

# Gerinotes

November 2020 • Vol. 27 No. 5



Special Continuing Education Module Issue  
Intentional Aging in the Age of COVID



**APTA Geriatrics.**

An Academy of the American  
Physical Therapy Association

*Age on.™*

# GeriNotes

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**APTA Geriatrics**

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**Age on.**

# From the President



Greg Hartley  
President,  
APTA Geriatrics

For many months, society has been distanced, quarantined, isolated, and grounded. These actions have affected every aspect of our lives, at home and at work. Like every family, school, organization, and institution, they have impacted the Academy in many ways. All our face-to-face regional courses (like CEEAA™) were cancelled during 2020 and Combined Sections Meeting 2021 pivoted to a virtual format.

These changes, among others, will impact the Academy for some time. They have also ignited us to work on several improvements which excite me.

Our member volunteers have remained diligent and steadfast in continuing to move us forward, focusing on our strategic plan, ongoing projects, and new initiatives. The Board has been busy, holding 10 meetings between January and October, with at least four more planned before the end of the year. This includes two meetings in November dedicated to development of a new strategic plan. Our regional course faculty are working to hybridize courses into remote and live versions, which will increase course accessibility while reducing overall participant cost. I also would like to highlight three new task forces that are working on important initiatives.

### **Diversity, Equity, and Inclusion Review Task Force.**

This task force is conducting a sweeping review of APTA Geriatrics documents, policies and procedures, website, and social media platforms to ensure they are not exclusive in any way and that they reflect the organization's

commitment to DE&I. A report from the task force to the Board is expected in November 2020.

**Best Practice Task Force.** This task force is utilizing current evidence, expertise, and stakeholder input to develop best practice recommendations for managing patients and clients in acute care, skilled nursing/sub-acute, long term care, home health and outpatient settings. A report from the task force to the Board is expected in November 2020.

**Governance Review Task Force.** This task force is reviewing the Academy's overall governance, including organizational structure, operational policy, and bylaws. The task force will present information to the Board at several junctures over the next two years. Importantly, there are some bylaw changes that cannot wait and must be addressed ASAP. These include changes related to holding virtual/remote meetings and Section/Academy Delegates being allowed to vote in APTA's House of Delegates beginning in 2021. This task force is also recommending some additional changes that will modernize and streamline the bylaws to reflect governance that is consistent with best practice for a non-profit, volunteer organization like ours. All APTA Geriatrics members will be invited to a special members meeting very soon where you will have an opportunity to vote on the proposed amendments.

Despite a pandemic, or in some cases because of it, we are laser-focused on our mission and strategic plan. We continue to move the organization forward in exciting, innovative ways. The entire Board is excited to see the work of these task forces and other volunteer groups as we grow, evolve, and improve member engagement, resources, and benefits. Stay well!

## APTA Geriatrics, An Academy of the American Physical Therapy Association

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### GeriNotes

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

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

# From the Editor

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Michele Stanley  
Editor,  
GeriNotes

This issue has been a struggle for everyone involved. But, heh! It is 2020 and should we expect anything different by this point? As the year winds down, the pandemic continues to ramp up. Predictably, all of you have been intimately touched by this virus in some manner: personal or family illness, social isolationism, less than favorable economic ramifications. Add in contentious national politics, record weather disasters, the list goes on – making

the optimistic and function-driven self-talk/pep-talk that PTs are known for somewhat of a struggle.

If you are actively searching for a bright spot in your day, I highly endorse reading the story of member Katie Wadland's reinvention on page 38.

If you want to feel motivated to be a change maker yourself, the GETLit column gets political on page 37.

And Ellen Strunk's Policy Talk advocates positive changes that you can make *thoughtfully but easily* within your practice (especially if you practice in SNF settings).

Nothing beats an informational boost that infuses translated and ready-for-clinical-application information to re-energize your PT spirits. Check out the CEU articles and treat yourself to an easily attainable 4 CEU credits (free of additional cost for our PTA members). These start on page 9.

Continue your education by participating in the Journal Club. The September meeting was recorded and can be found on the APTA Geriatrics YouTube page. The

excellent case report by Gina Pariser that accompanied the September meeting is in on page 34 of this issue. Prepare for the November JClub by reading the current case report on page 31. Then tune in and participate on Tuesday, November 17 (details on page 32).

Speaking of JClub, some members have reported difficulty with accessing the Journal article when "clicking" on the advertised URL which takes you to the Wolters Kluwer

*Prepare for the November JClub by reading the current case report on page 31. Then tune in and participate on Tuesday, Nov. 17 (details on page 32).*

webpage. It may look like the Journal is behind a paywall (which it is if you are not a member of APTA-Geriatrics) but *you* can log-in (right above the Journal of Geriatric Physical Therapy logo). If this gives you trouble with your browser, go directly to <https://geriatricspt.org/members/> and log-in there, then access the Journal under the members tab. Hint for the readily frustrated by technology (that would be me, for example): if you go to our webpage first, log-in and then go back to the advertised JClub link, it will automatically have the opened article there for you to read.

JClub, like GeriNotes, are member benefits. Encourage friends with whom you want to share articles or the JClub experience to join! [#AgeOn](#) – Intentionally.

*PICTURES! Send your favorite photos of active interesting older adults or therapy sessions for possible future use on the cover of GeriNotes. We'd love to feature the work of the photographers amongst us. You must own the copyright to the photo and be able to obtain a subject's release. Complete the [Photo Release Form](#) and send to [gerinoteseditor@gmail.com](mailto:gerinoteseditor@gmail.com).*

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## GeriNotes

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### Newsletter Deadlines:

February 10  
April 15  
July 10  
September 1  
November 15

### Statement of Frequency

5x/year:  
January  
March  
May  
August  
November

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

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# Interprofessional Collaboration: An Important Part of Demonstrating Value in Physical Therapy

by Ellen R. Strunk PT, MS

Have you visited the Centers for Medicare and Medicaid Services (CMS) new website *Care Compare* ([www.medicare.gov/care-compare/](http://www.medicare.gov/care-compare/))? It was launched in August and is a CMS effort to make it easier for consumers to locate and find the services they need. On the web page, you find almost all types of providers and can quickly and easily compare them using process measures, outcome measures, and resource-use measures.

## New outcome measures released

Four new outcome measures will be launched this fall. In October, the Nursing Home Compare website will be updated with information submitted by Skilled Nursing Facilities (SNFs) between 1/01/19 – 12/31/19 for assessment-based measures and 10/01/17 – 9/30/19 for claims-based measures. In December, the Inpatient Rehabilitation Facility (IRF) Compare website will be updated with the same information. The four new Application of IRF Functional outcome measures are:

1. Change in Self-Care (NQF #2633)
2. Change in Mobility (NQF #2634)
3. Discharge Self-Care Score (NQF #2635)
4. Discharge Mobility Score (NQF #2636)

These measures were discussed in a September 2018 Policy Talk titled *Have You Heard? Functional Outcome Measures Are Here*.<sup>1</sup> The change measures estimate the risk-adjusted mean change in score between admission and discharge for those residents with a planned discharge. The discharge score measures estimate the percentage of residents/patients with a planned discharge who meet or exceed an expected discharge score. In the SNF, only Part A residents are included; in the IRF both Part A and Part C patients are included. There has been one change, however, since the article in 2018 was written. The technical specifications for the IRF measure were updated to include the wheelchair items for residents who are unable to ambulate at both admission and discharge. *More importantly, these four measures are only calculated for residents who receive physical therapy and/or occupational therapy.*

So why bring this back up now? The results of care illustrated by these measures are a direct reflection of the result of care delivered that was focused on the patient's physical ability. These measures are not just "a therapy thing." Functional outcomes must be a focus of the entire interprofessional team in the SNF and the IRF. If the focus on function is limited to the time spent in PT and/or OT,

then the outcome will not be as strong, and it certainly won't be durable. If you see the results for your building and you don't like what you see, it is time to consider how to change them. That means looking hard at *your* clinical practice: *your* evidence-based interventions and *your* resident/patient engagement strategies. It also means looking at your interprofessional practice.

## Addressing needs with interprofessional practice

Most physical therapists working today were educated in a silo. In other words, they attended classes with other physical therapy (PT) students, studied with other PT students, and likely socialized with other PT students. Yet, we work in a variety of settings where we are expected to work with professionals of other health professions. Successful patient care requires that we share information, communicate effectively, and understand the role each person has in the delivery of that care.

The term "interprofessional care" is often misunderstood. In some ways, the terms "multidisciplinary care" and "interdisciplinary care" have been replaced by this more contemporary term "interprofessional practice." The World Health Organization's framework for action on interprofessional education and collaborative practice defines this concept to be when individuals "*from two or more professions learn about, from, and with each other to enable effective collaboration and improve health outcomes.*"<sup>2</sup> Practically speaking, it is the ability for professionals from different fields to coordinate and collaborate effectively.

In traditional models of care, the physicians were at the top of the pyramid directing a patient's care (Figure 1). Non-physician professionals "took orders" from the physician and carried them out. Since the Affordable Care Act (ACA), the landscape of health care delivery is forever changed. Federal and private payers are moving away from paying for the number and type of service provided to the outcome of care that service or level of service achieved. This shift has driven a change in how care in various settings is provided. Patient-centered care design is focused on understanding the right mix of services, by the right health care professional, delivered at the right time, and in the right setting (Figure 2). To achieve success in these models of payment, physicians cannot provide all the clinical and educational services a patient may need, nor can they be expected to always be available. Organizations must rethink how they deliver care – not

just the type and intensity of service they provide, but who is delivering the care and how effective it is. The implementation of the Patient-Driven Payment Model (PDPM) and Patient-Driven Grouper Model (PDGM) only added to the urgency for therapists working in these settings to act.

In 2001, the Institute of Medicine’s Committee on Quality of Health Care in America suggested that interprofessional teams can best address the complex and challenging needs that today’s patients typically require.<sup>3,4</sup> They were right. Research suggests that interprofessional collaboration improves patient outcomes. Collaborative teams are reported to demonstrate increased sharing of evidence-based practices between and among professions<sup>5</sup> and decision-making is improved,<sup>6</sup> two very important elements of patient-centered care. Other examples of how collaboration can improve outcomes are illustrated in Table 1.

### Preparing for enhanced team-based care

Where do you get the skills and knowledge to demonstrate interprofessional collaboration? Just because you

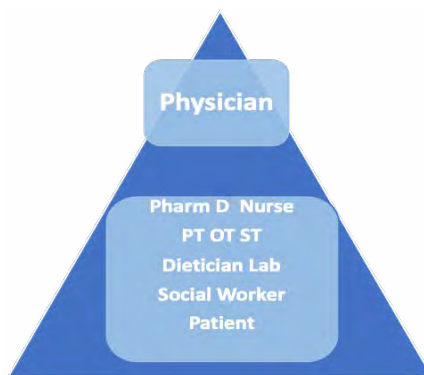


Figure 1



Figure 2

work with other health care professionals doesn’t mean you have achieved interprofessional collaboration. Elements of collaborative practice include responsibility, accountability, coordination, communication, cooperation, assertiveness, autonomy, mutual trust, and respect.<sup>8</sup>

Six national education associations of schools of the health professions formed a collaborative in 2009 to promote and encourage constituent efforts to advance interprofessional learning experiences. The goal was to help prepare future health professionals for enhanced team-based care which would improve the patient experience and population health outcomes. Since then, the Interprofessional Educational Collaborative (IPEC) has added new members representing several health professions, including physical therapy.<sup>9</sup>

In 2016, the IPEC board updated its Core Competencies for Interprofessional Collaborative Practice<sup>10</sup> in order to better achieve the ACA’s Triple Aim. Table 2 outlines the 4 competencies and includes some of the sub-competencies that are included in each one. One important characteristic that contributes to team effectiveness is that members see their role as important to the team. Physical therapists and physical therapist assistants are an important member

Table 1.

Examples <sup>7</sup>	Application to Physical Therapy
Coordination of care and education for patients	<ul style="list-style-type: none"> <li>• Do you know what other health care services the patient is receiving?</li> <li>• Do you know when those services will be delivered?</li> <li>• Are you considering where PT falls in terms of priority for the patient?</li> <li>• Are you reinforcing education delivered by other team members?</li> </ul>
Encouraging self-care in patients	<ul style="list-style-type: none"> <li>• Have you established what functional goals are most important to the patient? E.g. rather than just knowing they want to “walk again”, ask “why”. What activity is most important to them?</li> <li>• Are you sharing with other team members what the patient’s abilities are? What the patient’s goal is?</li> <li>• Are you sharing tips for how to support the patient’s ability levels outside the therapy visit?</li> </ul>
Supporting comprehensive management of chronic conditions	<ul style="list-style-type: none"> <li>• Do you consider the effects the patient’s medications have on exercise response and/or balance?</li> <li>• Are you addressing pain or just encouraging patients to take their pain medication or referring the complaint to nursing?</li> <li>• Are you sharing with other team members what they can instruct or ask the patient to do during their visit that will support the PT POC?</li> </ul>
Treating health concerns sooner rather than later	<ul style="list-style-type: none"> <li>• Do you ask the patient about conditions nursing might be monitoring so you can communicate any subtle changes?</li> <li>• Are you communicating subtle changes to the team timely?</li> </ul>

Table 2

Core Competencies	Sub-competencies (not an all-inclusive list)
<p>Work with individuals of other professions to maintain a climate of mutual respect and shared values.</p>	<p>Respect the unique cultures, values, roles/responsibilities, and expertise of other health professions and the impact these factors can have on health outcomes.</p>
	<p>Work in cooperation with those who receive care, those who provide care, and others who contribute to or support the delivery of prevention and health services and programs.</p>
	<p>Demonstrate a trusting relationship with patients, families, and other team members</p>
	<p>Demonstrate high standards of ethical conduct and quality of care in contributions to team-based care.</p>
	<p>Maintain competence in one's own profession appropriate to scope of practice.</p>
<p>Use the knowledge of one's own role and those of other professions to appropriately assess and address the health care needs of patients and to promote and advance the health of populations.</p>	<p>Communicate one's roles and responsibilities clearly to patients, families, community members, and other professionals.</p>
	<p>Recognize one's limitations in skills, knowledge, and abilities.</p>
	<p>Explain the roles and responsibilities of other providers and how the team works together to provide care, promote health, and prevent disease.</p>
	<p>Use the full scope of knowledge, skills, and abilities of professionals from health and other fields to provide care that is safe, timely, efficient, effective, and equitable.</p>
	<p>Communicate with team members to clarify each member's responsibility in executing components of a treatment plan or public health intervention.</p>
<p>Communicate with patients, families, communities, and professionals in health and other fields in a responsive and responsible manner that supports a team approach to the promotion and maintenance of health and the prevention and treatment of disease.</p>	<p>Choose effective communication tools and techniques, including information systems and communication technologies, to facilitate discussions and interactions that enhance team function.</p>
	<p>Communicate information with patients, families, community members, and health team members in a form that is understandable, avoiding discipline-specific terminology when possible.</p>
	<p>Express one's knowledge and opinions to team members involved in patient care and population health improvement with confidence, clarity, and respect, working to ensure common understanding of information, treatment, care decisions, population health programs, and policies.</p>
	<p>Listen actively and encourage ideas and opinions of other team members.</p>
	<p>Use respectful language appropriate for a given difficult situation, crucial conversation, or conflict.</p>
<p>Apply relationship-building values and the principles of team dynamics to perform effectively in different team roles to plan, deliver, and evaluate patient/population-centered care and population health programs and policies that are safe, timely, efficient, effective, and equitable.</p>	<p>Develop consensus on the ethical principles to guide all aspects of teamwork.</p>
	<p>Engage health and other professionals in shared patient-centered and population-focused problem-solving.</p>
	<p>Engage self and others to constructively manage disagreements about values, roles, goals, and actions that arise among health and other professionals and with patients, families, and community members.</p>
	<p>Use process improvement to increase effectiveness of interprofessional teamwork and team-based services, programs, and policies.</p>
	<p>Use available evidence to inform effective teamwork and team-based practices.</p>

of the interprofessional team. It requires us to keep the lines of communication open and active. *Interprofessional collaboration doesn't just happen. It takes work.* It may not include an invitation to the table; it may require action on our part to get to the table. It is important enough to the quality of patient care that it can't be ignored.

Have you ever thought about what the ideal care model would be for a person with acute on chronic diastolic heart failure? What about someone with lower extremity cellulitis and diabetes? What mix of nursing, therapy, aide, and social service visits would you provide? Would it be the same for both persons? The Centers for Medicare and Medicaid Services (CMS) sent a message when they finalized the PDPM and PDGM: Rethink how you are delivering care. Continuing with the same care practices used over the last twenty years is not going to be successful in the next year. What do providers have to do? Rethink how we are delivering care. That may mean change. While change is disruptive, it can be beneficial to both patients and therapists.

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*"You need to be aware of what others are doing, applaud their efforts, acknowledge their successes, and encourage them in their pursuits. When we all help one another, everybody wins."*

– Jim Stovall

# AGE ON: Intentional Aging in the Age of COVID

## A Continuing Education Module for APTA Geriatrics

### Module Chapters

1. Introduction to Intentional Aging as a Concept
2. Demographics and Social Determinants of Aging
3. Movement Systems Perspective of Growing Older
4. Mitigating Frailty: Opportunities Abound
5. Considerations for Motivating Purposeful Aging
6. Beyond the Sit to Stand : Interventions for Intentional Aging
7. Intentional Aging: Personal Perspective

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### Contributor

A very special thank you to William Staples PT, DHSc, DPT for editing and vetting all the questions and answers

### Reference List

References can be found at the end of each chapter in the module.

### Objectives

1. Explain the concept of intentional aging.
2. Discuss changes found in older persons from a movement systems perspective
3. Address and discuss frailty and possible interventions
4. Discuss use of the Sit to Stand test
5. Understand and discuss motivations and personal perspectives

### Target Audience

Physical Therapists and Physical Therapist Assistants

### Contact Hours/Continuing Education Units

Completion of this CE Module is equivalent to 4 contact hours (0.4 CEU units).

### Continuing Education Certificate of Completion

A Continuing Education certificate will be provided to each participant after successful completion of the course requirements (post-test and module evaluation) and payment of a processing fee. APTA Geriatrics is a recognized component of the American Physical Therapy Association. The Academy has not applied to any state licensure agency for prior approval of this course. The module has all the components (content, objectives, qualified instructors, reference lists, and post-test) that will allow participants to submit the certificate of completion to meet CE requirements in some states. Participants are urged to check with their state licensure board to see if this course counts towards continuing education credit.

### How to Obtain CEUs

To obtain CEUs for this unit, participants must complete the ONLINE post-test AND the ONLINE evaluation form. Go to [geriatricspt.org/exams](http://geriatricspt.org/exams).

A processing fee of \$40 for Academy of Geriatric Physical Therapy members and \$80 for non-members is required for all physical therapist and non-member Physical Therapist Assistants. *The processing fee is WAIVED for all Physical Therapist Assistant Academy Members – Congratulations on 50 years and many thanks for all that you do for older adults and the profession!*

*Test and evaluations forms must be completed online no later than December 31, 2022.* Upon submission of materials and a passing score of 80% or higher on the post-test, the Academy will email you a continuing education certificate for 0.4 CEUs. Those with incomplete submissions will be notified via email and given the opportunity to re-take the exam.

There is only ONE correct answer for each question.

NOTE: This is to be performed *online only* at [geriatricspt.org/exams](http://geriatricspt.org/exams)

**Focus Issue 2021:** What topic would you like to see explored in greater detail next year? Contact Michele Stanley at [gerinoteseditor@gmail.com](mailto:gerinoteseditor@gmail.com).

# Intentional Aging

by Dale Avers, PT, DPT, PhD, FAPTA

It is generally believed that aging is influenced by a combination of genetics (~25%),<sup>1</sup> diseases and illness, and lifestyle. The influence of lifestyle on aging has spawned much discussion on how aging can be controlled, as if to manipulate the aging process into a more palatable one. I suspect this desire to control and manipulate aging is most prevalent in the Third age,<sup>2</sup> the “golden years”, when aging is readily apparent, but has not yet resulted in disability. The desire to control and manipulate one’s aging process has produced the concepts of successful aging and optimal aging generally defined in terms of outcomes that include a lack of disease or physical disability and mental infirmity. Successful and optimal aging is particularly attractive to physical therapists because of its emphasis on physical independence and mobility that enable aging in place, one of the most fervent goals of aging adults.

The ruse of the manipulation of aging into something more successful can be useful to us when patients use aging as an excuse for the acceptance of the inevitable deterioration of the aging process. Statements like, “I’m just getting old” and “I won’t be able to do stairs someday” can be countered with exemplary aging examples. In fact, depending on the source, 60-70% of a person’s health is due to factors we can influence, if not control. So it’s tempting to embrace the concepts of successful and optimal aging as something to be strived for. However, embracing successful aging can result in trying to fix aging,<sup>3</sup> seen in actions like getting a new joint, undergoing surgery that has little evidence for long-term gain, and taking medications that have significant side effects with little additional value. While these actions may be indicated, too often they are done without participating in lifestyle choices known to improve pain, disability, and health.<sup>4</sup>

However, in spite of everything we can do to successfully age, to avoid disability, to maintain a high function of life, there is the unknown – that dose of bad luck that upsets all of our successful aging efforts. Are folks with a congenital disease or disability and are now dependent not successfully aging? Is the woman who has exercised all her life, but sustained a syncopal episode that resulted in a non-union hip fracture doomed to the label of a sub-optimal ager? Or how about the gentleman who decides that the quest for successful aging is just too much in the face of his cancer diagnosis and becomes passive about his aging? Is his decision one of giving in or of acceptance of the variability of the aging process?

I mentioned in my Carol B. Lewis Distinguished Lecture<sup>5,6</sup> that I observed residents who appeared to have

given up or given in to the aging process. These folks live in the independent living facility where my mother lives. They don’t participate in the exercise classes offered, only engage in minimal physical activity, and choose not to participate in mental or social challenges outside their narrowing comfort zones. My 90-year old mother suggested that perhaps these folks have exhausted their capacity to continue to manipulate and fight aging. She suggested that these folks may have lived in and taken care of their homes until the death of a spouse, an accident (bad luck), or otherwise life-altering event, resulting in embracing a “more protected” lifestyle. Now they begin the acceptance of the Fourth Age, the end of life period where little is controlled and most must be accepted.<sup>7</sup> At this stage, the major challenge is to gracefully accept growing dependency. A risk of using the successful aging label is that it leaves out those folks who are not independent or physically active. Many older folks do not embrace the effort required to achieve successful aging – that active engagement to maintain independence as described in

*It is our obligation to accept their decisions and desires and to help enable them to live their life to the fullest. These choices are the essence of intentional aging.*

Heitzman and Oluwole-Sangoseni’s article in this issue. Instead, some older folks embrace an interdependence with each other. They choose to walk with a walker because its less effort and instead of exercising, expend their limited energy on card playing and visiting family.

Intentional aging is about choices in how life is lived throughout aging. It has less to do with outcomes and more to do with process. Intentional aging requires the physical therapist to be on the same page with the patient (person-centered care), accepting the person’s beliefs and expectations for their aging. However, acceptance is not to be construed as lower expectations. We should always have a vision for the highest quality of life possible for the people entrusted into our care. This vision can be about the importance of building reserve to minimize the effects of “bad luck” and frailty. This vision also includes educating the person and family on what could be possible for their aging process and about the risks and benefits to various choices. But any advice given must be within the context that we don’t know how it feels to be approach-

ing the end of one's life – whether it's weeks, months, or years. Pushing someone into optimal aging without their full participation because the goals of optimal aging may require more effort and risk than the person desires, is not patient-centered care. It is our obligation to accept their decisions and desires and to help enable them to live their life to the fullest. These choices are the essence of intentional aging. Can intentional aging result in optimal outcomes, otherwise known as successful or optimal aging? Of course. But where successful aging leaves off, intentional aging continues. Intentional aging guides the vision and desires one has for the remaining time of life.

The physical therapist working with older adults is integral to intentional aging. Since intentional aging is about choices, providing thorough, evidence-informed education is critical. Many patients admit to not knowing the consequences of their previous decisions (active or passive). Remember the quote "If I knew I was going to live this long, I'd have taken better care of myself?" Our challenge is to provide education and information in an affirming and empowering manner, without using words and attitudes that harm with the outcome of acceptance and affirmation. We are also called to facilitate successful accommodation through maintenance of participation in valued activities.<sup>8</sup> Examples of education and interventions that empower successful accommodation and therefore intentional aging include:

- Person-centered goal setting and priorities and facilitation of achieving those goals and priorities<sup>9</sup>
- Discussion of the concept and condition of pre-frailty and frailty and what we know about its causes and consequences<sup>10</sup> (see page 19)
- Benefits and consequences of strength training and physical activity<sup>11</sup>
- Facilitation of engagement in the type of physical activity that the patient/client chooses
- Self-management education and techniques,
- Balance and falls management
- Advocacy for palliative care<sup>12</sup>
- Discussion of health proxies, advanced directives, and end of life decisions<sup>13</sup>
- Embracing concepts of Rehabilitation Light and Rehabilitation in Reverse<sup>13</sup>
- Coordination of care across continuum of care
- Annual visits to track mobility and balance abilities<sup>14</sup>
- Awareness of the effects of social isolation and how to facilitate social engagement through physical mobility<sup>15</sup>
- Advocacy for patient's choice in assistive devices<sup>16</sup>
- Home assessments to facilitate aging in place

## Conclusion

We have much to offer all individuals throughout their aging process. By focusing on the patient/client's goals, desires, and priorities we can facilitate not just successful aging but intentional aging – from the most successful outcomes of robust activity to the gradual decline that

ends in death. Part of intentional aging is facilitating the planning and successful adaptation to increased dependency and limited mobility to help the person achieve what is important to them. Intentional aging is about the choices an elder makes throughout their aging journey. Physical therapists are integral to the process of intentional aging.

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# Impact of Social Determinants of Health and Social Distancing on Aging

by Jill Heitzman, PT, DPT, PhD and Olaide Oluwole-Sangoseni, PT, PhD

Aging is a physiological process that occurs in various ways across society: many factors impact how aging appears and the variability across populations. Age in years does not necessarily correlate to physiological age; the rate of which is quite variable and can be affected by lifestyle, genes, and diseases.<sup>1,2</sup> Studies have tried to identify why aging has so many different presentations; most come back to how a person has lived their life.<sup>1,2</sup> Some would ultimately argue that the responsibility for how one ages is based on choices made throughout one's life. However, this argument does not take into account that the decisions are based on the opportunities available to them throughout their life. The recent social distancing and quarantine have accentuated opportunity differences that have deepened health disparities among populations and, most importantly, the cultural and age disparities that are present. This article will focus on how social determinants of health have been brought to the forefront and have impacted the older population during this unprecedented time.

## Predictors of successful aging

Successful aging means different things to different people. A widespread notion of aging well includes the terms successful aging, active aging, healthy aging, positive aging, productive aging, competent aging, and intentional aging. Active aging has been more prevalently used in Europe. It focusses on the rights of older people to remain healthy (thus reducing health care costs and social care), remain employed longer (reducing pension costs), and participate in community and political life.<sup>3</sup> The term successful aging has been more prevalent in the United States.<sup>3</sup> A historical perspective is necessary to understand the current concept of successful aging,

Hochschild proposed the first major gerontological theory regarding successful aging in 1975.<sup>4</sup> This theory was criticized for ignoring an older adult's perspective on aging by focusing solely on disability and disease, enforcing the concept of a deficit model of aging. The research model of successful aging required individuals to lead lives that avoided disability and illness, to maintain mental and physical functions to remain productive and engaged socially, with retention of values and lifestyles typical of those in middle age, thus denying the onset of old age.<sup>5</sup> This result was a productive aging concept that challenged the expectation that older people would exit the labor force at a fixed arbitrarily chosen age. This has

had some positive impact on the ability to allow people to remain employed longer and thus engaged in society; it has also produced negative biases in what is meant by an "economically productive" sector of society. Grouping individuals in terms of their economic productivity ultimately resulted in a two-tiered view of older age. First-tier is composed of people aspiring to meet the standards of successful activity, which is linked to employment. In contrast, in the second tier are those who are deemed unable to engage in a successful employable activity because of severe illness, disability, or other factors which impacted how health care financial resources are allocated.<sup>6</sup>

A model, developed by Paul and Margaret Baltes, describes aging success as "doing the best you can with what you have."<sup>7</sup> This model focusses on the ability to cope with challenges and changes by taking advantage of physical, social, and environmental opportunities. Rowe and Kahn elaborated on their original model and argued that aging and illness are separate processes.<sup>8</sup> They developed their initial model of aging to identify three components of aging well that include: minimizing the risk of disease and disability, maintaining mental and physical function, and engaging in life. This view of successful aging acknowledges opportunities for each individual to improve their ability to remain healthy and engaged. However, this model of successful aging ignores the fact that reaching old age is uncommon without some disease or disability.<sup>9</sup>

Strawbridge and Willhagen challenged models that labeled someone as being unsuccessful in aging based on disease or disability and surveyed 899 individuals aged 65-99 years on their views regarding aging successfully.<sup>10</sup> Their findings demonstrated that people identified successful aging with active aging intellectually, socially, and physically. Survey results also highlighted the significant differences between male and female opinions. Men viewed physical engagement as more important, women saw social and spiritual engagement as more important. A different study of over 1000 people aged 50-99 years found that resilience and reduced depression had a significant association with self-reported physical health and reducing physical disability; thus aging successfully.<sup>11</sup>

More recently, there is greater recognition of the interplay between physiological development and change with the dynamic social structures.<sup>6</sup> Social and cultural environments vary considerably in terms of the demand involved and the opportunities or resources available to

each.<sup>12</sup> Barriers to active aging have been found primarily among participants with the following markers: poverty; ill-health and deprivation; poor neighborhoods; ageism; and insecure, gendered, racialized and sectarian space.<sup>13</sup>

Overall, predictors of successful aging vary with an individual's point of view. Common in all definitions of what aging well means is living into the later years by being engaged in life.<sup>6</sup> **Successful** aging indicates an independent function in later life. **Active** aging is related to being involved with others and in activities that enhance the quality of life. **Positive** aging is correlated with self-efficacy, self-esteem, and optimism, and **Intentional** aging is based on choices made that impact a long life.<sup>6</sup> These are intertwined with the predictors of long life in the four areas shown in figure 1.

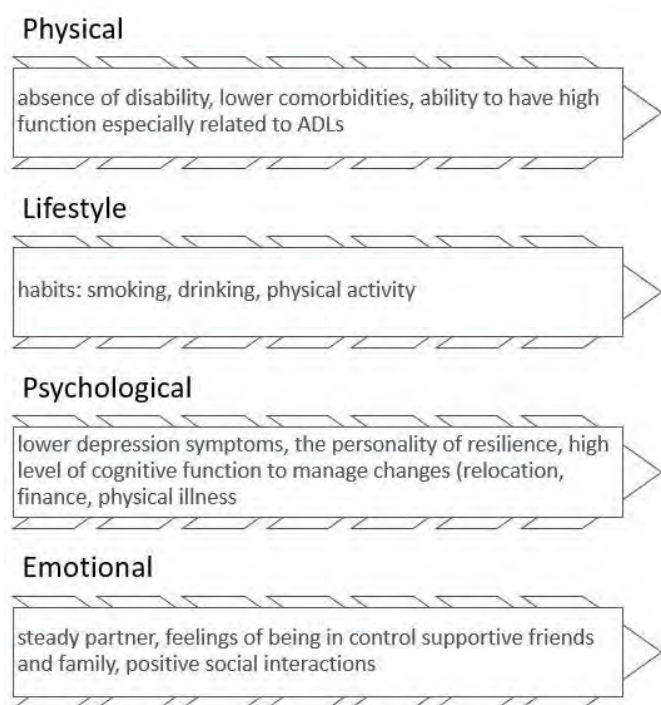


Figure 1. Predictors of Successful Aging

These predictors of long life and engagement are intertwined with a person's life experiences. The common theme is that to age well requires material security, social resources, life activity, cognitive efficacy, and physical health/functional status. All are impacted by the social determinants of health and, more recently, by current social distancing.

### Social determinants of health (SDOH)

Social determinants of health are identified as conditions in which people are born, grow, live, work, and age.<sup>14</sup> The United States Department of Health and Human Services added where people learn, play, and worship. These include the social, economic, physical conditions, patterns of social engagement, sense of security and

well-being, availability, and quality of life-enhancing resources: housing, education, public safety, healthy foods, and an environment free of toxins.<sup>15</sup> Various levels of these resources between communities result in a continuum of inclusion/exclusion characterized by unequal access to resources and opportunities leading to health inequalities.<sup>14,15</sup>

Healthy living starts long before the illness. The opportunity for healthy living begins where one works, lives, and plays as well as people in our families (not just those biologically-related or immediate families), neighborhoods, schools, and jobs. Braveman et al. identified factors that affect health and wellbeing.<sup>16</sup> These include social and environmental factors, individual behavior, genetics, and health care. Each area will be discussed in relation to the impact on health and include economic stability, neighborhood/physical environment, education, food, community/social context, and health care system. Some of these are interconnected, so a review of all of these factors is beyond the scope of this module, but a few primary ones related to aging adults will be discussed relative to the current social distancing guidelines.

### SDOH-Economic Stability

Economic stability includes employment, income, expenses, debt, and bills. While the poverty rate among those 65 years and older have declined by almost 70% in the past five decades, 9.2% of those over age 65 years had income levels below the poverty threshold. However, the actual **number** of poor among this group has **increased** as the total number of aging adults has increased.<sup>17</sup> This rate is even higher for those over the age of 80 years (11.6%), women (13.5%), and those living alone (18.6%). Poverty rates also vary by race. The lowest poverty rate for those age 65 and older was in the non-Hispanic white population (5.8% for men and 8.0% for women) and highest among those identifying as black or African-American (16.1% men and 21.5% for women).<sup>17</sup>

Singh et al. found that social distancing and personal behaviors varied across different demographics based on these social determinants of health, mostly age, culture, living environment when studying the effects of influenza.<sup>18</sup> Grooms et al. collected data between March and July 2020 related to employment status and race/ethnicity.<sup>19</sup> Essential workers included health care, food service, and public transportation. Unemployed and essential non-health care workers experienced the most difficult challenges. Essential non-health care workers are more likely to have no health insurance coverage and jobs with low wages.. Many of these workers are members of racial and ethnic minority groups. Income well below living wages already puts this population at high risk for poor health before the added emotional stress of worry regarding transmission to family and friends results in greater social isolation. Lack of income and health insurance increases the emotional stress for those who have become unemployed, Economic stress, in turn, may lead

to food insecurity and housing insecurity with fear of evictions.<sup>19</sup> Health care is challenging even for those without financial pressure during the pandemic with the reduction of primary care follow-ups, limited access to telehealth, reduced health care visits from social distancing clinics; all lead to more significant emotional stress.

### **SDOH - Neighborhood Factors**

The neighborhood and physical environment include not only housing but also safe access to transportation, parks, and walkability from housing, and factors such as the number of people in the home, as well as livability. The neighborhood includes safety, noise, and sanitation/health hazards. Variations in regions related to weather, public policies, and social norms may also be included in neighborhood factors.<sup>20</sup>

Another neighborhood factor is the availability of health care, including competent providers and available hours for consultation. As clinics reduced hours and visits during the recent quarantine, depending on where one lived, access to the required health care was further reduced. Even before the current pandemic, Quinn and Kumar identified areas of social inequities that lead to unequal levels of illness and deaths.<sup>21</sup> These included: population overcrowding (especially in low-income areas), lack of access to clean water and sanitation, inability to stay away from work due to economic factors, psychological stress, nutritional status, access to health providers/care/insurance, and quality of health care available.<sup>21</sup> These factors lead to an inability to socially distance, leading to increased transmission of diseases, and lack of treatment options for both current infections and managing chronic conditions.

### **SDOH - Food Accessibility**

Access to food includes an impact on hunger, access to healthy options, cultural preferences, and ultimate impact on overall health.<sup>20,22</sup> Food insecurity can be observed in neighborhoods with food deserts that offer limited choices in food options, lack of fresh fruits/vegetables, increased fast food access. Individuals with limited incomes tend to live in crowded areas without healthy food decisions.<sup>22</sup> Many with low income are also limited in food choices and tend to choose foods that decrease the hunger.<sup>23</sup>

### **Summary of social determinants of health**

People with lower levels of income, higher unemployment, and greater levels of food and housing insecurity, have fewer buffers to absorb the economic shocks of a pandemic. The accompanying restrictions or limitations exacerbate their vulnerability as a result of social distancing, changing work environments and economic crises.<sup>23</sup> Overall, COVID-19 related-social distancing has resulted in decreased access to health care, increased financial stress, and increased emotional stress. These, in turn, negatively influence intentional aging choices, limit the

probability of successful health outcomes, and lead to increases in mental health issues.

### **Aging/frailty impact**

People of all ages have been impacted by the COVID-19 pandemic.<sup>25</sup> These impacts may be infection of themselves or their family members, economic impact, or social distancing (especially for those who are caregivers for others). Ageism is an additional layer of consequence and can lead to the undervaluing of older people, neglecting the range of long-term services and support systems that impact overall mental and physical health. Implicit ageism is the internalized negative attitude of aging; this affects the health of this population.<sup>25</sup> Interesting that while those over the age of 65 years are at higher risk of complications resulting in hospitalization, 74% of the reported COVID-19 cases are in people ages 19-64 years.<sup>24</sup> The SDOH that includes health status, age, sex, race, ethnicity, economic status, geographic location, and occupation are higher risks for COVID-19 than age alone.<sup>26</sup> The higher death rates in older adults are more likely related to a decline in immunity that accompanies aging and increasing number of comorbidities including cardiovascular and pulmonary diseases and diabetes; all impact the ability to fight the infection due to decrease in the physiological reserve available to fight the infection.<sup>26</sup>

Social isolation leads to loneliness and emotional, and physical side effects.<sup>27</sup> The decrease in the frequency of interactions with family and friends and the inability to attend events that include exercise classes, educational courses, religious services, and other social gatherings impacts the psychological factors needed for successful or intentional aging.<sup>28</sup> Social Isolation also brings stress if the aging adult is still working in a required workplace setting that results in increased fear of bringing home viruses. Furlough from employment at any time leads to mental stress from economic changes.<sup>29</sup>

Many people have utilized technology connections through internet usage of video chat software or apps such as Zoom, Houseparty, Facebook, What'sApp, and others. This time of quarantine has also highlighted the impact of low income and rural locations concerning access to technology.<sup>30</sup> Over 32% of older adults do not have internet subscriptions at their homes, 18% of those with an annual income of less than \$30,000.00 do not have internet, and 24% of those in rural areas report unstable internet access.<sup>30,31</sup> These issues also have an impact on the type and frequency of telehealth, thus reducing health care access further.

### **Reframing ageism**

As part of the Gerontological Society Reframing Ageing Initiative, O'Neil presented a webinar regarding applying reframed language to counteract ageism in the current response to COVID-19.<sup>32</sup> The emphasis of this webinar

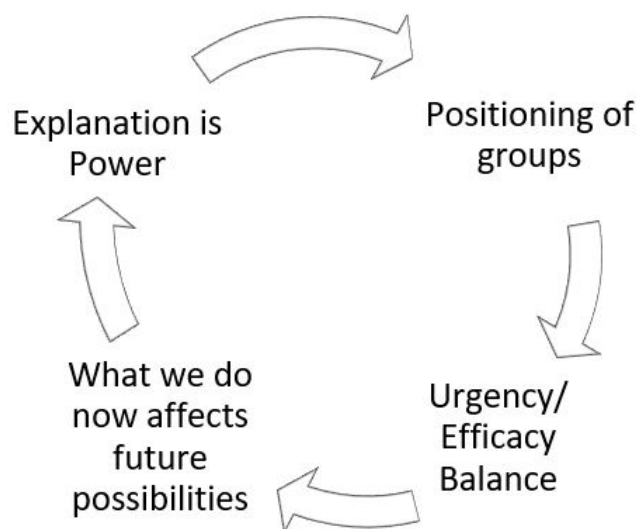


Figure 2. Reframing Ageism

focused on how the choices a person makes in information presentation determine how the receiver of the information may think/feel/act. O'Neil broke this into four steps (Figure 2).<sup>32</sup>

Looking at these steps in Figure 2 individually can change the perception of how older adults move forward in aging that is more successful and reduces age bias. A message that is presented as *all urgent* results in a fatalistic response of the receiver, yet a message *all on efficacy* can lead to receiver disengagement. Explanation of the situation with a possible solution in a tone of encouragement can lead to better outcomes. Avoiding terms that stereotype (vulnerable), stigmatize (victims/saviors), or imply a deserving impact (worthiness) can disconnect people from the activity; this results in decreased resources for the older adult. Focusing on the interconnection of shared experiences and advancing principles to improve the life of targeted individuals will achieve more positive responses. Explaining a situation, developing actions, and providing solutions to improve the situation is a more effective response than just a “do as I say” answer. Interaction with individuals today impacts what that interaction will be in the future.<sup>34</sup>

As health care professionals, physical therapists have a role in working within the American Physical Therapy Association and communities along with policymakers to enhance health care, assure after disease care, and reduce the unequal burden of morbidity and mortality among ALL populations of the aging adult. Taking into account the pre-existing inequalities, change must occur for aging adults to “Move Forward” and “Age On.”

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## Who Assumes Care? Taking Steps to Prepare for the Next Phase

by Alisa Curry, PT, DPT

Physical Therapists specialize in assessment, establishing a plan of care and the provision of treatment. We are reminded daily of our own morbidity, mortality, and the fragility of health. We promote wellness with our patients but how well do we focus on our own health?

As a clinician and educator, I repeat the phrase “you can’t take care of other people if you don’t take care of yourself” when I train on body mechanics, patient safety, and staff education. Articles and research highlight the mental and physical health risks for health care providers.<sup>1,2</sup>

I am starting to look at the next phase of my career after working as a provider for over 25 years. Retirement is not an immediate goal. However, I am also closer to the end than to the beginning of my career. This generates thoughts about my own aging, long term planning, and what I want the future to hold.

There is an expectation for family responsibility, particularly for those who are married with children, that your family will assume your care. Therapists and other providers do this regularly in the acute care setting when patients are ready to leave the hospital. If we encounter patients who say they have no one, we may assume that they are estranged from family, will get assist from friends, or hire outside help.

The lesbian, gay, bisexual, transgender (LGBT) community is a growing subset of older adults. Societal

acceptance and acknowledgement of same-sex couples is variable across the country, with potential for discrimination in both urban and rural areas.

According to Services and Advocacy for GLBT Elders (SAGE), “there are three million adults over the age of 65 who identify as lesbian, gay or bisexual. By 2030 those estimates are expected to double.”<sup>3</sup> LGBT older adults are similar to their straight counterparts in risk factors for and detrimental effects from disablement. They are also more likely to rate their health as poor, have higher prevalence, and earlier onset of disabilities.<sup>4</sup>

The country has moved in a positive direction with the implementation of several Federal changes: the passage of the ACA in 2010, the Supreme Court’s ruling overturning DOMA in 2013, and subsequent ruling in Obergefell in 2015 (guaranteeing the right to same-sex marriage nationally), have significantly affected access to care and coverage for LGBT individuals and their families, expanded nondiscrimination protections, increased data collection requirements, and supported family caregiving.<sup>5</sup>

There is a current effort to eliminate the Affordable Care Act, which could remove some of the protections given in the coverage. This will affect any persons that may not have been previously covered by insurance, likely those with lower income positions, blue collar and/or part time roles.

Making a plan for my “golden” years has now taken

on greater significance. I have been fortunate to have benefitted employment, investment in a 401K retirement account and, hopefully, will be able to use the Social Security benefits that I have paid into since my first job. Since I do not have children, I have a large group of friends whom I consider family and we have begun the discussions of legal authority for decision making to protect our interests. This is a responsible way to guarantee that your wishes are followed and that you make your wishes clear.

Any person with a limited support system needs to consider establishing a hierarchy of care. While marriage gives legal responsibility to your spouse, for LGBT couples prior to 2008, it was not nationally recognized.

For those people estranged from their families, using the law to designate a legal power of attorney for health care and/or financial oversight is the best option to protect your interests.

There are four different types of POA that can be established – Limited, General, Durable, and Springing.<sup>6</sup> Each will identify when and for how long the powers take effect. A power of attorney can be printed out from online resources in your state, signed, and notarized with a notary public with the identified person to whom you are giving authority. People should consult an attorney, ombudsman or certified advisor for details. Proactive planning is especially important with aging since comorbidities increase; none of us can ever start too soon.

I hope to never have to be involuntarily hospitalized or incapacitated but I have a plan and a good support team in my corner. I have a wife of 12 years and a responsible circle of friends who are very clear on my medical care and wishes. I recommend that we all make that plan.

In the words of Apple CEO Tim Cook – "Life is fragile. We're not guaranteed a tomorrow so give it everything you've got."

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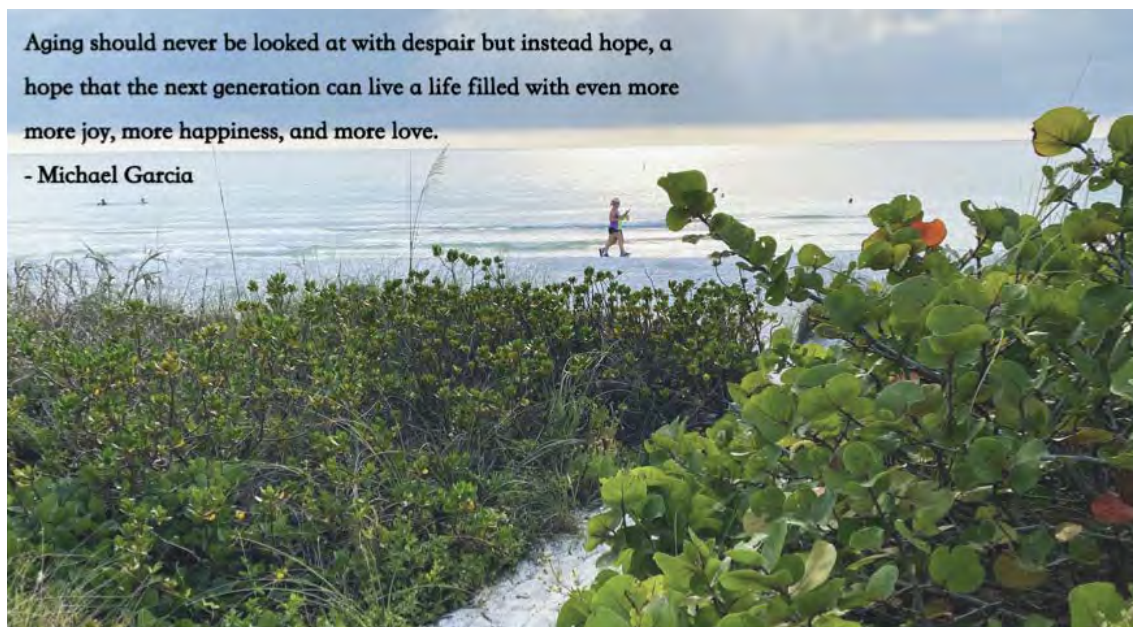


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**Aging should never be looked at with despair but instead hope, a hope that the next generation can live a life filled with even more joy, more happiness, and more love.**

**- Michael Garcia**



*Photo Courtesy of University of St. Augustine Geriatric PT Summer 2020 program*



*Modified leg press using resistive bands*

## Mitigating Frailty: Opportunities Ahead

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

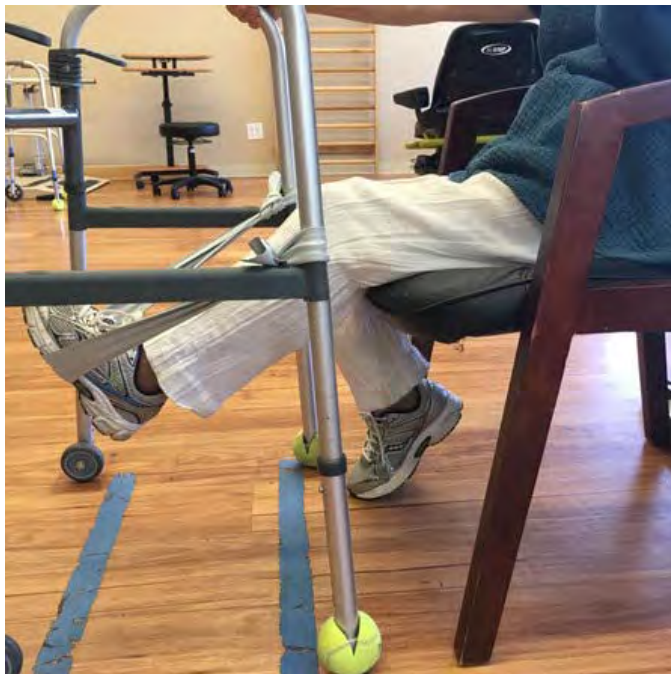
As the proportion of the older adult population rises in the United States, the number of older adults with frailty is also increasing. Frailty has been defined in varying ways, but a well-accepted definition marks frailty by unintentional weight loss, low strength, reduced physical activity, the feeling of exhaustion, and slow walking speed.<sup>1</sup> Frailty can have a slow, insidious onset, with sarcopenia often silently present and putting one at increased risk for developing frailty. A critical feature of frailty is that it is a state of vulnerability. Frailty can lead to a downward spiral. Older adults with this syndrome have increased risk for falls, disability, hospitalizations, and mortality.<sup>2,3</sup>

Varied approaches toward addressing frailty have been studied. One component emerges from systematic reviews that shows more promise for improvement: physical activity intervention.<sup>4</sup> Muscle weakness is a key marker of frailty; targeting this weakness is essential. Resistive training protocols stand out as being “consistently effective” in the treatment of frailty.<sup>5</sup> Muscle strength training with protein supplementation have also shown consistently greater effectiveness.<sup>6</sup> Physical therapists can play a key role by applying well-dosed, robust strengthening interventions. Falvey et al have proposed that high-intensity resistive training should be the cornerstone of interventions for hospital associated deconditioning (which can rapidly uncover frailty) instead

of a traditional lower intensity approach.<sup>7</sup>

Decades of research has shown that older adults, even sedentary and those with multi-morbidity, can participate in higher intensity strength training and demonstrate meaningful improvements.<sup>8</sup> Benefits include reduced falls and fear of falling and improved physical performance. High-intensity resistive training is also shown to be one of the most effective exercise modalities to improve preferred gait speed.<sup>9</sup> High-intensity motor control interventions of gait and balance can also mitigate frailty: participants have demonstrated an improvement in their frailty classification, e.g., moved from “frail” to “pre-frail.”<sup>10</sup>

Many referrals to PT are reactive, initiated because of an illness or injury. Frailty puts older adults at higher risk for these negative events. Physical therapists are uniquely poised to identify and address this vulnerability. Although our typically reactionary medical system pushes us to focus on the new injury or illness, physical therapists can look deeper to see underlying frailty or susceptibility to frailty. Here is a great opportunity for prevention! Therapists can address the weakness that made one vulnerable to an adverse event in the first place. Although getting “back to baseline” is a common therapy paradigm, one’s baseline can potentially be improved with the right exercise interventions, increasing functional reserve and resilience to help prevent future adverse events.<sup>7</sup> Often,



*Modified leg press with bands stabilized on a walker.*

the prior level of function was insufficient to prevent them from getting into trouble.

Many therapists are working with reduced visit numbers and restricted time with older adults in the wake of changed payment models. The Covid-19 pandemic has been another barrier to access older adults susceptible to frailty. In the precious therapy time we have with older adults, what might it look like in various settings to capitalize on the most effective interventions to mitigate frailty?

### Here are some suggestions to consider when using strengthening interventions for older adults with frailty:

1. Target important muscle groups for function. Some examples from the literature are: knee extensors, hip extensors, hip abductors, plantar flexors and triceps<sup>12</sup>
  - The leg press is used in many research protocols and uses a combination of the important muscle groups listed above.
  - Sit - stand, squats, lunges or similar closed chain functional exercises are also included in many studies and target the muscles listed above and can be strengthened appropriately, with the addition of weights or bands as needed for sufficient intensity.
2. Choose an appropriate resistance level: 80% of one-repetition maximum is ideal for strengthening.
  - While the older adult may need a lighter resistance level especially at first due to comorbidities, this does not exclude them from resistance training. Start with a lower level and intentionally work towards a higher level.
3. Know how to dose the appropriate resistance level, using one of the following methods:
  - Use perceived rating of exertion (e.g., “hard” to “very hard” for 80% of one repetition maximum).
  - Count the number of repetitions that the patient can perform and look for signs of fatigue and failure. For a high intensity exercise, make the exercise hard enough that there is failure at 8-10 repetitions – e.g., they physically are unable to perform an additional repetition past the set.
  - Use a formula (there are many in the literature) or a 1-repetition maximum app to determine what one repetition maximum is for an exercise. Use this one repetition maximum value as a basis to calculate the amount of resistance needed.

**Acute care.** Consider initiating strengthening interventions at a lower intensity. Recent work by Martinez-Velilla et al in an acute setting demonstrated that a 5-7 day, 20 minute intervention including progressive resistive training at 30-60% of 1 repetition maximum, with balance and gait training, significantly improved function and cognition.<sup>11</sup>

**Skilled nursing facilities/post-acute inpatient settings.** Therapists can incorporate well-dosed resistive training, alternating muscle groups on different days. Re-

sistive training can be included for all key muscle groups, not just those directly affected by the illness or injury. Therapists can use specific principles to progressively upgrade the activity. In addition to teaching safe mobility strategies, therapists can use high-level motor control gait and balance activities.

**Home health.** Therapists can continue robust strengthening interventions and determine what high-intensity exercises the patient can safely perform at home on their own or with assist. While home safety is critical and should be addressed, the correct level of intensity for exercise is also crucial to mitigating frailty.

**Outpatient settings.** Older adults who access therapy in this setting for any reason can be screened for sarcopenia and risk for physical decline and frailty. Therapists can educate on the risks of weakness and teach preventative strengthening programs.

Much research demonstrates the effectiveness of the leg press, unfortunately this piece of equipment is lacking in many clinics. Using resistive bands to mimic a leg press has been demonstrated in the literature.<sup>13</sup> Bands can be stabilized on a gait belt, or walker, which is stabilized by a therapist or assistant (see photos). Portable leg presses are also available for a lower cost than gym equipment and can be transported to different rooms and locations.

Every encounter with an older adult, in any point on the continuum of care, offers an opportunity to educate on the critical need to maintain or improve muscle strength. It provides an occasion to initiate higher intensity interventions that can reverse a downward spiral. Physical therapists can use their unique position and expertise as strength experts to work toward preventing or reversing frailty whenever possible.

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**COVID-19**  
Resources for Geriatric PTs

*APTA Geriatrics continues to collect resources related to geriatrics, physical therapy, and the response to COVID-19. Resources include webinars, documents and links to related organizations.*

[geriatricspt.org/practice/covid-19](http://geriatricspt.org/practice/covid-19)

# Kindness is a Tool in Your Toolbox

by Patrice Antony, PT, GCS

After being a Physical Therapist for nearly 40 years and a geriatric care manager for more than half of that time, I am still struck by how hard it is sometimes to get my seniors motivated to improve themselves. So many patients truly feel that being sedentary is an earned “right of passage” for aging. It can seem nearly impossible to get some people “fired up” about taking positive action toward self-advocacy and efficacy. Here are some of the excuses I have heard in my travels:

*Chronic disease is depressing. Just when you start making progress, you get sick again with an “episode” and you go back to square one. What is the point?*

*I am 90+ years. Who cares if I have skin or breast cancer? I don't have long to live and the effort of getting the problem diagnosed and treated seems hardly worth it . . . I am overwhelmed with what I would have to go through . . . Lets just let it be.*

*I don't need socialization – just give me a good book.*

*I can't afford to move to assisted living. What would I do with all my stuff? The thought of packing and moving makes me need a nap.*

*I don't need PT – I have a whole collection of home exercise programs in that drawer over there.*

*I know none of the lights in my house work. Electricians are expensive. That's why I have a good flashlight – Now where did I put it?*

What I have found is that seniors, like everybody else, want to improve but they seem to be easily overwhelmed with how to get there. They may have well-intending family/spouses who insist on helping or doing things for them (perhaps to avoid a fall?). Sometimes they have given up initiating tasks over time. For example, a memory loss patient with balance issues is told to sit down every time he attempts to stand, so he quits standing over time. This leads to weakness, knee and hip flexion contractures, and worsened balance which makes the fall more likely.

Those who work with older adults who seem to lack motivation should bear in mind that breaking down tasks into manageable “bites” makes goals achievable. There is less sense of failure although there may be setbacks.

The big goal may shift with advanced aging (although it doesn't have to!) but smaller task components are still intact. Reduce discussing or thinking of functional tasks as going back to “square one” after an illness or other setback. Focus on need to rebuild one or two skills to get back to previous or better function. This reduces the sense of helplessness and enormity of the task

Some seniors seem to weigh the energy or other cost of the activity with the value it brings. Doing exercise with a therapist does not improve quality of life unless it is tied to an activity that needs to get done every day. I had a patient who kept refusing me at the door. She told me she was sick of doing exercises. I asked her (through the door) “if you were well and able, what would you be doing right now?” She answered, “vacuuming the living room and doing the laundry.” I said, “then that's what we should do.” Her curiosity got the best of her and she answered the door. I asked her where she kept the vacuum and the laundry basket and we got to work. She got more exercise in that 45 minute home visit than she had done in quite a while. Her sense of accomplishment when the tasks were done, was evident; it bothered her to see things that needed doing and feel helpless to get them done. She proudly told me on the next visit that she had already gotten the living room vacuumed before I got there. Could I help her with walking her garbage to the complex dumpster? By the time we completed the six visits allotted by her HMO, she was arranging to go grocery shopping with her neighbor and thinking ahead to what else she could do. Mission accomplished!

Other older adults are very motivated by upcoming events: a grandchild's graduation, birthday party, a wedding, etc. Helping that senior think through what skills they will need for that event can motivate them for skill building. It can be as simple as helping them decide what to wear and choosing the appropriate shoes for the day. Working on car transfers for getting to/from the event. Building standing tolerance in case they must wait to be seated at a restaurant. Stair climbing if the event is at an arena or church where stairs are likely. Side stepping to move down a pew. There are so many ways to translate what we do to a relevant function for the patient. Therapists often just fail to analyze the problem and miss the opportunity, through motivational interviewing, to establish the steps for meaningful goals.

I am amused at patients who like a little competition. I have some clients who will repeat the Timed Up and Go to the point of exhaustion trying to beat their last time. They beam with victory when they can shave off

a fraction of a second. Pouring a little sugar-free ginger ale in plastic champagne glass for a toast on a job well done may seem silly, but makes their day. Throughout a lifespan, it is often celebration of the little things that makes the most memorable interactions.

Fear of failure may result in failing to initiate or continue a usual activity; this can appear as lack of motivation. Consider the person with Parkinson's who starts having weight loss and refuses to go to the dining room. A skilled therapist, when breaking down the task, may find that she is embarrassed about spilling food and soiling her shirt in front of the other residents when she can't control the tremors. A discussion about adaptive feeding equipment and possible medication timing provides new hope for joining the others and eating with friends again. Building other skills such as practice with upper extremity coordination activities, sit-to-stand practice, and walking to the dining room are components of concrete, measurable goals that are relevant to the patient need and payor source requirements.

Some seniors, especially, are primarily motivated by money. They want a cost analysis of the value of what you offer. You may need to be prepared to show cost savings of independence with hygiene tasks if they can safely shower and dress themselves without help. Showing a patient in a rehab setting the cost-per-day will often result in miraculous recoveries – usually about the time that the co-pay kicks in. Do not laugh – this has motivated many a client. They must feel that they got their money's worth to make the effort last, however. It is our job to demonstrate that value.

Empowering responsibility and accountability for their own health can motivate some patients. For example, provide them with a log to record their vital signs daily, before and after performance of a home exercise program. Teach them to use a blood pressure cuff; review and encourage diabetic elders to monitor blood glucose when exercising. This has the added benefit of awareness of their own health status and the impact of their activities, which will hopefully lead to a movement habit. Let them know that a copy of the log will be sent to their doctor when a progress report is sent. This can give a little push to encourage daily participation. Let patients know that they can only get well if they do their part.

Some patients are simply housed in the wrong setting. They would do so much better in a small assisted living and not the big hotel type. They are lost in the space and having trouble connecting with peers. They have trouble finding their way back to their room and avoid leaving the room as a result. They are not "joiners" and have never been the type to enjoy group activities. The pretty place appealed more to their kids but it's too much for the senior. As a care manager, I must advocate for the patient all of the time on this topic. The kids are well-intended, but guided by their own reaction to the setting and not what mom's reaction and needs might be.

The one motivator that works every time is to simply show that you care. Simple acts of kindness do not go unnoticed – even by the toughest client. If you know the patient had a doctor's appointment, try to call, and see how it went. Offer to do something for the client each time you are leaving their house: fix a quick lunch, get them some water, grab the mail for them, bring in the garbage can from the curb. It does not have to take a lot of your time, combined with education on healthy food choices, staying hydrated and electrolyte health, writing letters to connect with and give grandkids memories, etc, is part of your skilled services. It also reminds you why you got into this business. The "feels good" goes both ways. Rise and Shine!

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***"Act as if what you do makes a difference.  
It does."***

***– William James***

# Breaking Down the Sit-to-Stand

by J. Kele Murdin, PT, MPT

In relation to quality of life, the value of being able to rise from a seated position cannot be overstated. Standing up from sitting is considered one of the most mechanically demanding tasks that older adults must perform daily. We must remember that being able to stand is the gateway to all bipedal mobility.

There are several physiologic processes that occur with aging that may lead to barriers for the successful, safe, and independent ability to stand from a seated position. **Dynapenia** (the age-related loss of muscle activation and strength) may be compounded by age related changes, such as sensory motor system deficits, joint movement restrictions, vision or hearing changes, or vestibular loss. It is certainly understandable that some older adults may have difficulty with this task. When these underlying impairments lead to activity limitations, there are common, unfortunate, and often, an avoidable subsequent loss in function. A decline in health status may follow. The good news is that many of these age-related changes are modifiable if, and only if, they are identified. The purpose of this discussion is to highlight the analysis of movement of the sit-to-stand task in order to align interventions with the impairments that inhibit a person to be able to stand from a seated position.

Therapists need to be able to pinpoint interventions specific to each patient. This requires identifying each of the breakdown points within the components of the task. Only then can the analysis offer effective and specific remediation strategies. Schenkman characterized four separate phases that were mechanically distinct during a sit to stand activity<sup>1</sup>. For this discussion, Schenkman's four stages of "the sit-to-stand" will be used as a framework:

**Phase I** (flexion-momentum phase) begins with initiation of movement and ends just before the buttocks are lifted from the seat (liftoff). During this phase the trunk and pelvis rotate anteriorly (toward flexion, generating upper-body momentum).

**Phase II** (momentum-transfer phase) begins as the buttock lift and ends when the ankles reach maximal dorsiflexion. The transfer of momentum occurs when the upper-body momentum of phase I transfers to the total body and contributes to total-body upward/anterior movement.

**Phase III** (extension phase) begins just after maximal dorsiflexion and is complete when the hips first cease to extend, this includes extension of the knees and trunk.

**Phase IV** (stabilization phase) starts after hip extension is reached and is complete when all motion associated with stabilization is completed.<sup>1</sup>

We can predict strategy and patient-related factors using this format that may impact success, impairment, and potential remediation strategies.

For Phase I (flexion-momentum phase), let's review momentum and flexion separately. How is the momentum created? Momentum is a product of force and velocity (speed). To create speed, many people use arms to get the Center of Mass (CoM) over the feet. Speed requires the body to move quickly, so working on force production quickly, power strengthening, may be an effective treatment technique, and is one often not utilized in older adults. What muscles are involved in this forward momentum creation? Rectus abdominus and psoas are possible answers. Testing strength of rectus has been shown to be effective either with a timed plank or timed curl up.<sup>2,3</sup> Eckstrom and Kong both demonstrated that strengthening trunk flexor muscles could be done in a prone bridge/plank position.<sup>4,5</sup> The static curl-up also was shown to be an effective position to activate rectus abdominus.<sup>6</sup>

To review the flexion portion of this movement contemplate what could impair forward flexion? Possibly, restrictions in anterior pelvic rotation, spinal flexion, or hip flexion will negatively impact this phase. Strategies for improving anterior pelvic rotation include: joint mobilization of the lower lumbar spine/sacrum, increased mobility of lumbar/pelvic tissues, improved segmental movement of the lumbar spine on the pelvis, and improved ability to perform an anterior pelvic tilt. Range of motion (ROM) of shoulder, hips, knees, ankles, lumbar and cervical spine are also necessary to complete the quick forward lean. Measurement of ROM of each area may reveal restrictions that can be addressed.

The second phase (momentum-transfer) can be simplified as lift off and forward movement of the CoM to the feet. Lift off is driven primarily by the gluteal muscles, quadriceps (quads), and eccentric control of gastrocnemius (gastroc). Weakness of any of these muscles could be a barrier to successful sit to stand. High intensity resistance training (HIRT) at 70-80% of the maximal load that can be completed in one repetition (1-RM) (achieving biomechanical failure at 8-10 reps) has been shown to be an effective intervention to improve strength in older adults.<sup>7</sup> Applying these principles to these key muscles would build strength for this movement. A second component of this is ankle dorsiflexion (DF) ROM. When decreased DF ROM is a barrier, flexibility exercises are appropriate. Johnson demonstrated 12.3-degree improvements in ankle DF with 1-minute holds of a standard runner stretch four times a day, 5x week for six weeks.<sup>8</sup>

This is also the phase where the CoM makes the largest shift forward; many older adults have deficits in sensing true vertical posture; they perceive correct postural alignment to be posterior to actual. During this phase, the CoM may be shifted in the posterior direction. When this is observed it can be specifically targeted for retraining.

The third phase (extension phase) is driven primarily by quads and gastric contractions. Adding HIRT for gastroc would be a possible intervention. Gluteus medius (Gmed) strength has also been shown to be key in hip/knee extension stabilization. Macadam did a systematic review and found side stepping with a resistive band was a highly effective exercise to strengthen gluteus medius.<sup>9</sup> Another common difficulty is the speed by which the older adult is able to execute extension. Power training may particularly benefit those with slowed movements since insufficient power has been associated with accidental falls.<sup>10,11</sup> Shortened and tight hip flexor musculature is a common side effect of chronic flexed postures. For adults 65 and older, Feland found flexibility exercises with isometric holds of 60 seconds produced the most improved ROM.<sup>12</sup>

The fourth phase (stabilization phase) does not involve significant movement but appears to require more reliance on sensory motor mechanisms to create stability. The ability to attain postural control upon the initial stand is a complex task. This phase would be considered by Shumway-Cook as an associated postural adjudgment.<sup>13</sup> She describes postural adjustments as the interplay between postural muscles, prime movers, behavior, speed, familiarity of the skill, timing, and how each influence the person's ability to perform associated postural adjustments. Teasing out which of those the patient is struggling with also would refine your interventions.

If this phase is challenging, review the patient's bilateral lower extremity sensation, proprioception, and kinesthetic awareness. Proprioception is the awareness of joint position tested in the foot by moving distal toe joints and asking the patient to articulate the position. Kinesthetic awareness is the cognizance of joint movement that is tested in the ankle by moving the ankle into DF; the patient is asked to replicate the movement on the other side. Distinguishing specificity of the sensory impairment is valuable. Additionally, the Clinical Test of Sensory Interaction on Balance (CTSIB) test may uncover additional specific sensory/vestibular system impairments that will help document and guide interventions.

Improving a person's ability to independently and safely rise from a chair is life altering. Mobility is critical to independence and intentional aging. This review is by no means the only all-inclusive, definitive approach to analysis of the sit-to-stand nor of treatments that can be used to improve it. It illustrates how to take a task and break it down to help offer specific targeted interventions to achieve the best outcomes for each of the one in five elderly people who struggles with limited mobility.<sup>14</sup> We, as physical therapists, possess very strong tools that

have the power to radically change lives. In these critical times, when much of our population is in social isolation, our older adults need these tools more than ever to continue healthy, purposeful aging.

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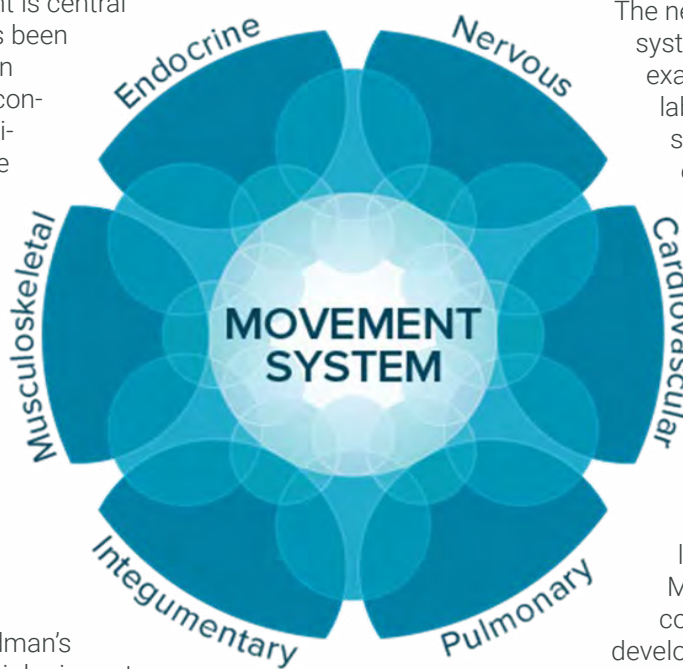
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# The Movement System in Geriatric Physical

by Myla Quiben, PT, PhD, DPT, MS

Movement has long been implied as the core of physical therapist practice and is central to the vision adopted by the American Physical Therapy Association (APTA) in 2013 asserting that movement is an integral part of the physical therapy profession. The vision states, "The physical therapy profession will transform society by optimizing movement to improve health and participation in life."<sup>1</sup> This paper will provide updates on the movement system, describe how its use is relevant to the practice of physical therapy with aging adults, and provide practical considerations of an examination framework that can be applied to aging adults that considers movement at its core.

Discussion that movement is central to a professional identity has been in conversation for more than four decades. However, the concept of movement as a physiologic system surfaced more recently. While conversation started back in the 1970s, in 1983 the APTA House of Delegates adopted a definition of physical therapy that identified the diagnosis and treatment of human movement dysfunction as the primary focus of physical therapist patient management. Years later, with input from physical therapy luminaries Florence Kendall and Scott Irwin, the movement system was defined in Steadman's Medical Dictionary as a physiologic system that functions to produce motion as a whole or of its body parts.<sup>2,3</sup> Shirley Sahrman PT, PHD, FAPTA, in the 1998 McMillan lecture, challenged the profession to further develop the concept of movement as a physiological system.<sup>2</sup> Dr. Cynthia Coffin-Zadai discussed the human movement system, the complexity of the diagnostic process related to movement, and called for advancing diagnostic classification categories in the 2004 John Maley Lecture.<sup>4</sup> Two years later, Barbara Norton PT, PhD, FAPTA convened a series of conferences, known as the Diagnosis Dialog, to discuss diagnosis in physical therapy that continued for the next 10 years.<sup>5</sup>



APTA Movement System

## Since the conversation started, what has happened?

The vision statement of 2013 came with guiding principles to communicate how the profession and society will look when the vision is achieved. The Identity principle articulates that the movement system will be the core of physical therapist practice, education, and research.<sup>1</sup> In 2015, APTA released its definition of the movement system along with a description of its relationship to physical therapist practice.<sup>6</sup> The movement system is defined as a "collection of systems (cardiovascular, pulmonary, endocrine, integumentary, nervous and musculoskeletal) that interact to move the body or its body parts."<sup>6</sup>

The next steps, once the movement system was defined, focused on the examination and the diagnostic labels specific to the movement system. The APTA House of Delegates adopted the position, the Management of the Movement System, that endorses the development of diagnostic labels and/or classification systems that reflect and contribute to the physical therapists' ability to properly and effectively manage disorders of the movement system.<sup>7</sup>

The Academy of Neurologic Physical Therapy (ANPT) Movement System Task Force, convened in 2015, was charged to develop expertise in the conversation regarding the movement system and diagnosis of movement system in neurologic physical therapy. The Task Force published a white paper on Movement System Diagnoses in Neurologic Physical Therapy<sup>8</sup> and has since developed separate task forces to, 1) develop a structured examination, i.e. movement analysis framework and, 2) develop movement system diagnostic labels specific to the postural system.

The Movement System Summit of 2016 had the goals of describing the implications of using movement system diagnostic labels and developing an action plan to integrate movement system concepts into practice, education, and research.<sup>9</sup> Over 100 participants comprised

of clinicians, researchers, administrators, and educators were asked to identify activities or tasks that are essential to a movement system examination and criteria for diagnostic labels specific to the movement system.

In 2018, the APTA Movement System Task Force assembled two work groups (task analysis and diagnosis groups) to move forward with an action plan item from the Summit to “promote the development, implementation and dissemination of diagnostic classification systems/labels that adhere to the established and validated criteria.”<sup>10</sup>

### Where are we now?

Evolving discussions on movement as the focus of the profession have been occurring for many years. Consensus on describing, organizing, and labeling concepts of movement continues to be a challenge. Clinicians, educators, and researchers come from multiple philosophies in examination and intervention approaches, in addition to varied frameworks of clinical decision-making and practice. While there seems to be unanimous agreement across many physical therapists that we are “movement experts”, the examination framework centered on movement, diagnostic labels focused on the movement system, and targeted interventions are still a work in progress. Over the next several years, the integration of the movement system is expected to continue as the profession debates and discusses strategies to infuse the movement system into practice, education, and research.

### How may focusing on the movement system apply to geriatric practice?

One of the primary reasons older adults seek physical therapy is limitations and difficulties with movement performance that result in difficulty or inability to complete functional tasks. Pain and multisystem symptoms are common in aging adults. The overarching goal for our patients is to return back to their prior level of function or improve function to return to independence or be as independent. It is critical to examine the movement system and determine the primary systems that contribute to movement dysfunction to facilitate this. Only when the systems that cause movement limitations or dysfunction are identified can targeted interventions be developed to rehabilitate the movement impairment. This is a shift from just treating the symptoms through a generalized program that does not address the contributing causes of movement limitations.

### Movement System and Geriatric Practice

Critical to a framework that utilizes movement system are two related yet separate processes: movement observations of tasks **and** diagnostic labels or movement system diagnosis. The first entails observations and analysis of tasks that will begin hypotheses building of potential

causes of movement limitations and provide guidance on further testing. These observations are envisioned to feed into the development of patterns or clusters of movement observations that will be standardized into diagnostic labels leading to movement system diagnoses.

Using a movement system framework in the examination is not a new concept. However, there is no current standardized method: to identify and describe the movements that are atypical, to observe individual’s movement abilities and limitations during performance of activities or tasks, or to document findings in universally consistent terminology. Across clinical settings, among clinicians, and across educational programs, the examination of movement dysfunction occurs variably. The ANPT Movement System Task Force asserted that movement observation and analysis is central to the process of assigning a movement system diagnosis.<sup>9</sup> Many clinicians examine movement to some degree yet no universally accepted standardized approach to movement observation and analysis currently exists.

The lack of standardized method should not preclude the clinician from incorporating a movement system observation and analysis of an aging adult’s movement abilities and limitations. Reconsider a new examination framework using a movement system focus: which tasks to observe, how tasks should be performed, and how the tasks should be analyzed.

The *Guide to Physical Therapist Practice*<sup>11</sup> describes examination as a comprehensive screening and specific testing process comprised by the patient history, systems review, and tests and measures of body structure and function, activities and participation. Movement observation and analysis as envisioned to assist with a movement system diagnosis is *not* explicitly nor clearly identified in the Guide as a component of the patient/client management model. Movement observation and analysis are *not* routinely and consistently documented as a part of clinical examination, even if clinicians examine movement using different approaches. Therapists are encouraged to screen for movement limitations and dysfunctions beginning with the health interview. Ask if any limitations in movement exist, and include questions on specific tasks that are difficult to perform or cannot be performed without any assistance.

### What tasks to examine for older adults?

Currently, there is no consensus on what tasks or activities should be observed. The Movement Summit (2016) identified several tasks to be observed to provide insight on potential impairments that contribute to movement dysfunction across patient populations. There are no standardized methods and guidance on what tasks are most appropriate for specific groups to date.

The Academy of Neurologic Physical Therapy Movement System Task Force, through consensus, identified core tasks recommended for movement observation that include both static and dynamic tasks: sitting, standing,

sit-to-stand and stand-to-sit, walking, step up and down, reach, grasp, and manipulation.<sup>8</sup> Part of clinical decision making, the therapist can choose tasks that should be relevant for the patient, with consideration for the patient's goals and current functional abilities. For the aging adult, one may consider additional tasks such as rising from the floor and bed mobility. Tasks are likely to change or to be added onto with further discussions regarding what activities/tasks *at the minimum* should be observed to provide the most insight on movement dysfunction. A set of tasks is yet to be validated for this population.

### How should tasks be performed?

Because human movement is a complex behavior within a specific context<sup>12</sup> it is logical to examine how the older adult moves during purposeful, functional activities. Therapists can use structured environments and standardized instructions to allow for consistency and less variability in testing. At this time, while no standardized methods exist for movement observation, it should not hinder the therapist from applying consistent methods of movement observation within their own practice and within their own practice sites.

To determine an individual's true abilities, the therapist should allow the individual to move on his/her own independently and attempt to complete the task without any cueing or assistance. If unable to successfully complete the task, the clinician can hypothesize underlying causes of failure.

After observing the individual perform the task and the task is unsuccessful, the therapist provides an opportunity to complete the task with environmental modifications. These may be necessary to achieve the desired outcome and provide an understanding of impairment/s that limit movement. Modifications may include verbal and/or tactile cueing, physical assistance, external supports, environmental change, or a combination of these.

### How should we analyze movement?

Movement analysis remains the core of the examination process. While there is no consistency on how this is performed across clinical settings and patient populations, we can start from basic concepts and build on that. At the minimum, clinicians are recommended to have the patient/client perform key tasks methodically and to observe performance consistently. Performance of the task one to two times allows the therapist to observe closely while not bringing performance fatigue and variability into the picture. While technology continues to grow at a fast speed, movement analysis using technology is not typically the most cost effective, feasible, or readily available method for most practices. In many cases, technology may not be necessary and the therapist's skill in movement analysis may be enough to determine the underlying cause of movement limitation. One can argue that we have relied heavily on visual observations of movement and skilled movement analysis for years and we should

continue to hone this skill and formalize the process and documentation in clinical practice.

A useful framework to describe movement observations in a standard manner is described by Hedman and colleagues' movement continuum<sup>13</sup> The six stages of the movement continuum begin with initial conditions and preparations for movement and continue through the observable stages of movement initiation, execution, and termination. This model allows therapists to organize and document movement observations in a standard manner across all tasks.

Therapists are further encouraged to describe and document the quality of movement/s using common observable motor control concepts such as symmetry, alignment, sequencing, speed, and smoothness. As with the need for a standardized movement analysis framework, these concepts need to be further validated and refined to consider the contribution of typical age-related changes to movement performance.

### Hypothesis Driven Physical Exam

The therapist develops a hypothesis of the possible impairments that cause movement dysfunction with information from the history and interview, systems review, and task analysis. The examination data is used to determine whether further standardized testing is needed to confirm the hypothesis of impairment/s that limit task performance.

### Complexity in Geriatric Practice

Age-related changes naturally come with changes in motor control and movement performance, such as increased reaction times, increased postural sway, changes in muscle activation, and slower speed of performance, among others. These typical changes that accompany aging are further complicated by the presence of chronic disease and multimorbidity. Broadly defined as the presence of two or more chronic disease in an individual, multimorbidity significantly overlaps with frailty and disability, although these are distinct concepts.<sup>14</sup> It is a challenge to determine the primary impairment limiting the aging adult's movement; it may be a combination of multiple impairments across multiple systems. Add to these the effects of other external and internal factors that may influence movement, particularly in the older adult: cognitive deficits, depression, effects of pharmacologic agents and possible polypharmacy, pain (which is often normalized with the aging process), geriatric syndromes, and the effects of social determinants of health.

One of the premises of using movement analysis to guide the examination is that patterns of movement impairments will emerge leading to a movement system diagnosis. The diagnostic process occurs after a consideration of all possible sources of movement dysfunction, along with pertinent information from the patient history, systems review, and results of standardized tests and movement analysis. Movement system diagnostic labels

are envisioned to be based on description of clusters or patterns of movement observations and associated examination findings that have a greater potential to drive interventions.<sup>15</sup> While some diagnostic labels specific to the movement system have been published,<sup>16,17</sup> they have not been validated through rigorous process nor are they universally utilized in clinical practice specific for aging adults.

The lack of a standardized examination framework that incorporates movement observation and analysis, recommended tasks that should be observed and analyzed in the aging adults, or movement system diagnostic labels, are palpable challenges to integration of the movement system across physical therapist practice, education, and research. Movement system diagnoses, once developed, will need to be validated and examined for clinical use. The permeation of the movement system into the profession will be lengthy and challenging; universal professional acceptance will be dependent on the entire profession embracing this new identity.

While there is much work in the horizon, therapists caring for the aging adult can begin utilizing the movement system into their practice. Clinicians are in a unique role to identify a primary system or multiple systems that impact movement and need to be examined closer.

Begin with the history and ask about tasks that the aging adult has difficulty performing or is unable to perform independently.

### **Perform a structured movement observation and analysis of relevant functional tasks.**

Hypothesize system impairment/s that contribute to movement dysfunction and utilize standardize outcome measures to support your hypothesis. Consider that the underlying cause of movement limitations may not be a single entity but a combination across multiple systems.

### **Develop a plan of care that targets specific impairments that directly impact the older adult's ability to move.**

To put this in clinical context: a 78-year old male with a significant orthopedic and cardiac history is referred to physical therapy with a history of falls and decreased activity levels. He is observed to perform the series of tasks slowly, requiring more than one attempt to successful complete several of the tasks observed (sitting, standing, sit-to-stand and stand -to-sit, walk and turn, step up and down one step, reaching and manipulation). The therapist notes shortness of breath with dynamic tasks. This observation is used by the therapist to determine that further aerobic capacity and strength testing of the lower extremities is warranted. Upon performance of standardized testing to confirm the hypothesis, the therapist concludes that aerobic capacity is primarily limiting this person's ability to perform functional tasks and develops a plan of care that targets this impairment.

This appears to be simplistic, considering movement is complex and in the aging population, the presence of mul-

timorbidity, frailty, disability can attenuate the effects of a single system. However, it provides an example of how the movement system is incorporated for older adults. Multiple factors that contribute to movement should be considered. Multi-morbidity, frailty, disability, age-related changes and other external and internal factors further complicate the movement system observation, analysis, and diagnosis in aging adults.

### **In summary:**

- Considerable variability in PT practice occurs with the examination process including movement observation and analysis.
- Clear and standardized movement observation and analysis is not consistently and typically performed or documented.

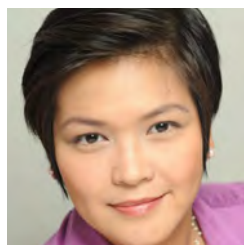
### **We have much to do:**

- Identify and validate a set of tasks that will provide information on the aging adults overall ability to move.
- Recommend standardized movement observation and analysis.
- Develop movement system diagnoses for older adults.

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## You Never Know What a Person in a Chair Can Do

by Suzanne Rodriguez, PT

*Editor's Note: This clinical case commentary was part of content for the November 2020 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.*

### Subjective examination

**Primary complaint:** Mrs. Nackid is a 91-year-old female referred to home-based outpatient physical therapy for management of bilateral knee pain as a result of bilateral knee osteoarthritis. She reports a significant worsening of knee pain following a fall one year ago that resulted in a right hip fracture corrected with surgical ORIF. She attributes a quick progression of the arthritis in her knees to a period of decreased mobility immediately following the injury. Mrs. Nackid states that her knees are very stiff in the morning and she has a difficult time rising from a seated position throughout her daily routine. She also reports that she now finds herself knock-kneed, bent over and states that she is very fearful of falling again.

**Medical history and current medications:** Hypertension, bilateral knee osteoarthritis, right hip fracture s/p ORIF (October 31, 2019), lung cancer, and incontinence. Her vision is corrected with glasses, post cataract surgery for correction. She has age-related hearing loss for which she wears hearing aids. Her fall history is significant

for two falls in the past year. Daily medications include: Metoprolol ER 25 mg 1x/day, Simvastatin 20 mg 1x/day, Hydrochlorothiazide 12.5 mg 1x/day, and Meloxicam 7.5 mg 1-2x/day prn.

**Home environment and current level of function:** Mrs. Nackid is widowed and lives alone in a multi-story home. Her bedroom is on the second level; there is a full tub/shower combination bathroom on the second level and a half bathroom on the first level. There are four stairs to enter the home, two without access to rail. She is unable to climb a flight of stairs to access her bedroom and full bathroom upstairs since the hip fracture and is not interested in installing a stair lift. Mrs. Nackid sleeps in a twin bed in the TV room on the first level but misses her bedroom immensely. She was widowed early, at age 40, is childless, and has lived alone in her home since that time. She worked as a secretary until her retirement at 65 years of age. Social support is provided by neighbors, a good friend and a nephew from her husband's side of the family who come in and check on her, assist with

instrumental ADLs and provide transportation for various appointments. Her neighbor takes her weekly for her hair appointment. She sold her car and gave up driving, following the fall that led to her hip fracture. She longs for the independence of driving but is aware of her sensory and physical limitations. Mrs. Nackid does not engage in a daily exercise routine and is quite sedentary; she spends the majority of the day in her recliner watching favorite television programs and reading a daily newspaper. Mrs. Nackid ambulates with a rolling walker (RW) to assist her in household and limited community walking distances.

**Patient goals:** Mrs. Nackid would like to be able to rise from a chair without so much difficulty and pain in her knees. She would also like to be able to walk longer distances with better posture and less fatigue.

### Objective Examination at Initial Evaluation

**Cognitive Screen:** Mrs. Nackid is A+O x3 and scored a 22/30 on the Montreal Cognitive Assessment (difficulty with memory and delayed recall components).

**Balance Confidence:** 15.6% on the Activities-Specific Balance Confidence Scale.

**Vital Signs at Rest:** HR 84 bpm, BP 134/78 mmHg, SpO<sub>2</sub> 97%, RR 16 breaths / min.

**Pain:** Pain in her knees is worst in the morning (8 out of 10 scale), less at night (4/10) when she retires to bed for the evening. Weight bearing activities, including standing from a seated position and walking, exacerbate the pain.

**Posture:** Mrs. Nackid stands with mild thoracic kyphosis and significant forward head posture. She stands with knees in moderate genu valgum bilaterally.

**Flexibility:** Mrs. Nackid presents with moderate tightness in hip flexors, hamstrings, hip abductors, and plantar flexors bilaterally. She has significant dorsiflexion limitations of -8 degrees on the left and -10 degrees on the right.

**Strength:** 2/5 bilateral hip extensors, 2/5 bilateral hip abductors, 3/5 bilateral hip flexors, 3+/5 bilateral knee flexors, 3/5 bilateral knee extensors, 2/5 bilateral plantar flexors, 2+/5 bilateral dorsiflexors.

**Gait:** Ambulates with the rolling walker 129 feet indoors on even terrain while demonstrating a decrease in bilateral step length, absent bilateral heel strike, decreased bilateral step height, moderate genu valgum bilaterally, forward head / rounded shoulders posture, and a self-selected walking speed of 0.7 m/s. Mrs. Nackid requires frequent standing rest periods ambulating household distances secondary to fatigue and impaired activity tolerance.

**Timed Up and Go Test:** 28.27 seconds with use of RW.

**Modified 30 Second Sit-to-Stand Test:** 4 repetitions.

**Berg Balance Scale:** 22 (out of 56).

**Assessment:** Mrs. Nackid presents with bilateral knee pain, lower extremity muscle weakness, decreased flexibility, impaired balance, impaired postural awareness, decreased balance confidence, gait instability, and activity restriction limiting her in all functional mobility. Mrs. Nackid would benefit from skilled physical therapy to maximize functional mobility, improve ADL function and decrease fall risk. Mrs. Nackid would benefit from the prescription of an exercise program focused on strengthening, flexibility, transfer training, gait training, and balance training to address her significant difficulty in performing a sit-to-stand transfer from a standard height chair with the use of arm rests, and difficulty in ambulating household distances with significant pain in bilateral knees and fear of falling.

**Plan:** Mrs. Nackid will receive home-based outpatient services twice a week for eight weeks prior to reassessment. Treatment sessions will focus on strengthening and flexibility exercises for the lower extremities, postural exercises, transfer training from different surface heights, balance activities and gait activities. A home exercise program will be provided to focus on lower extremity strengthening, flexibility, transfer training, and walking activities.



### Meet the Authors: Be Part of the Discussion in the Journal Club

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

The next APTA Geriatrics Journal Club will be held **November 17, 2020** at 8 pm ET.

We will discuss **Modified 30-second Sit-to-Stand Test: Reliability and Validity in Older Adults Unable to Complete Traditional Sit-to-Stand Testing**; *Journal of Geriatric Physical Therapy*; 20120; July/September 2020.

Watch your email or see the APTA Geriatrics Calendar for log-in information to be posted prior to the event.

### Three weeks later

**Cognitive Screen:** Mrs. Nackid is A+O x3 and scored a 23/30 on the Montreal Cognitive Assessment (difficulty again with memory and delayed recall components).

**Balance Confidence:** Improved from 15.6% to 24.0% on the Activities-Specific Balance Confidence Scale.

**Vital Signs at Rest:** HR 78 bpm, BP 126/72 mmHg, SpO2 97%, RR 16 breaths / min.

**Pain:** Reported pain level of 6 on a 0-10 scale at the worst and a 3/10 pain at the least. Weight bearing activities, including standing from a seated position and walking continue to exacerbate the pain.

**Posture:** Mrs. Nackid stands with mild thoracic kyphosis and significant forward head posture. She stands with knees in moderate genu valgum bilaterally (Mrs. Nackid is able to achieve improved posture with 75% verbal / visual / tactile cueing throughout session).

**Flexibility:** Although improved, moderate tightness in hip flexors, hamstrings, hip abductors, and plantar flexors with ongoing intervention is noted. She has continued dorsiflexion limitations with improvements in flexibility to -6 degrees on the left and -6 degrees on the right.

**Strength:** Mrs. Nackid presents with overall improvement in bilateral lower extremity strength measured as: 3-/5 bilateral hip extensors, 3-/5 bilateral hip abductors, 3+/5 bilateral hip flexors, 4-/5 bilateral knee flexors, 3+/5 bilateral knee extensors, 3/5 bilateral plantar flexors, 3-/5 bilateral dorsiflexors.

**Gait:** Mrs. Nackid ambulates with the rolling walker 451 feet indoors on even terrain demonstrating an improvement in bilateral step length / step height, and improvement in bilateral heel strike, and ongoing presence of moderate genu valgum bilaterally, forward head / rounded shoulders posture (partially corrected with 50% verbal / tactile cues provided throughout gait), and a self-selected walking speed of 0.91 m/s. (Improvement in gait distance, gait quality and self-selected walking speed post intervention).

**Timed Up and Go Test:** Improved from 28.27 to 22.14 seconds with use of the RW.

**Modified 30 Second Sit-to-Stand Test:** Improved from 4 to 5 repetitions.

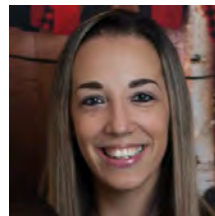
**Berg Balance Scale:** Improved from 22 to 26 (out of 56).

### Assessment/Discussion

Following physical therapy intervention, Mrs. Nackid improved her performance on all measured domains demonstrating good progress toward her established short-term and long-term goals. Mrs. Nackid demonstrated an improvement in the modified 30-second sit-to-stand from four repetitions at initial evaluation, to five repetitions following three weeks of physical therapy intervention. The research by McAllister & Palombaro, 2020 reports a minimal detectable change (MDC90) of 0.70 indicating that an increase of one additional repetition on the modified 30-second sit-to-stand is a change beyond error.<sup>1</sup> Mrs. Nackid presented with a significant change in her performance beyond error on the modified 30-second sit-to-stand based on the reported MDC90. The modified version of the 30-second sit-to-stand test permitted her to receive a score by allowing the use of bilateral upper extremity strength to achieve a standing position from a standard height (17-inch) chair with arm rests. Due to her low level of function, Mrs. Nackid is unable to complete a sit-to-stand transfer from a standard height chair without the use of her upper extremities, and would therefore not be eligible to receive a score on the five-time sit-to-stand test or the 30-second sit-to-stand test. Use of upper extremities to achieve a standing position, allows low functioning individuals, such as Mrs. Nackid, to receive a score on a new standardized outcome measure and provides physical therapists with standardized data to measure change over time. The modified 30-second sit-to-stand test is a reliable and feasible tool for use in a general geriatric population with a lower level of function.<sup>1</sup>

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*"Chair or no chair: a binary relation. But the vicissitudes of moving the body around are infinite. You never know what a person in a chair can do."*

– Sarah Manguso

# Walk to Wendy's - A Role for Physical Therapy in Chronic Disease Self-Management Training

by Gina Pariser, PT, PhD, LDE and Dawn Hall-Bibb PT, PhD

*Editor's Note: This clinical case commentary was part of content for the September 2020 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 Description

The participant, a 68-year-old African American male, had an ischemic stroke (Left CVA) five years prior to enrolling in Active Steps for Diabetes (ASD), a 12-week diabetes self-management training program delivered by physical therapists and other interprofessional health care providers. He presented at ASD with increased tone in the right upper extremity and synergistic movement in the right elbow and wrist/hand that resulted in functional difficulty buttoning clothes, writing, and using a lancet to check his blood sugar. Increased tone was also noted in the right lower extremity. When walking he kept more weight on his left leg, hiked his hip to initiate right leg swing with his foot in plantarflexion to neutral and inversion, and used a cane. His gait speed was slow (0.78 m/sec). He was able to climb stairs using a step-to-step pattern. He had mild aphasia. He was able to read and converse, but sometimes had trouble finding words or understanding complex conversations. He had no signs of a visual field deficit or hemineglect. Additional health conditions included peripheral arterial disease and benign prostate hyperplasia.

The participant was overweight (BMI = 27). His blood glucose (HbA1c=10.1%) and BP (172/85mmHg) were not in control despite multiple prescriptions, including two medications for diabetes, three for hypertension, and one for hypercholesterolemia. He was sedentary and had a poor diet, reporting that he ate fast food for breakfast or lunch every weekday while his spouse was at work. Functional outcomes assessed at the beginning of the program showed he had poor cardiovascular endurance and balance (Table 1). His wife, employed as a certified nurse assistant, expressed frustration with his lack of motivation to be physically active and to eat better. "He eats good when I am home, but he drives to Wendy's and meets our friends every day when I am at work," she said. "We used to travel some and dance. He won't do that now because he gets winded and is afraid he will have a heart attack or another stroke." He also expressed fear of having another stroke if he exerted himself.

## Intervention

During the first six weeks of ASD the participant's resting BP and blood glucose levels were high (RBP range =172-182/88-92 and blood glucose = 280-320mg/dl). Program team members consulted with the participant's primary care physician to recommend medication changes. PT and nursing team members collaborated on teaching the participant how to measure his blood glucose with a single-use disposable lancet and positioning his elbow and wrist in a weight bearing position to improve his hand dexterity.

**Physical Activity (PA) Goal Setting and Motivational Interviewing.** Initial PT sessions involved PA counseling, goal setting, and motivational interviewing; the participant reported that the Wendy's restaurant he drives to on weekdays is 5 blocks from his house (approximately 500m or 0.3 miles). He noted that some of his friends walk there, which he would also like to do but does not have the endurance to walk that far. "I get winded just walking to the mailbox." He also stated that prior to his stroke he and his wife enjoyed dancing to music at home. His initial six-minute walk test distance (6MWD) was 260 meters; he stopped briefly to rest twice (at 1.5 and 4 minutes). He set a goal to walk to Wendy's. In addition, a DPT student working with him taught him that one song is approximately three minutes long and since during the 6MWT he walked 2.5 minutes without stopping, he could also set a goal to dance to at least one song with his spouse.

**Approach to PA Prescription and Promotion.** The whole-of-day and graded activity approaches were utilized to start to change the case participant's PA behavior. The whole-of-day approach focuses on reducing sedentary time and increasing light intensity activity. The participant used a Fitbit and an egg timer to incorporate the whole-of-day approach.<sup>1</sup> The Fitbit was used to set goals for number of steps/days. The egg timer was used to cue the participant to do intermittent bouts of light activity during prolonged sitting. The American Diabetes Association recommends prolonged sitting be interrupted with 2-3

minutes of light activity every 30 minutes for blood glucose control.<sup>2</sup> The graded activity approach incorporates principles of exercise physiology and cognitive behavioral therapy to address psychological barriers to PA, such as low self-efficacy, pain-related fear, or fear of an adverse cardiovascular or neurological event.<sup>3</sup> In graded activity, PA is consistent with the patient's goals and dosage is based on a quota rather than exercising to tolerance. Initial targets are approximately 75% of baseline measurement of the patient's exercise tolerance. During ASD sessions the participant repeated bouts of walking at his self-selected speed for a distance and duration set by the PT, followed by passive rest or active rest including upper extremity activities such as practicing buttoning and shoulder girdle muscle strengthening exercises in seated or standing. This was repeated until the PA session goal was achieved. During the pre-program six-minute walk test the participant's longest duration without stopping was 2.5 min and his total distance was 260m. Thus, the target for the first session was to walk two minutes without stopping, followed by two minutes of rest. This was repeated until he had walked 195m. Targets were gradually increased. Meeting the quota was followed by praise and rest; not meeting was followed with collaborative discussions about the importance of continuing the activity and encouragement to step-up. Vital signs are monitored to ascertain normal physiological responses. At the end of the 12-week program the participant was able to walk 500 m, with one rest period and was elated to report he had walked to Wendy's. Both nursing and PT encouraged the participant to select the healthier food options at Wendy's.

### Outcome Measures

Outcome measures, assessed during the first and last week of the ASD included: resting BP, HbA1c, BMI, average number of steps/day, gait speed, 6MWD, Timed Up and Go (TUG), and the Modified Physical Performance Test (mPPT). The mPPT consists of nine tasks. Seven tasks are timed; these include: 50-foot walk, donning/doffing a jacket, picking up a penny from the floor, standing up from a chair five times, lifting a five-pound book overhead onto a shelf, climbing one flight of stairs, and static balance in three different positions (side-by-side, semi-tandem, and full-tandem). The remaining two tasks are turning 360° and climbing up to four flights of stairs. The score for each task ranges from 0 to 4 points; 36 points is the maximum score.

The participant showed improvement on all outcome measures (Table 1). ASD participant improvement is attributable to active education, supervised and home PA programs, consultation with physicians to optimize pharmacological management, and the patient. The case participant's resting systolic BP decreased 10mmHg. In people with hypertension, a systolic BP reduction of 10mmHg is associated with a 41% reduction in risk of

**Table 1. Participant's Outcomes in the ASD Program**

Outcome Measures	Pre-Test	Post-Test
Resting Blood Pressure (mmHg)	172/85	162/83
HbA1c (%)	10.1	8.2
Total Cholesterol (mg/dl)	220	200
Body Mass Index (%)	27.0	27.0
Ave Steps/Day	3,127	5,458
Gait Speed (m/sec)	0.77	0.85
6MWD (m)	260	291
TUG (sec)	16.1	13.2
mPPT (points)*	17	23

\*17-24/36 points is classified as moderate frailty; 32-36 points is no frailty

stroke. The Breaking Up Sitting Time After A Stroke Trial (BUST-STROKE) provides support for use of the whole-of-day approach to PA promotion for reducing hypertension in stroke survivors.<sup>4</sup> In this trial, interrupting sitting with three-minute bouts of light-intensity exercise in standing every 30 minutes decreased systolic blood pressure by 3.5 mmHg (95% CI 1.7–5.4) compared with sitting for eight hours uninterrupted. Using the whole-of-day and the guided activity approaches, the participants steps/day increased from the sedentary (< 5,000 steps/day) to the light active (5,000 to 7,499 steps/day) category. The case study participant's HbA1c decreased 1.9%. A 1% reduction is associated with a 45-60% decreased risk of cardiovascular and kidney disease progression.<sup>2</sup> The participant's gait speed improved .8m/sec (MDC for chronic stroke = .1m/sec). His 6MWD increased 31 meters (MDC for chronic stroke = 35m). His TUG score improved 2.9 sec (MDC for chronic stroke = 2.9sec). His mPPT score improved from 17 to 23 points (17-24 points is defined as moderate frailty; mild frailty is 25-31; > 32 is not frail).

In a recent phone conversation, the participant reported that his: SBP is 150mmHg; HbA1c is 8%, body weight is the same. He stands up and does resistance band exercises during television commercials a few times a day and he walks to Wendy's five to six days a week. He stated he is doing well, and he did not think he needed PT services again.

### Discussion

#### **How do the results of the study, *The role of physical therapy in multiple risk factor management poststroke: A scoping review*, impact PT management of stroke survivors?**

PTs possess the expertise needed to assist stroke survivors in overcoming physical and psychosocial barriers to staying active after a stroke. The Scoping Review impacts PT management of stroke survivors by strongly reinforcing the need for and benefits of post-stroke education in chronic disease management delivered by an interprofessional team of health care providers that includes a PT. The study authors acknowledge that it is

not yet commonplace for PTs to be recognized members of teams addressing chronic disease in stroke survivors, particularly survivors with severe mobility or communication deficits. The scoping review is a call-to-action for PTs to (a) increase awareness among other health care providers and patient's about the role of PT in management of multiple health conditions and to (b) innovatively increase our clinical practice and research in this realm.

### **How can you implement changes in the clinic to integrate the study findings into patient care and improve self-efficacy for clinicians?**

*Make clinical-community connections* that help stroke survivors be physically active and manage chronic health conditions after discharge from PT. In recognition of the need for accessible community-based exercise programs for survivors of stroke some YMCAs and Silver Sneakers Programs have developed programs that follow American Heart Association Guidelines for aerobic and resistance exercise. Refer stroke survivors with type 2 diabetes to the *CDC National Diabetes Prevention Program (DPP)*, 16-week evidence-based lifestyle change program that has been shown to prevent or delay the onset of type 2 diabetes in people at risk for diabetes. People with diabetes can enroll in and benefit from the program too. The DPP program is commonly offered by public health departments and YMCA's.

*Create clinical-community connections* that help stroke survivors be physically active and manage chronic health conditions after discharge from PT.

- Check out the innovative interprofessional program for making clinical-community connections described in the August issue of *GeriNotes* in the article titled *Staying Active After a Stroke: A Customizable Community Resource Guide for Stroke Survivors* co-authored by Katherine Callanan PT, DPT5
- Network with organizations to provide education for clinicians and patients on the important role of PT in management of multiple health conditions
- The proof is in the pudding. Evaluate and document the effects of your PT intervention on patient's knowledge of chronic disease management strategies, implementation of strategies, and changes in medical markers, such as resting BP and blood glucose levels, that can be partly attributed to PT intervention.

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# Putting Pen to Paper Should be Paid

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

The field of law would fall apart if those professionals were not paid for their time to document what they are doing: researching and analyzing. Why are physicians, therapists and others in the medical field being denied payment for the same professional services? If you would ask a payer, you would get an answer that says the charge is inclusive of the time to document the activity. But is it? I know in the physical therapy profession, billing codes are designed and strictly monitored for the time spent face-to-face with the patient. If that is the case, how can the documentation time be included under these codes? While point-of-service documentation may have some merits, writing a thoughtful analysis and plan is hardly feasible while giving needed focus to our patients. And we do not want therapists sitting in front of patients documenting instead of providing the care, do we?

So much time and lip service has been given recently to burnout and fear of too much pressure on those in the medical fields. The medical literature even analogizes physicians to “Canaries in the Healthcare Coal Mine”.<sup>1</sup> According to Talbot and Dean in this article, physicians are not burnt out but suffering from moral injury because of the broken health care system. The suggestions for improving this are to have these fried professionals take an hour to meditate.<sup>2</sup> This won't fix the problem; this study shows that meditation may help the symptoms, but the symptoms come from the frustration of not being valued for what we do. Lawyers document and get paid for every second they spend of a case. Why don't we?

Let me tell you a sad but common scenario. One of my faculty was telling me about his night in bed with his wife. (Do not worry, this is not going where you think it might.) He said in the evenings, he and his wife are in bed and his wife sits on her laptop catching up on shows and he spends hours keeping up with his documentation. This is the life of many of us in medicine and it is wrong. We need to be paid for what we document. We need codes to do this separately from the codes for the procedures. This will allow the medical team to be valued for what they do and the process of diligently recording their findings.

Payers do not want an undervalued workforce or one that is burned out from the injustices of the health care system. Many of us accept this extra burden as “part of the job” and contribute documentation time off the clock to keep to our productivity standard. We, as health care providers, need to educate the payers on the current situation and try to fix it instead of continuing to take the hit in our private lives.

Our column is usually about clinical issues – this is

a particularly important clinical issue. This is a rough time right now to be asking for more payment but are we really asking for more or just to be paid appropriately? We do bring so much to the health care table that no other discipline can. The system needs to be redesigned and those redesigning need to take this into the models for future care. Take the time to write to CMS, payers, and stakeholders and ask for additional codes for documentation time or, even better, a better system.

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# From Covid to Career Change: Finding a New Path in the Middle of a Pandemic

by Katie Wadland, PT, DPT

Sometime between “Covid What?” and learning to crisis-school my kids, when wearing a mask in public became the status quo, I decided to quit my job. The funny thing is, I actually really liked my job.

Seven years ago I started in home care, scared that I would hate it. I thought, for sure, that I would miss the outpatient setting: the laughs with colleagues, easy access to mentors, journal review meetings, and the clinic environment itself. I worried about hoarders, bedbugs, and about having to make hard decisions on my own. What I found, instead, were mostly sweet senior citizens, happy for the company, and grateful for the help. I was pleasantly surprised at how much I enjoyed this work setting. Eventually, I grew to love it.

I loved walking into people’s homes, learning about their lives, seeing their family pictures on the wall, and finding out that I could not only treat them, but help them, in meaningful ways. It is one thing to have a patient report that she struggles to get in and out of bed, to set a goal, and work on strengthening. It is another altogether to actually walk her upstairs, have her lay down, analyze, and then solve the problem in situ.

Fast forward seven years: I finally felt like I knew what I was doing. I wasn’t calling my manager every other day to ask if a blood pressure was too low. It had been years since I had an Oasis document returned for revisions. Home health was a whole new world, but I eventually found my way. I had earned respect within my department, I was productive with my patients, and I was working with a group to improve our physical therapy processes. I enjoyed the work. I had a great work-life balance, completed my visits in time to pick up my kids, and I was helping people in my community. The money was good. I never had to deal with billing minutes or CPT codes! It was all too good to be true. I was pretty sure I’d work there until I retired.

What I didn’t foresee was having to take a leave of absence to “crisis-school” my kids in the middle of a pandemic. I did not see that one coming. Not one little bit.

Despite 12 years of happily practicing without any interest in owning a private practice, I came to the conclusion that becoming an independent practitioner, a mobile PT, would not only be the best thing for me and my family, but that it could be the best thing for my patients.

I often grew close with the people I treated in home care. Seeing them in their homes, in their own space, surrounded by personal things and all of their personal problems, invested me in their lives. It was one of the



*My office*

best things about doing home care. It was also one of the hardest. Walking out the door after a discharge, the home therapist often knows full well that the person will struggle to stay compliant with their HEP and is unlikely to make it to an outpatient clinic. It doesn’t feel like a good transition. Too often, I knew I’d see them again: after their next fall or when they returned home from another hospital stay.

I started thinking a lot about these individuals and how their lives could be better if they received the right therapy at the right time delivered in the best way for them.

COVID-19 closed outpatient clinics and everything became virtual. I realized this was the perfect time for me to transition to a model where I could keep seeing people in their homes while giving them outpatient-level care. I hoped to develop a program that would allow me to provide services beyond a typical plan of care, venturing into wellness territory, and coaching my patients to remain active well after “traditional” discharge. Just maybe I could build a bridge from “Congratulations, you’re discharged, keep up the good work” to actually being healthy, preventing that next fall, and keeping them out of the hospital. I could help people stay home, in better control of their bodies, function, and futures.

I started thinking about what a course of therapy would look like if I did it my way. Once I got the idea in my head that I could do this, on my own terms, I couldn’t shut it down. Of course, while I was already off and running with daydreams and big ideas, I also had no idea where to start. I knew that I would probably need malpractice insurance, that I would have to learn how to bill for services. I didn’t know an NPI (National Provider Identifier) from an

EIN (Employer Identification Number). What in the world is a PECOS (Medicare Provider Enrollment, Chain, and Ownership System)? How do you even begin to choose an EMR (Electronic Medical Record)? Fortunately, I have friends (from graduate school and prior co-workers) who run/own successful independent practices. I started asking questions.

Text messages turned into phone calls; phone calls turned into action items. I joined Facebook groups and attended networking meetings. If someone didn't know the answer, they would refer me to someone who did. What started as an overwhelming quest quickly became more manageable; I started to feel like this was actually possible. It was comforting that not one of these connections felt competitive. I have always found physical therapists to be down-to-earth, kind people; this experience reinforced that. Everyone with whom I've consulted has been helpful, generous with their guidance, and happy to root me on.

Defining my mission and values was easy. Twelve years into practice, I knew all the "PT stuff," and I was confident in my skills. Moreover, having worked across different settings, I knew their respective limitations. I knew how I wanted to do things differently so that I could increase my impact. I thought of a name I loved, designed a logo, and HAE/PT (Healthy Aging Essentials) was born.

I still did not know how to start doing business. With the support of other professionals and a fair amount of research, I started checking off one item at a time from my list. Every time I started to reconsider my decision, or doubt my plan, I'd refocus that energy toward taking another step forward. In July, although starting to wonder if this was really the right call, I decided it was time to go public and let my friends and family know I was preparing to launch my business. Every step forward, I was more invested and another step further from turning back. I've decided to give this my all for a full year before I even think about reassessing my plan. Until then: it's HAE/PT or bust!

It is easy to become overwhelmed by all of the problems of the world. In our line of work, we see trauma, decline, sickness, and sadness every single day. It has been especially easy to get lost in it lately, in the midst of a year none of us could foresee. The effects of 2020 have been personal, vocational, emotional, and global. I have always made peace with the fact that I can't change the world or fix all of its problems; I choose to make whatever positive impact that I can, within my small part of the world. I am raising kids who I hope will be part of the solution. I try to be kind to friends and family and to be helpful within my community. I chose a profession that allows me to help people heal and feel their best. I can't stop all the people in the world from falling or keep them all from getting sick. I can do my best to help my patients feel better, function better, and experience a better quality of life. I've adopted the phrase "Stronger, Fitter, Functional" and think it complements my mission nicely.

I believe that HAE/PT will help my patients while also making a continuum of care for community-dwelling elders within my community more comprehensive. My goal for each person who comes to me is simple: find out what they want in life and help them achieve it. I value patient education and individualized treatment and strive to use the concepts that drive neuroplasticity to guide everything I do. I know that no matter how hard therapists work with a patient during a plan of care, we need to do better to establish continuity after discharge. Physical therapists, in any setting, cannot expect people to be compliant with recommendations if we do not give them the "why", the "how," and the confidence that they can be successful. We cannot help people achieve their goals without knowing what they are and why they matter. Nor can we always expect them to follow through on the best discharge plans, without a structure in place to support them.

I filed my "Doing Business As" name (DBA) on July 9 and established my LLC on the 15th. I drafted a business plan, consent forms, and hand-crafted patient education worksheets. I chose and learned my EMR system, applied to participate in Medicare, and developed a fee structure. I created a website, started blogging, and built a social media presence. I continue to expand on my vision for this company while I learn about the logistics involved in running it.

I evaluated my first patient in mid-August. By the month's close, I had a caseload of five. I am working toward and hoping for continued growth as I enter this fall. I love that this new venture has me constantly learning, always creating, and finding my own way. I'm proud of the product I am creating and can stand behind the services I offer.

I am grateful that 2020 forced me to take a break. The time off work gave me a chance to take stock and really think about how I want to focus my time and my energy. It forced me to think more creatively. Taking a step back from my daily routine also gave me the chance to better identify the parts I love about my work as a physical therapist from the parts that I simply *do* just because I have to. This time, and these thoughts, have enabled me to design a practice that I feel confident can offer my patients the best care possible. Sometimes adversity spawns opportunity. For me, HAE/PT represents a new path and exciting future.



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