedestrian trails in or near my neighborhood that are easy to get to. (3) · Sidewalks are separated from the road/traffic in my neighborhood by parked cars. (1) · There is a grass/dirt strip that separates the streets from the sidewalks in my neighborhood. (1)
<p>Pedestrian/traffic safety</p> <ul style="list-style-type: none"> · There is so much traffic along the street that I live on that it makes it difficult or unpleasant to walk in my neighborhood. (3) · There is so much traffic along nearby streets that it makes it difficult or unpleasant to walk in my neighborhood. (4) · There are crosswalks and pedestrian signals to help people cross busy streets in my neighborhood. (2) · The crosswalks in my neighborhood help walkers feel safe crossing busy streets. (2) · When walking in my neighborhood, there are a lot of exhaust fumes (such as from cars and buses). (2)
<p>Crime safety</p> <ul style="list-style-type: none"> · My neighborhood streets are well lit at night. (2) · There is high crime rate in my neighborhood. (2) · The crime rate in my neighborhood makes it unsafe to go on walks during the day. (2) · The crime rate in my neighborhood makes it unsafe to go on walks at night. (3)

Abbreviation: NEWS-A, Neighborhood Environment Walkability Scale-Abbreviated.



Talk the Walk: Dual Task Walking and Visual-verbal Processing

by Valerie Carter, PT, DPT; Carole Lewis, PT, DPT, PhD, FAPTA; and Linda McAllister, PT, DPT

Persons with Parkinson's Disease (pwP) fall a lot! In fact, they are 3 times more likely to fall than persons their same age without Parkinson's.^{1,2} Why is this? Recurrent falls in persons with idiopathic Parkinson's disease are often attributed to deficits in postural stability, gait, saccades, and cognition. When completing dual tasks while walking, pwP demonstrate decreased step length and velocity, as well as increased double-support time and freezing of gait.³

Currently there are no clinical tests that assess the pwP's ability to safely complete the dual task of walking, scanning, and processing the environment accurately and safely. Just having a pwP turn their head while walking such as in the Functional Gait Assessment (FGA) is not enough to understand the interplay of vision and cognitive challenge. The visual-verbal Stroops test can be used to measure a person's selective attention capacity and processing speed.⁴

Recently a cohort study was conducted (spring of 2022) to assess the pwP's ability to safely complete the dual task of walking 10 meters while scanning, reading, and verbally reporting visual-verbal Stroops (e.g. the word "RED" is colored blue and the participant needs to state the color, not the written word). Twenty pwP, (average age 73) and 20 older adults (average age 71) were compared to 20 younger adults (average age 29) as they completed this timed dual task assessment.

The results showed that the older adults without Parkinson's were faster than pwP and made fewer errors. In fact, although the older adults were typically slower than the younger adults, the older adults without Parkinson's made the same number of errors as the younger adults. The pwP made more errors and were slower than the older adults without Parkinson's. These errors in processing while walking are one of the reasons pwP fall more often as their ability to attend to a task is

reduced without completing specific types of dual task practice. Research has shown, that with a lot of practice, pwP can improve their ability to complete dual tasks while walking equal to adults their same age without Parkinson's.

There currently are no clinical tests that assess a pwP's ability to complete the dual task of visual scanning and accurately processing their environment while walking safely. The new 10-meter walk test with visual-verbal Stroops may be able to assess PwP's ability to safely navigate in the community. This test is completed on a 14-meter walkway with visual Stroops placed at eye level every 7 feet along the 14 meters. The participant is instructed to walk as quickly and safely as possible while alternately turning their head from side to side, reading the placed word, and reporting their answer (see the Stroops handout to be given or displayed for the participants). The middle 10 meters of the 14-meter walkway are timed and errors counted. The authors recommend a baseline 10-meter walk test time be taken and compared to the second trial of the 10-Meter walk test with visual-verbal Stroops; the first trial is used as a practice test. Current data shows, on average, there is not more than a 10% difference between the 10-meter walk test and the 10-meter walk test with visual-verbal Stroops in both the young and older adult participants with zero errors. For pwP, the average increase in time between these 2 tests is over 20% difference with the average amount of errors equaling 2. An error is counted if the participants begin to say or says the word and not the color of the word.

It is necessary for clinicians to complete tests and measures that can accurately assess the pwP's cognitive capability in a single cognitive task without a gait task prior to testing the 10-meter walk test with visual-verbal Stroops. Therefore, the pwP needs to complete a sitting visual verbal Stroops test, either on paper or on a computer, to determine their capability to complete this task before adding gait. This allows the clinician to establish a baseline for the single task and to gain an understanding of the pwP's cognitive capabilities to complete incongruent cognitive tasks. This paper or computer-based test will start with a congruent cognitive challenge (the word and the color match) and then will progress to an incongruent challenge where the word and the color do not match. This way you can see how well the pwP performs on the single task before adding the gait/dual task challenge of the 10 Meter Walk test with visual-verbal Stroops.

It is critical for clinicians to accurately assess a pwP's dual task capability to move in and process their environment safely. Knowing that pwP are slower and make more errors than healthy older and young adults while completing the 10-meter walk test with visual-verbal Stroops can help us to understand how to create interventions that might be able to reduce falls in this

population. Further, this new test can be used to evaluate effects of interventions that target dual task practice and the relationships of dual tasking and falls in pwP.

[Editor's Note: This is the second article on visual implications for working with pwP and is from a series of articles synthesized from lectures in the Great Seminars and Books courses]

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Table 1. Stroops Handout

RED	YELLOW	BLUE	GREEN	BLACK
PINK	ORANGE	BROWN	GRAY	PURPLE
GREEN	GRAY	BLACK	BLUE	YELLOW
GRAY	BROWN	PINK	ORANGE	BLUE
YELLOW	RED	GREEN	BLACK	GRAY
BLACK	BROWN	PURPLE	ORANGE	PINK
PURPLE	BLACK	YELLOW	RED	GREEN
ORANGE	PINK	BROWN	GRAY	PURPLE

The real hard test:

Name the **COLOR** (not what the words says).

(Note that it is the same list of words but written in different color.)

(PAY ATTENTION: The **COLOR** of the word is **different** from what the word says.)

RED	YELLOW	BLUE	GREEN	BLACK
PINK	ORANGE	BROWN	GRAY	PURPLE
GREEN	GRAY	BLACK	BLUE	YELLOW
GRAY	BROWN	PINK	ORANGE	BLUE
YELLOW	RED	GREEN	BLACK	GRAY
BLACK	BROWN	PURPLE	ORANGE	PINK
PURPLE	BLACK	YELLOW	RED	GREEN
ORANGE	PINK	BROWN	GRAY	PURPLE