

GERI NOTES

Academy of Geriatric Physical Therapy

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IN HONOR/MEMORIAM FUND

Each of us, as we pass through life, is supported, assisted and nurtured by others. There is no better way to make a lasting tribute to these individuals than by making a memorial or honorary contribution in the individual’s name. The Academy of Geriatric Physical Therapy has established such a fund which supports geriatric research. Send contributions to:

The Academy of Geriatric Physical Therapy | 3510 East Washington Avenue | Madison, WI 53704

Also, when sending a contribution, please include the individual’s name and any other person you would like notified about your contribution. If you are honoring someone, a letter will be sent to that person, and if you are memorializing someone, the surviving family will be notified of your contribution.

In the field of geriatric physical therapy, we receive many rewards from our patients, associates, and our mentors. A commemorative gift to the Academy of Geriatric Physical Therapy In Honor/Memorial Fund is a wonderful expressive memorial.

PRESIDENT'S MESSAGE: OPIOIDS

William H. Staples, PT, DHS, DPT, GCS, CEEAA



Before I get to the main topic of this message, I want to congratulate Kathleen Mangione, PT, PhD, as being selected to attend the

Movement System Summit as the Academy's representative. A goal of the summit, which will be held later this year, is to develop a "road map" for incorporating the movement system into education, practice, and research. This will also include discussions of standards in such areas as a patient or client examination that focus on the movement system. There is a great article in the May 2016 issue of *PT in Motion* that describes this initiative.

According to the Centers for Disease Control and Prevention (CDC) nearly 20,000 people died from overdoses of prescription opioids in 2014.¹ Additionally, nearly 2 million met diagnostic criteria for substance abuse disorder involving prescribed opiates.¹ The CDC has developed new guidelines on prescribing opioid medications for chronic pain that were recently published (March 2016) in the *Journal of the American Medical Association*.¹ Opioids have serious risk factors involved in long-term use including misuse, addiction, and possible death. There is little evidence found to support long-term use of opiates to treat chronic pain (more than 90 days). The CDC is recommending that other non-opioid interventions should be used for chronic pain other than active cancer, palliative care, and end-of-life care. Specific recommendations include non-opioid medication prescription among the 12 stated. The CDC cited "high-quality evidence" supporting exercise as part of a physical therapy treatment plan for some conditions including pain or function problems that are related to low back pain, hip or knee osteoarthritis, or fibromyalgia. In fact, the first recommendation is nonpharmacological therapy and non-opioid therapy as the preferred treatment for chronic pain. Further in-depth recommendations include exercise

therapy and cognitive behavioral therapy (CBT).

As physical therapists working with older adults, we may begin to see an influx of patients with chronic pain for which opioid prescription has been reduced, terminated, or not initiated. Physical therapists may be key in this equation. We know several interventions that can relieve and reduce pain in our patients. There is an epidemic of painkiller overuse, and we can provide some guidance on different approaches to pain relief, as well as tips on what to do to respond to different kinds of pain. In June, the APTA will begin a consumer awareness campaign about the opioid epidemic.

Last month I received two referrals for pain relief due to one person's dose of Ultram (tramadol) being reduced by half, and another person completely removed from the opioid and put on an OTC (Aleve) after being on that medication for 8 years. The first patient had significant knee arthritis and is waiting until he turns 65 so "Medicare can pay for the joint replacement." I fitted him with an "unloader" brace to improve valgus malalignment, began a lower extremity resistive exercise program (started slow but quickly got to 1-rep max as the evidence would suggest to make the best gains), and began some lifestyle modification instruction. All of these were new to the patient and had never had physical therapy suggested. The second patient had a history of significant back pain, but when first seen was not only in intense pain but was having withdrawal symptoms. This was new to me, so as a review for all of us signs of opioid withdrawal can include diarrhea, abdominal cramping, goose bumps, nausea and vomiting, dilated pupils and possibly blurry vision, rapid heartbeat, and high blood pressure. I did get nursing involved with this home care case and she was able to convince his physician that a short-term use of buprenorphine (Subutex) might be a good choice. This patient is also clinically depressed and has been on an anti-depressant for 5 years. His course has been a bit of an adventure and our (the patient and my) goal

is not zero pain, but to make it tolerable to function for IADLs. We have tried TENS, moist heat, ultrasound, manual therapy, and manual traction, in addition to a core strengthening program, all with minimal change so far, but he is much more active than the last 3 weeks with the utilization of CBT. The nurse has also consulted with the physician about trying the non-opioid medication celecoxib, a COX-2 inhibitor. If you recall, COX-2 inhibiting drugs were given a black box warning. Clinical trials revealed that COX-2 caused a significant increase in heart attacks and strokes. But this may be a good option as he has no history of heart disease.

We are all trained in multiple modalities and interventional techniques to reduce pain. May I suggest dusting off a modality text, taking a continuing competence course and/or reviewing CBT techniques, I know it helped me.³ The medical management of chronic pain patients presents primary care practitioners with significant challenges. Hopefully, we can take advantage of this situation by educating physicians better. Chronic pain patients are very difficult to treat and with the new guidelines we will most likely see an influx of patients when the time comes to re-prescribe their medications or newly diagnosed and prescribed low levels of medication. There has been a number of recent clinical findings that indicate that patients should try physical therapy first. So let's prepare and review our pain relief options. Our patients will be depending on us!

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EDITOR'S MESSAGE: GERIATRIC SYNDROMES— IDENTIFY, COLLABORATE, AND COMMUNICATE

Meri Goebring, PT, PhD, GCS



A former student and a peer faculty member collaborated on a 2014 article entitled, “Health Reform and the Geriatric Syn-

dromes: A Call for Interprofessional Practice,” which dealt with geriatric syndromes and the importance of inter-professional practice. In the article, the authors recommended improving care through careful examination of geriatric syndromes, using a multidisciplinary approach.¹ However, a recent article in the *Journal of the American Geriatric Society* found that, despite the high prevalence of geriatric syndromes in older adults who are discharged (following hospitalization) to skilled nursing facilities, information about these syndromes is rarely communicated to the skilled nursing staff.² As a physical therapist and active clinician in a hospital setting, I found this to be concerning. I asked myself the following question, How well do I identify, collaborate, and communicate about individuals with geriatric syndromes when their health care settings change? As I reviewed this topic, I considered it to be a good message to share with *GeriNotes* readers.

As physical therapists and members of the Academy of Geriatric Physical Therapy, we should be able to identify the common geriatric syndromes. Geriatric syndromes are health conditions that share a common cause and involve multiple organ systems. This term has been adopted to better explain clinical conditions in older adults that do not easily fit into specific disease categories.

Geriatric syndromes include pressure ulcers, incontinence, falls, functional decline, and delirium. Some authors

include malnutrition, eating/feeding problems, sleeping problems, dizziness, and syncope.³ Emerging syndromes include sarcopenia, poly-provider, poly-pharmacy, pain, and frailty.⁴ Certainly, physical therapists should be among the clinicians best suited to identify many of these issues, as we often work with older adults. Furthermore, if the health care team held a discussion (during the patient’s hospitalization) about the patient’s geriatric syndrome, it could help the patient get the care they really need.

So, how do we best identify these syndromes? As physical therapists, we are skilled at screening for falls, dementia, and pressure ulcer risk, but there are many tools available that we may find better and/or easier to use. One good resource for these diagnostic tools is from our colleagues in nursing. The “Try This” series (available at <https://consultgeri.org/tools/try-this-series>) is provided by the Hartford Institute for Geriatric Nursing. It offers numerous tools on how to determine if a patient has one or more of these syndromes. It also provides information on how each tool was developed, along with validity and reliability information when available. It is well-referenced and complete.

Once these syndromes are identified, how do we communicate these to other health care professionals? A team approach to discharge planning is best. The care team should communicate that an individual, if he or she has one or more of these syndromes, is to receive targeted interventions. The patient should also receive a specific plan to continue treatment in the next care setting. Research shows that we need to improve our communication in this area.² Let’s take an example. A hospitalized older adult is found to be depressed, has unintentional weight loss, and is a high fall risk. Once this is communicated to the staff in a skilled nursing facility, ac-

tive social engagement can be initiated immediately. The staff can begin monitored meals with frequent snacks, and quickly initiate fall risk precautions and appropriate physical therapy involvement. This can help the skilled nursing staff provide the best care for their newly admitted patients.

In conclusion, it is important for us to recognize geriatric syndromes, collaborate with other health professionals to provide the best plan of care for these syndromes, and communicate to others as our patients change health care settings. With this enhanced communication and care, hospitalized older adults who are admitted to skilled nursing facilities may be able to avoid hospital re-admission or further functional decline.

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POLICY TALK: STUDENTS TALK

*Jennifer Webb, SPT, Texas Women's University and Joey Renee Miller, SPT, University of Miami
Intro by: Ellen R. Strunk, PT, MS, GCS, CEEAA, CHC*



Federal Advocacy Forum

From Left to Right

Joey Miller, SPT, University of Miami

Ellen Strunk, AGPT Federal Affairs Liaison

Jennifer Webb, SPT, Texas Women's University

The Academy of Geriatric Physical Therapy recognizes the value of engaging its members in advocacy efforts at all levels of government to influence policy beneficial to the aging adult. The Academy not only “talks” about it, but also “takes action.” This year, the Academy assisted two students with funding to the Federal Advocacy Forum held in Washington, DC, on April 3-5, 2016. I was privileged to meet Jennifer and Joey, two future physical therapists who have

already shown an interest in advocacy and policy issues. After reading about their experience, I hope their excitement rubs off on other physical therapists and physical therapy assistants who will plan to visit their Representatives in DC, or even better, back home in their district. For more information on all of these issues, please visit the APTA website (<http://www.apta.org/FederalIssues/>) or download the APTA Take Action app.

I feel extremely honored and thankful for the opportunity to have represented the student section of the Academy of Geriatric Physical Therapy (AGPT) at the Federal Advocacy Forum in Washington, DC! This award has allowed me the amazing experience of representing the physical therapy profession to our representatives and senators regarding current legislation affecting our profession and our patients. I am very grateful to the AGPT as well as my faculty and mentors who have assisted me in achieving such an honor. I don't have extensive experience in political processes or legislative influence. However, as I graduate next year, I will have spent 7 years dedicated to preparing myself to enter this profession, and I see advocacy as a personal duty and investment to the preservation and progress of this wonderful profession that I love!

Attending the Federal Advocacy Forum, I was blown away by the passion and dedication of everyone leaving their lives and responsibilities for 3 days to meet with the legislators who make things actually happen on the Hill. Witnessing hundreds of physical therapy professionals, leadership, and students walking the halls of our national offices and having important conversations about real physical therapy issues was empowering and inspiring. It made me realize the great strides those before me have accomplished in order to transform the PT profession into how we know it today, and how excited I am to continue this progress for all of us in the future.

While visiting the Hill this year, I had the pleasure of meeting with my local representatives to discuss key bills directly affecting our patients, professionals, and students. One of the key issues included repealing the Medicare therapy cap so patients can get the rehabilitation they need and not be limited by an arbitrary typographical error restricting physical and speech therapy from those who need it most. Next, I highlighted a bill preventing interruptions for physical therapy patients by allowing our profession to enter into locum tenens arrangements in the case of emergent situations for the physical therapist. The final key issue would add physical therapy as an eligible occupation for the National Health Services Corps (NHSC). The NHSC brings underserved areas a rehabilitative therapy option by providing incentives for professionals to work in these areas referred to as Health Professional Shortage Areas (HPSA). Additional bills included defining physical therapist roles in rehab research, brain injuries and concussion management, inclusion of physical therapist protection in traveling with sports teams, and the physical therapist role in emerging telehealth services.

This valuable experience will not only be implemented into my future career, but has already begun to shape my direction. Every time I work with a Medicare patient, consider taking a job in an underserved area, or approach treating a concussion, I will appreciate this advocacy experience and all of the advocates I stood alongside this year. Ultimately, my involvement in federal advocacy has really shown me how valuable it is to be involved in caring for and shaping the future of a profession I so passionately care about. When I see how simple it is to be a part of a process making huge, influential changes impacting our practice, I get a sense of having my finger on the “pulse” of physical therapy. It is exciting and so very meaningful as a student, and I know it will only become more meaningful as I continue as a professional. – Jennifer Webb, SPT, TWU Dallas

ATTITUDES ABOUT AGING: READERS' COMMENTS

The open letter to members of The Academy of Geriatric Physical Therapy written by Jacqueline Osborne, PT, DPT, GCS, CEEAA, in *GeriNotes*, March 2016 addresses the necessary change in attitude about aging from the top down. While attending a geriatric-centered PT meeting, I heard comments from the presenters that reflected their reticence in being included in the elder population! When elder specialists, such as a PT, GCS, MD, RN, find it personally difficult to acknowledge aging as a normal process, to embrace the inevitable changes of aging, and to age with dignity and grace, they perpetrate the negative bias of aging. How is it that the President's Message, in the same publication, speaks to the discomfort of the aging process? Why does one, who specializes in geriatrics, not celebrate with gusto, each and every birthday? Consider the alternative! I see our mission as one of normalizing aging; after all, we begin to get old from the moment we are born. Old is not a 4 letter word, sick is. We have a lot of work to do within our own ranks and certainly in the world, which is aging exponentially! We are the role models of wellness and healthy aging in our profession, in our education, and in our person.

Terry E. Ruby, PT, LMHC, PhD, GCS, CEEAA

RESPONSE TO OPEN LETTER

The President's Message in the March issue discussed the real science about how a person feels about aging, referencing two articles on the topic. Attitudes about aging can affect how well our interventions and outcomes are developed with our patients. I continue to provide home care services, and hear my patient's say that they are "too old to exercise" indicating their self-ageism. The tongue-in-cheek ending of the message may have been misconstrued with a negative thinking on ageism and nothing could be further from the truth. I retired from playing soccer last spring due to a labral tear in my hip, which is not normal aging but an overuse injury. I do miss playing. Ageism has been

encountered in commercial advertisements for products that imply illness or disability with age and are targeted for older adults. Feeling "younger" is one way to keep us doing active things that commercials and the media, and maybe some close to us, say we can't! That was the emphasis of the message, and is where we need to strike a match. Has anyone ever written to a corporation about ageism seen in their advertisements? Visit You Tube where NYU has a list of ageist commercials to back up what was stated. <https://www.youtube.com/playlist?list=PLaqYFTJsYioqkeF7aUmDCYDwtSgQ7pYL->

Being a backpacker, runner, and a gym rat, I do cherish my age change this year because I'm now in a new age group for running. It's positive ageism for me! The conversation continues. Thanks for being a member.

Bill Staples, PT, DHS, DPT, GCS, CEEAA

Dear *GeriNotes*:

I am happy to respond to the letter from Dr. Ruby regarding the aging process and our response to it as geriatric specialists.

Your point that the aging process is normal and should be embraced is well taken with its intent, but maybe not so realistic. How many seniors have you met that have said "I just love getting old"? Let's get real....aging comes with a series of losses that really can't always be prevented and certainly aren't welcomed. I have a genetic type of osteoarthritis handed down from mother to daughter. It has only just begun gnarling my fingers like my mom's and my sister's hands. I know that it is coming as a natural process of aging in women in my family and genotype, but please don't expect me to be happy about it! I do what I can to protect my joints and move on. It will eventually affect my function and impair my ability to do things I want to do. Knowing that there is nothing I can do to stop it doesn't make me feel better. It also doesn't paralyze me.

Embracing aging is not the same as ageism. We should never "profile"

seniors by their age. This is ageism. It's a judgement based on an assumption that lumps people together. People have varying skill sets – many of which are common by the time they turn 90. But to say all people age 90 should not be driving is ageism. It might be true most of the time- but it's still ageism. Am I embracing my dependence on others to drive me where and when I want to go somewhere? Not really. I'm really hoping that the smart cars are geniuses by the time I get there.

By the same token, I can't judge people who fight the aging process. As physical therapists, no one really expects us to look glamorous every day. We can wear our wrinkles as badges of honor and hope for discounts at the movies. When your livelihood is at risk because of those wrinkles, such as, broadcast journalists, aging actors, etc., it's not so easy to embrace the wrinkles. It's not really an aging issue in this case either. It's having your skill sets being trumped by your appearance. That stinks at any age.

Accepting that the aging process is coming is different than embracing it. I know my 92-year-old best friend/mom is going to pass away soon. I certainly don't look forward to it, even though it is a natural process. I CAN treasure every minute with her and provide her dignity (and humor!) in assisting her with the inevitable losses – that are unique to her. This is what we do as geriatric specialists for our seniors. Actually being the gracious receiver of care that my mom is – well that's a whole different kettle of fish!

I do what I can to preserve function in myself based on the knowledge that I have. The inner child in me wants to see herself in the mirror each morning, but we can laugh at what is really there. I want to seize every moment I can on this planet, but I accept that I will be leaving some day. Don't expect me to be happy about it! And don't discount my value to society as I move through my inevitable life cycle. I'm still me.

Patrice Antony, PT, GCS, Care Manager

CEEAA INSTRUCTORS AND GRADUATES



CEEAA Instructors

Ken Miller, Lucy Jones, Bill Staples, Jill Heitzman, Larry Hochreiter



CEEAA Graduates May 2016

Manchester, New Hampshire

THE A CLUB CAMPAIGN UPDATE

Lise McCarthy, PT, DPT, GCS
CMH SIG Chair

The Cognitive and Mental Health Special Interest Group (CMH SIG) is in its second year. In addition to our yearly progress report (see page 9). I would like to highlight the A Club campaign our CMH SIG began last summer. Specifically, the A Club campaign is a means for us/you to convey and promote the message that it is important for all members of our profession to achieve excellence in **assessment** of the whole person (including areas of cognitive health and mental health).

In case you missed it, here is an excerpt from our 2015 Letter of Introduction to the A Club:

“The year 2020 is expected to bring 5.7 million people with dementia into our health care system. In all areas of health care, efforts are underway to improve how our communities can help people affected by dementia. Many of us are identifying and developing areas where we can work more effectively with other medical health care professionals to provide better care. There are now tremendous opportunities for physical therapists and physical therapist assistants to provide dementia care services.”

The number one modifiable risk factor for prevention of dementia in the United States is inactivity, followed by depression, mid-life hypertension, mid-life obesity, low education, and diabetes.¹ Ongoing research continues to support functional status models as very good predictors of acute hospital readmissions and discharge dispositions, and as vital indicators of functional pathology and care burdens.²⁻⁵

Last year we produced 3 A Club assessment documents on the Mini-Cog, Pain Assessment in Advanced Dementia

(PAINAD) and Function Assessment Stage Tool (FAST). We plan to produce two more A Club assessment documents this year on the Confusion Assessment Method (CAM) and Global Deterioration Scale in Primary Degenerative Dementia (GDS).

We warmly invite you to join us and participate in our A Club campaign by sharing these documents and engaging your colleagues (especially those who may not yet be members of the AGPT) in discussions about these topics!

Last, if you like what we are doing, please let us know and show your support of our efforts by becoming an active member of our CMH SIG. You can do this by signing up here:

www.geriaticsppt.org/members/special-interest-groups.



Wishing you every success, wherever you practice!

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Lise McCarthy is President of McCarthy's Interactive Physical Therapy and an Assistant Clinical Professor, Volunteer, with the Department of Physical Therapy and Rehabilitation Science at the University of California, San Francisco. She has a gerogeriatric house calls practice focused on people age 80 years or older and/or adults who are medically complex with cognitive and/or mental health conditions.

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**Academy
of
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COGNITIVE & MENTAL HEALTH (CMH) SIG ONE YEAR PROGRESS REPORT

~ Submitted at the CSM 2016 CMH SIG Meeting on 2/18/2016 and updated ~

Lise McCarthy, PT, DPT, GCS—CMH SIG Chair

Here is the brief recap of our completed projects and works for 2015:

1. *GeriNotes*: 4 articles published in 2015. Contributors: Laura White, Alisa Curray, Lise McCarthy.
2. Monthly posts of links to CMH resource information on the geriatricspt.org listserv. Lead Contributor: Jan Bays.
3. Development of “The A Club 2015” campaign: Cognitive Health Assessment, Pain Assessment, Functional Assessment. Contributors: Lise McCarthy, Michele Stanley, Mike Studer, Sue Wenker, Grace Knott.
4. Webpage developed and updated 3 times. Contributors: Michele Stanley, Sue Wenker, and Lise McCarthy.
5. Laid groundwork for two national presentations in 2016. Contributors: Mike Studer, Michele Stanley, Danille Parker, Jen Nash, Christy Ross, Lise McCarthy.
6. Dementia Measure Work Group: Submitted “Pain Assessment and Follow-Up Measure” along with recommendation for language modification to be more inclusive (eg, involve caregivers), and additional safety measures (eg, safe sex). Contributor: Lise McCarthy.

2016 projects already completed:

1. CSM 2016 Presentation. Title: “Mission Cognition: Advancing the Role of the PT in Chronic Progressive Cognitive Impairment.” Presenters: Mike Studer, Jennifer Nash, Christy Ross, and Lise McCarthy.
2. June NEXT 2016 Presentation. Title: “Functional Outcomes in Individuals with Cognitive or Mental Health Impairments.” Presenters: Michele Stanley and Danille Parker.
3. AGPT 2017 Calendar Project: Cognitive Health and Brain Health.
4. Finalization of Joint Committee Project: Update on Dementia Work Group Measures; lead by the American Academy of Neurology and the American Psychiatry Association.

tion. Contributor: Lise McCarthy.

2016 project in the works:

1. Monthly CMH Public Liaison informational posts to geriatricspt listserv. Project Leaders: Jan Bays and Marissa Cruz.
2. Biannually CMH Research Liaison resource update posts to our webpage. Project Leaders: Sue Wenker and Michele Stanley.
3. The A Club 2016 campaign: Confusion Assessment Method (CAM) and the Global Deterioration Scale for Primary Degenerative Dementia (GDS). Project Leaders: Michele Stanley, Christy Ross, Sue Wenker, Mary Fischer, Jill Heitzman, and Lise McCarthy.
4. November 2016 CEU *GeriNotes* Issue. Selected presenters at 2016 CSM and NEXT have agreed to author 10 CEU articles for this special cognitive and mental health issue.
5. PT Exam cognitive and mental health areas/items (in conjunction with AGPT’s Board of Directors). Project Leader: Grace Knott.
6. PowerPoint presentation for our communities and for the PT/PTA schools. Project Leaders: Jan Bays and Marissa Cruz.
7. Caregiver Resources (with input from other AGPT Section members). Project Leaders: Jill Heitzman and Lise McCarthy.
8. Cognition/Dementia Task Force recommendations for Practice Committee’s future focus on cognitive and mental health issues. Project Leaders: Laura White, Christy Ross, Betsy Ross, and Lise McCarthy.
9. Officer nominations for the fall election, and on-going liaison recruitment.
10. CSM application submitted for a 2017 CSM 2-day preconference course entitled “Working with Cognitive/Mental Health Issues Across the Care Continuum.” We have 4 teams:

- The Academic Team = Laura White and Nicole Dawson.
- The Hospital Team = Michele Stanley and Betsy Ross (Acute Care Section member).
- The SNF/HHA and Long-term Care Team = Grace Knott and Missy Criss.
- The Outpatient Team = Christy Ross and Lynn Steffes (Private Practice Section member).

We are laying good foundations. Much of what we did in 2015 is being repeated and will be expanded in different ways this year so we reach more people and areas of interest. New members are joining our CMH SIG each month. If you are interested in helping us, please let us know! If you like what we are doing you can show your support by signing up and becoming a CMH SIG member at: www.geriatricspt.org/members/special-interest-groups.

Many, many thanks for sharing your interests, ideas and talents with us! Keep it up!

Lise McCarthy is President of McCarthy’s Interactive Physical Therapy and an Assistant Clinical Professor, Volunteer, with the Department of Physical Therapy and Rehabilitation Science at the University of California, San Francisco. She has a gerogeriatric house calls practice focused on people age 80 years or older and/or adults who are medically complex with cognitive and/or mental health conditions.

ADVOCATING FOR THE AGPT

Eddie Smith, SPT

As a first year Doctorate of Physical Therapy student, I have had the privilege to attend not only national professional conferences such as the National Student Conclave (NSC) and Combined Sections Meeting (CSM) but also to be a member of the Academy of Geriatric Physical Therapy (AGPT). Since starting my adventure as a doctoral student, I have actively sought out opportunities to broaden my perspective of what the physical therapy profession could offer me, what I could offer the profession, and what paths I wanted to pursue post-graduation. Taking advantage of all these opportunities lead me to a realization that I was interested in the realm of working with the geriatric population.

The epiphany came to me after my time in Omaha, Nebraska where I attended NSC. I talked with many sections about what they offered students as well as their individual mission and vision. The AGPT really struck me as the one that aligned the best with my own aspirations and future practice mentality. At this time, I was already a member of the Section and by the end of the conference I was determined to become as involved as possible with the AGPT.

Sometime after the conference, I received an email stating the AGPT was in need of people interested in joining a public relations committee. I was chosen to be a member of the committee and was challenged with a task to ask my own classmates and other physical therapy students about their interactions with both the geriatric population and AGPT. This project took place in the few weeks before CSM in Anaheim, California. While attending CSM, I made it a point to attend as many AGPT presentations as possible. I learned valuable information about the treatment of persons with Parkinson's disease, as well as new and innovative protocols for the elderly athlete. I also had the opportunity to interact with leaders within the AGPT. From the sections presentations to networking at the after hour events,

I enjoyed my stay in Anaheim while attending my first CSM. I never thought just one conference would enable me to learn about residency programs, contracting agencies, and other future professional opportunities as much as I did. Moreover, CSM provided me with the opportunity to network with the American Physical Therapy Association (APTA) President, Sharon Dunn, PT, PhD, OCS. I am fortunate to have had all of these opportunities this early in my career. I do believe it will shape my own future and help me to sustain an active membership, and aid in the advancement of our profession.

While choosing a great profession has been highlighted since day one in my degree progression, I still found that certain areas of the profession were not as prevalent as others. The lack of utilization and lack of awareness of professional resources for both students and practicing clinicians, was probably the biggest. Through all of the experiences I had, attending NSC and CSM, I gained an understanding of the APTA and its inner workings. In talking with other students, I found myself sharing my experiences on connections I had made and the networking opportunities I had entertained. One in particular was my membership on the Public Relations committee for the AGPT. When talking with some classmates, I found that most had no idea what all of the different APTA Sections were. Even if my classmates knew of some of them, almost none had heard of the AGPT, which lead me to question why.

After talking with my classmates, I noticed a common theme: physical therapy students realize the high probability of treating a member of the geriatric population in the future, yet were unaware of the AGPT and resources available that provide the best practice techniques to treat and advocate for the geriatric population. This lack of awareness creates a problem with the treatment of this population. Once that idea resonated with me, I decided to broaden

my scope. I conducted a survey in which a few very simple questions were asked: *how long have you been a practicing physical therapist; would you feel comfortable treating a geriatric patient, why or why not (please provide a rationale to the previous question); and do you know what the Academy of Geriatric Physical Therapy is?* I received about 50 responses ranging from first year students to clinicians who have been practicing for more than 10 years. Within these responses, I observed the same trend that I had seen with my own classmates. When analyzing the data, 98% of respondents indicated that they would treat a geriatric patient. The rationale of these choices followed 3 major themes. These themes were that this population of individuals are like any other patient that we may see as physical therapists, there is an increasing number of geriatric patients because of our aging societal demographic, and that geriatric patients have intriguing personalities, diagnoses, and comorbidities that make their treatment different more challenging than other populations. I am ecstatic to see that physical therapists are readily willing to treat these patients. When asked if students and practicing physical therapists knew what the AGPT was, 78% of both groups indicated they did not. Yet again, I saw that a vital resource such as the AGPT was not being used or even recognized.

Even though the Public Relations Committee of the AGPT has recognized the problem of the AGPT's lack of usage, this committee cannot possibly handle the task of fixing it alone. Therefore, I want to advocate that all members of our professional community spread the word about the rewards of geriatric physical therapist practice. Advocates of the AGPT must continue practicing at the top of their license through the use of evidence-based practice and other methods, but also advocate for not only membership in the APTA but also within the AGPT. The concept of

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EMPLOYMENT OPTIONS IN GERIATRIC PHYSICAL THERAPY

Patricia Honda, DPT

Being laid off without warning can send even the calmest among us into a tailspin. That's exactly what happened to me in February of 2016. I am a 45-year-old woman who has practiced geriatric physical therapy for 13 years and I was enrolled in the last semester of a doctoral program when I got the news that the skilled nursing facility (SNF) where I worked for 4 years was being converted to an assisted living facility. This is my story of searching for job opportunities in a rapidly evolving health care market that I hope may serve as a guide for others who find themselves in a similar situation, or for those who enjoy working with seniors and are looking for a new direction in their career path.

I was working in a premier SNF in a suburb of Austin, Texas. No other SNFs in the area could boast of offering all private rooms, high end luxury accommodations, Wi-Fi internet, full cable, a coffee bar, movie theater, library, and gourmet dining. As all of us often do, my coworkers and I became very comfortable in this beautiful setting and believed we had found a place we would never leave. But the day came when we were all laid off without a severance package and only 1 to 3 weeks of remaining work. The room was so still it was like a vacuum had sucked all of the air out. As the news sunk in, the questions started and a few teary-eyed glances were exchanged. I have never been on a luxury cruise liner, but I could imagine I had been vacationing on a luxury cruise liner, enjoying the people and the amenities. Somehow, disaster struck and my friends and I were tossed overboard. We were treading water, watching our ship sail away...

So here I was, treading water, soon to be without a paycheck and health insurance, with no idea of work opportunities that were available in today's job market. I knew that physical therapists (PTs) were employable, but what were my options? My first thought was transitioning to another SNF. There were

many advantages to this option including familiarity to this patient population and setting, virtually identical job requirements and expectations, comparable salary and benefits package, my extensive training and experience working with seniors and a good understanding of the primary payers for this population: Medicare Part A, Part B, and Managed Care insurance plans. Working in an SNF is convenient because all of the patients are in one location and this allows a flexible schedule. The pay rate for this setting is second highest (following home health) at roughly \$38-42/hour for SNFs in this area. The disadvantages of transitioning to another SNF included working in a facility that would be a step down from what I was familiar with, higher productivity expectations (90-95% for evaluating therapists in this area as compared to 80% with my current company), drive time, and expenses would increase if the location was a greater distance from home. There was also the possibility I would not find such a stellar group of therapists to work with, and a caring and accommodating management team as I was accustomed to. A further consideration was my future career path; I had little interest in moving into management as a Director of Rehabilitation or Regional Director, and I wanted to stay in the clinical arena if possible. While this may have been the easiest move, I decided to see what other options were available.

After considering positions similar to my current job, I decided to search the internet for a broader look at PT job opportunities.

There were numerous jobs available in home health care. Home health physical therapy primarily involves working with the geriatric population and the treatment interventions are similar to those in a SNF setting. Patients are frequently at a higher level of function so there tends to be fewer physical demands for heavy lifting. It requires a bit of cre-

ativity at times due to the lack of access to some of the traditional rehab equipment. The pay is generally higher than in a SNF, but there is more paperwork to complete, and more driving and wear and tear on your personal vehicle (unless your company provides a car). One home health company I interviewed with offers the option of a "community therapist" where the PT is the sole clinician in an assisted or independent living community. This clinician is responsible for providing all of the physical therapy interventions in the building (unless the caseload exceeds a normal workday), regularly meeting with the building's Wellness Coordinator to discuss patients' outcomes and possible referrals, and conducting routine educational meetings for patients and caregivers on various relevant topics (fall prevention, disease management, diet and nutrition, benefits of regular exercise). A variation of this included a "home therapist" who would travel from one setting to another or multiple private homes in a day to see patients. The community therapist position would be much like working as a therapist in the SNF setting as you would have all of your patients in one location, use of a facility's equipment, and scheduling flexibility. There is obviously more autonomy with home health care which some may really enjoy, but others may miss having a group of therapists available for collaboration and/or co-treatments as in the SNF setting. I found a greater variation in pay among the home health care employers in my area, ranging from \$60 to \$80 per visit.

My internet search revealed a large number of positions in the SNF and home health settings, but I noted a few unique opportunities that peaked my interest. The first position I found was a marketing position for a PT with a home health company. The physical therapist would be in charge of marketing "Specialty Programs" offered by the company to specific patient groups (ie, those with total joint replacements, frac-

ture repairs, wounds, etc.) and surgeons (based on their treatment protocols and preferences) to improve outcomes. The clinician meets with surgeons to market these programs, learn their preferences for their patients' postoperative care (incision care, pain management, rehab protocols, and chronic disease management), train the company's home health clinicians, and assess the clinicians' documentation for compliance and outcomes. The base salary was about \$80k with a small bonus for every patient referred to our home health company by doctors in the clinician's market area. This position was unlike any other I had encountered, not clinical care but marketing clinical. You may think, like I did, that surgeons would love this. Unfortunately, that's not the case. Talking to other medical representatives marketing to physicians, I found this type of job is challenging. Surgeons are busy and generally not interested in talking to people about their post-op preferences; they usually refer this to their support staff. I argued with myself that this is likely to change since a goal of the Affordable Care Act is to promote cost savings in health care. Since Accountable Care Organizations are "groups of doctors, hospitals, and other health care providers who come together voluntarily to give coordinated high quality care to their Medicare patients,"²¹ marketing coordinated care "to ensure that patients get the best care, while avoiding unnecessary duplication of services and preventing medical errors,"²¹ is needed. Who would be better to market physical therapy services than a PT? As DPTs we need to be visible in all areas of health care to assure our services are represented where decisions are being made. If outcomes are good, then the profits are higher. The idiom "money talks" may open the door for PTs to show that they have an important role in better, faster outcomes which means more profit. The doctors may become more inclined to listen. A similar marketing position was advertised within the same company and involved marketing specialty programs to social workers and case managers in the hospital setting. Although these two positions would not allow hands-on care of geriatric patients, a PT would be an advocate for this population and indirectly involved in helping them acquire the best care. For me, the advantages of these positions were the challenge of

using my education and training in an entirely new way. I would essentially be an advocate for the patients and for the proven benefits of physical therapy. I would use my knowledge to explain to surgeons and/or hospital case managers what we do and how we can improve their patients' postoperative care, functional mobility, and outcomes, and decrease re-hospitalizations. *The position would require a considerable amount of day travel from one location to another, frequent meetings where I may not be received well or may feel rushed, pressure to get referrals, and no opportunity to use my clinical skills and develop relationships with patients. How well would I handle rejection from a provider who is not interested in what I have to say? And how would it feel to not be providing hands-on care to patients? My search continued...*

I discovered a third home health position that interested me. The title of the position was Care Transition Coordinator. This position was designed based on the work of Eric Coleman, MD, MPH, and Mary Naylor, PhD, RN. Coleman's Care Transitions Intervention "seeks to engage patients at critical transition points" relying on "specially trained coaches...to educate patients about medication management, and the use of personal healthcare records, along with other efforts to facilitate care continuity and communication with their providers."²² The coaches visit patients in the hospital, and at home following discharge, to provide guidance for managing their health care conditions. Naylor's approach, the Transitional Care Model, uses nurses to assist with transitions. These nurses develop individual care plans for hospitalized patients, then follow-up through home visits.

In assessing my skills for this position, I recognized to oversee patients' transitions from the hospital. The nurses develop a customized care plan for each patient and then make routine home visits for up to 2 months following discharge from the hospital. Both models "seek to develop patients' ability to manage their own conditions"²² and prevent hospital readmissions. The Centers for Medicare and Medicaid launched a program in 2011 "to improve the care of beneficiaries who are moving from the hospital to their homes"² as part of the Affordable Care Act. This program was designed to "put community-based organizations in charge of identifying...patients' needs

and coordinating care to address them."²² This home health company created a position for a nurse or PT to fill this role. *I could use my experience, my DPT knowledge, and passion for providing quality care. A lifeboat to consider.*

I discovered a few positions for a *Prior Authorization Therapist*: a desk job for a PT to review medical claims for appropriateness of treatment and compliance with applicable insurance criteria, member eligibility, benefits, and contracts. The PT reviews patients' clinical information and ensures that they have access to medically necessary, high quality, cost effective health care throughout their episode of medical care. The preferred qualifications for this position include a current license, a minimum of 2 years clinical experience, prior authorization experience, a minimum of 1 year customer service experience, claims/review and audit experience, data entry skills, and basic computer knowledge. The salary offered was in the \$80k/year range with a full benefit package. There are productivity expectations to complete a designated number of claims reviews per day and much reading is required as well as phone calls and problem solving skills. *I was not interested in an office job where I would be sitting for most of the workday. Not the right fit for me, but an interesting opportunity that I was not familiar with from previous job searches.*

All of these avenues were job possibilities. But what about not working for someone? Self-employment?

Over the previous year I had entertained the idea of private practice with an outpatient clinic for seniors. As I started to learn more about private practice, I realized it might be a bigger undertaking than I was ready to commit to. The cost of renting a business space in Austin or surrounding areas is expensive and I would need to get a loan, borrow money, or find investors. And there are so many factors to consider such as, the demographics of the area, competing businesses, and effective ways to market the business. How much space would I need initially and what was my growth potential? The cost of insurance, equipment, marketing, facility registration, and taxes seemed daunting to me. The biggest disadvantage and barrier to this idea was my own lack of knowledge. But what if I could do something

on my own that required less expense and risk? Over the years as a geriatric PT in the SNF setting, I had watched patients come on and off of therapy. I affectionately referred to them as “repeat offenders.” There seemed to be a cycle of rehabilitation followed by decline and repeat rehabilitation. Families and loved ones never wanted the patients to come off of therapy because they were all too familiar with this cycle. One of the reasons for the cycle is that insurance often does not reimburse therapists for maintaining function or preventing decline, despite the landmark settlement in the *Jimmo vs Sebelius* case which provided “clarifications to safeguard against unfair denials by Medicare contractors for skilled therapy services that aid in maintaining a patient’s current condition or to prevent or slow decline.”³ Medicare covered services were designed to improve function and must be skilled and medically necessary. By Medicare standards, walking with someone and cueing them to improve the quality of their walking, working on increasing the distance they are able to walk, putting someone on a bike to build endurance, and completing basic leg exercises is not considered “skilled.” My documentation needed to show that what I do as a PT cannot be provided by someone without my education and training, and that my interventions are skilled and medically necessary. The non-skilled activities may not be covered by Medicare, but their value in the geriatric population is undeniable for improving and/or maintaining health and quality of life. So could I assist in maintaining a senior’s health and function and/or preventing a decline? What if I, with all my training as a PT, started a business where I work with seniors after they finish rehab? What if I could do all of those things that Medicare does not approve of as “skilled” and help prevent the decline that often happens when therapy ends?

The first hurdle to consider is the fact that a therapist cannot bill a Medicare recipient out-of-pocket for skilled services. But if those services are not skilled and non-reimbursable by Medicare, is it considered physical therapy? If it is not physical therapy but restorative care, then it needs to be clear that physical therapy is not being provided. The next hurdle? The PT Board. I contacted the Executive Council of PT and OT Examiners (ECPTOTE) in Austin and

spoke with Karen Gordon, a PT Coordinator. I told her of my business idea of working with seniors after they are discharged from therapy. She informed me that the *Jimmo vs Sebelius* case meant that “maintenance therapy is now covered under Medicare” and therefore I would be providing physical therapy. I asked her if I could provide this service under my personal training certification and her response was that it would be too difficult to distinguish when I was providing physical therapy vs personal training in a population where I am known to be a PT. I was informed that if I provided this service to a population who is not familiar with me as a PT, that it would be allowable. The obvious advantages of this business idea include the ability to work with seniors, work autonomy, lack of time constraints related to payer standards, and freedom to document my work as I deem suitable. I would be my own boss and able to make business decisions based on my own priorities and concerns. The risks included the responsibility of marketing my business to maintain an adequate clientele base to provide a steady income, personal provision of benefits (health insurance, retirement account), maintaining organized business records of expenses and profits for tax purposes, planning visits to minimize driving and maximize “billable” time, and ensuring adequate liability insurance. Great caution should be taken to establish what is being provided and by whom in order to abide by all applicable laws set by the Physical Therapy Board and Medicare.

By this time, my cruise ship was just a speck on the horizon, having sailed far away beyond my reach. But the waters seemed calmer and I floated easily on the surface. As I looked around, I noticed there were life preservers and floats for me to latch onto. Job opportunities. There was an abundance! Physical therapists are an employable group of professionals and there are numerous clinical positions available in various settings as well as administrative/management jobs and marketing positions.

I was ready to try something new. I accepted the Care Transition Coordinator position with the home health company. I found that it was a perfect balance for me of less physically demanding work, a good amount of time interacting with patients and their families to coor-

dinate a smooth progression through the health care environment for their episode of care, and a new challenge. I liked the idea of working in a different setting, primarily in the hospital, with case managers and social workers, promoting the company’s programs, and assisting patients and their families’ transition to the next level of care to become more independent in managing their health.

Planning the next phase of my career following sudden unemployment was frightening but eye-opening. New laws, emerging health care models and trends, and cost containment strategies are reshaping health care delivery. Physical therapy job opportunities related directly and indirectly to caring for the geriatric population is growing and evolving. With total national health care expenses reaching \$2.3 trillion annually, and the aging population contributing to a large part of the expense, physical therapy can positively impact plans to reduce health care spending by improving patient outcomes, preventing declines in health and function, and assisting with management of chronic diseases. With the increasing amount of evidence-based research promoting the benefits of physical therapy for improving outcomes and decreasing health care spending, our profession will have a greater impact on health care delivery and health promotion in the years to come. Our transition to direct access, doctorate-level practitioners will foster our important role as primary care providers for people of all ages. Physical therapy will play a vital role in the changing landscape of health care for our seniors. Being laid off unexpectedly from a job I valued forced me to look at how health care is changing and where a PT fits in to this rapidly evolving health care landscape. What I found is that there are more and exciting new opportunities for PTs than ever before. After working as a geriatric clinician for 13 years, I decided to try something different. I’m thrilled to see where this new career path will take me. If you are a PT or considering physical therapy as a career, you will not be disappointed with all of the possibilities that are available to us to positively impact the health and livelihood of those needing medical care. And as geriatric patients are the fastest growing segment of the population, those who enjoy working with seniors will undoubtedly be in need!

Who knows what other doors have opened for me. Perhaps I will write about my new job in another article?

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advocating may include joining the Public Relations Committee of the AGPT, mentoring physical therapy students and other practicing clinicians, and speaking to colleagues about the benefits of the Section. The true reason I am advocating for

help in raising this awareness is because I love working with the geriatric population and the AGPT can help not only me, but many others to do this in a more beneficial way.



Eddie Smith is a first year Doctorate in Physical Therapy student attending

Northern Arizona University. He is interested in practicing with a predominantly geriatric population or in a military affiliation capacity. If anyone has any questions, please feel free to contact me at ers94@nau.edu.

Academy of Geriatric Physical Therapy STATE ADVOCATES

Did you know that AGPT has State Advocates working locally in many states, advocating for older adults, promoting geriatric-related issues, courses, meetings and AGPT SIGs and being a liaison between AGPT and state chapters?

We are actively looking for new State Advocates in the following areas:

Alaska, California, Colorado, DC, Illinois, Indiana, Kansas, Kentucky, Louisiana, Massachusetts, Nebraska, New Jersey, New Mexico, New York, Ohio, Rhode Island, South Dakota, Tennessee, Utah and Washington

From another state than is listed above?

Find out your State Advocate contact info at www.geriaticspt.org. Select "Members" tab, then "Contact Your State Advocate"

If you are interested in being your State Advocate, or want more info about the program, contact AGPT Advocate Coordinator **Beth Black, PT, GCS**, at BBlackPT@gmail.com.



THE ROLE OF PHYSICAL THERAPY IN TREATING CLIENTS LIVING WITH BEHAVIORAL AND MENTAL ILLNESS

Neely Sullivan, PT, CLT

SCOPE OF THE CONCERN

Mental illness is the leading cause of disability in the world.¹ Most people in nursing homes have a chronic physical illness or have failed to recover from injuries. Yet at least 50% of this population has co-occurring mental illnesses—especially dementia, depression, and anxiety disorders.² In 2005, there were 1,150,734 new nursing home admissions in the entire United States. Of these admissions, 31,335 (2.7%) indicated they had schizophrenia or bipolar disorder (narrow mental illness definition). A total of 315,003 (27.4%) indicated they had schizophrenia, bipolar disorder, depression, or anxiety (broad mental illness definition).³ A 1996 study estimated that 68% of nursing home clients have some mental illness—5.9% have schizophrenia, 21.3% have depression, 50.4% have dementia and related disorders, and 12.3% have anxiety and other disorders. This study also found 16.6% of nursing home clients have a primary diagnosis of mental illness other than dementia, second only to circulatory diseases.⁴

In addition, in 2003 approximately 6.2% of spending on direct mental health services was in nursing homes.⁵ Nursing home staff and long-term care ombudsmen have both reported a rise in the number of people in this setting with serious mental illness, substance abuse, and severe behavior problems. Much of this rise appears to be related to the trend to reduce length of stay in hospitals by transferring clients to nursing homes for short-term rehabilitation.¹

Individuals living with behavioral and mental health problems often have co-existing health conditions that can be addressed by Physical Therapy. Historically, people living with behavioral and mental health concerns were treated within the medical model of service delivery. The focus of service delivery has shifted and is now focused on recovery as a long-term process, with the ultimate goal being full participation in community activities.⁶ Using this approach for

people living with behavioral and mental health concerns is congruent with the goals of Physical Therapy. The purpose of Physical Therapy is to enhance the individuals' ability to move and perform functional activities in their daily lives to increase their ability to live as self-sufficiently as possible in the community while participating in significant and productive life roles. Because Physical Therapy is client-centered, it plays an important role in the success of those living with behavioral and mental health concerns in society. In addition, research has illustrated that Physical Therapists are a highly effective alternative to prescription medication and surgery for many conditions.⁷

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BEHAVIORAL AND MENTAL ILLNESS OVERVIEW

The Centers for Disease Control defines mental illness as disorders generally characterized by dysregulation of mood, thought, and/or behavior,⁸ as recognized by the Diagnostic and Statistical Manual, 4th edition, of the American Psychiatric Association (DSM-IV). These disorders may include but are not limited to:

- Schizoaffective Disorder
- Schizophrenia^{9,10}
- Attention Deficit Disorder/Attention Deficit Hyperactivity Disorder
- Anxiety Disorders
- Autism
- Bipolar Disorder
- Borderline Personality Disorder
- Depression
- Dissociative Disorders
- Eating Disorders
- Obsessive-compulsive Disorder
- Posttraumatic Stress Disorder
- Distrust/Paranoia
- Verbal or physical abuse of caregivers
- Refusal to adhere to treatment
- Not eating properly
- Dangerous behaviors such as smoking in bed

A behavioral and/or mental illness impacts a person's thinking, feeling, or mood and may affect his or her ability to relate to others and function on a daily basis. Each person will have different experiences, even people with the same diagnosis. Providing client-centered care such as modifying care plans to meet each individual's unique needs, preferences, and life story is essential in treating clients experiencing behavioral and mental health concerns. As members of the Interdisciplinary Team, it is the Physical Therapist's responsibility to participate in the provision of care to assist a client with behavioral or mental illness concerns in maximizing his or her highest level of functional independence. This can be achieved through determination of how mental and psychosocial factors impact quality of life, interaction skills, mobility, and functional performance of ADLs. The Interdisciplinary Team should use a problem solving approach to care, designed to prevent problems before they occur and modifying care strategies as the client and/or the condition changes.

REASON FOR SKILLED PHYSICAL THERAPY SERVICES

It is within the Physical Therapists' scope of practice and educational training as well as the Medicare regulations/guidelines to evaluate and treat clients with behavioral and mental health illnesses. The purpose of this skilled therapy is to address the physical, cognitive, and psychological issues related to function for individuals with secondary diagnosis of mental illness within long-term care. Behavioral and psychological symptoms may include:

- Wandering
- Lack of personal and/or household cleanliness
- Hoarding

One of the Physical Therapist's role is to evaluate the client's current physical, cognitive, and behavioral functioning and provide strategies to provide stress management and health promotion to prevent occurrence/resurgence of behavioral and mental health illnesses. In addition, Physical Therapists need to be knowledgeable about decreasing negative behaviors associated with mental illness when treating clients for physical deficits not related to their behavioral or mental health status. Finally, Physical Therapists will develop compensatory strategies and modify the environment to enhance each client's ability to perform functional tasks.

Establishing a Rehab Program for Clients with Behavioral and Mental Health Problems

In order to ensure success of clients living with behavioral and mental health issues, it is essential the interdisciplinary team work closely together to establish systems to consistently identify and track clients who have experienced decline in functional skills. The community must also establish systems to notify Physical Therapy when functional changes occur. By accurately identifying clients who could benefit from skilled Physical Therapy intervention, the risk of the following occurring is reduced:

- Social isolation/reduced environmental participation
- Falls/unsafe functional mobility
- Behavioral changes and/or safety decline during daily living tasks

Physical Therapists need to increase communication with caregivers to achieve the least restrictive living environment and participate in decision making for life skills/performance. It is also necessary that Physical Therapists establish systems to ensure that plans of treatment are tailored to individual client abilities and changing needs. Ongoing facility education is required regarding the role of the Physical Therapy in preservation of functional skills for clients diagnosed with behavioral and mental illness.

In general, Physical Therapy goals need to address pain management, bal-

ance, gait, and the ability to complete functional ADLS. The goals must be discipline-specific with no duplication of services and/or treatment approaches.

PHYSICAL THERAPY CANDIDATE IDENTIFICATION

Appropriate candidates may be identified through screening for changes in cognitive, behavioral, mobility, balance, strength, functional skills, etc. Screens can be easily incorporated into any community activity (eg, exercise classes, crafts, bingo, etc.), hallway, or dining "rounds." Observation can also be completed during spontaneous interactions and/or other functional ADLS. Nursing staff, activities personnel, and interdisciplinary therapists are also readily available at these times to answer screening/data collection questions, which facilitates time efficiency and lends to accurate data collection. When incorporated at various times, with different caregivers and/or communication partners in diverse environments/situations throughout the day, subtle changes, behavior and mood patterns, responses to change, and functional performance will be observed.

TREATMENT PLANNING

Treatment planning for clients with behavioral and mental health illnesses typically focuses on restoration of skills, developing compensatory strategies for lost skills, capitalizing on spared skills, and adapting the environment or approach for successful functional performance.

When using the compensation approach to treatment, Physical Therapists should consider that their client may require cueing or assistance to optimize performance. The compensatory techniques most effective for the client must be identified. Physical Therapists also need to identify and educate their clients regarding the use of adaptive equipment for functional and/or leisure tasks. Training in compensatory strategies to assist the client in the performance of functional skills should be also provided. In addition, family/caregiver education and maintenance programs to facilitate carryover of learned compensatory techniques needs to be delivered.

The adaptation treatment approach involves caregiver learning to increase safety, quality of life, and decrease the burden of care. It is important to note that clients may have decreased learn-

ing potential. Thus, the Physical Therapist must identify strategies to prevent further deformities and/or dysfunction. The focus of treatment is on the adaptation of the environment to enhance function and caregiver education. Using this approach, plans for long-term care, and support should be implemented.

As the Physical Therapist designs the client's plan of care, she/he needs to consider other general treatment approaches to determine the client's strengths, weaknesses, and spared skills in the areas of ADLS, mobility, etc. The client must be provided with appropriate choices of activities to stimulate spared skills. This may result in decreased negative behaviors. The therapists should structure treatment sessions with simple repetitive activities as clients with behavioral and mental health concerns tend to perform familiar simple repetitive activities with greater ease. Physical Therapists must also set up Functional Maintenance Programs during which the client participates in and carries out as much of the program as possible. This eases caregiver burden, optimizes function, and may reduce behavioral outbursts. External memory aides need to be developed for clients with appropriate visual acuity and visual graphic skills. Memory aides can also be in the form of pictures, words, and color-coding in various combinations. The Physical Therapist should determine cueing methods most effective for the client's current communication level: tactile, visual, visual graphic, and/or auditory.

BEHAVIOR MANAGEMENT AND TEACHING STRATEGIES

Behavior management strategies must be incorporated into treatment sessions. A lot of what Physical Therapists encounter when working with clients with behavioral and mental health illnesses is managing the behaviors associated with these disorders. The treatment session should occur in a calm environment and distractions need to be eliminated. The session must focus on activities/tasks appropriate to level of resident to maintain highest functional skills. If the client becomes combative or non-compliant, the source of behavior (eg, loud noises, visual stimulus) needs to be identified before the treatment session can continue. Additionally, the therapist must establish methods of approach to the client to reduce behavioral episodes (eg, approach resident from front with

face-to-face contact versus coming from back, putting arm around resident). Alternative strategies, such as providing a structured daily routine, volunteers spending time with residents during their “most difficult” times for distraction, etc. may also be implemented. The client needs to be removed from an escalated situation. The Physical Therapist must avoid arguing with the client, especially about orientation. Instead the Physical Therapist should agree and/or reminisce with the client. Furthermore, the Physical Therapist needs to praise and encourage their client often. Finally, the Physical Therapist needs to ensure the client’s safety by removing obstacles, installing hand-rails, etc.¹¹

Physical Therapists must also identify the appropriate teaching method to use with the client. The following are different teaching strategies that may be used during a treatment session:

- Substitution – teaching a new set of responses to a given cognitive demand.
- Compensation – teaching an alternative response to a given cognitive demand.
- Control of Stimulus Complexity – controlling the stimuli to limit or increase the number or amount of stimulus input.
- Repetitive Materials Practice – using the same or similar materials in different situations.
- Anchoring – providing a resident with a cue as to where to begin a task.
- Elaboration – providing visual images or verbal mediation to assist the resident to pursue a task.¹¹

SKILLED PHYSICAL THERAPY TREATMENT TECHNIQUES

Epidemiological studies show that depression, stress-related conditions, long lasting musculoskeletal disorders, and anxiety affect millions of people worldwide often having negative consequences for their ability to work and quality of life.¹² People living with behavioral and mental health problems often have bodily oriented symptoms that warrant treatment from a Physical Therapist.¹³ Conditions like back pain, shoulder pain and injuries, arthritis, neuritis, sciatica, nerve injuries, and musculoskeletal injuries often affect intervention in individuals with behavioral and/or mental illness. Physical Therapists commonly work with patients to

alleviate pain correlated with the neck, shoulders, lower back, and knees.¹⁴ Research shows that individuals who receive regular Physical Therapy treatment experience greater improvement in function and decreased pain intensity.¹⁵ It is important to take into account that the behavioral and mental health deficits may impact a person’s ability to comply with recommendations and are important to take into consideration when establishing a plan of care or management program. The following are treatment ideas to consider when designing a Physical Therapy plan of care:

Gait

- Use of assistive device
- Assess client’s cognitive and physical ability to use an assistive device
 - Rolling walker vs. standard walker
 - Cane vs. hand-held assist
 - Is this a new device?
 - Ability to learn to use new device
 - Ability to re-learn to use current device
 - Is this the least restrictive device?
- Provide visual and proprioceptive/tactile cues
 - Demonstrate task while providing tactile cues
 - Provide tactile cues to trunk/hips/lower extremities during gait
- Provide safe environment/assess environment
 - Use proper footwear during gait
 - Lighting/nightlights
 - Remove environmental hazards
 - Rearrange room to facilitate safe mobility
 - Provide appropriate bathroom equipment
 - Properly maintain assistive device
 - Provide visual cues on wall/floor to increase safety/path recognition (eg, red feet/arrows from bed to bathroom, from room to dining room)

Bed Mobility and Transfers

- Environmental modification
 - Provide visual cues
 - Provide safe environment
 - Use appropriate bathroom equipment (eg, elevated toilet seats, grab bars) for transfers
 - Rearrange room to facilitate safe mobility (eg, dressers in corners, bathroom caddy on shelf vs. on floor, color contrast between bed and walls)

- Use of appropriate equipment (eg, trapeze bar, side rails)
- Adapt environment (eg, change height of bed, type of mattress used, remove chairs with low surfaces, rubber vs. glass picture frames)
- Properly maintain assistive device

Balance

- Postural response training
 - Ankle strategies: movements used to correct small perturbations on firm wide surfaces
 - Hip strategies: movement used to correct larger, faster perturbations or when support surface is smaller than the feet
 - Stepping strategies: step taken in any direction to prevent falls and realign base of support
 - Training strategies
 - Provide progressive therapeutic tasks to facilitate balance reactions/postural strategies
 - Provide visual and proprioceptive/tactile cues, demonstrate task while providing cues

Behavioral and mental health concerns can significantly impact an individual’s ability to engage in daily life activities that are meaningful and lead to productive daily routines. As the number of people living in nursing homes with serious mental illness, substance abuse, and severe behavior problems continues to increase, Physical Therapists working in long-term care settings need to be prepared in order to provide care for clients experiencing these concerns. Treatment approaches that consider behavioral and mental health treatment techniques provide clients with secondary diagnosis of mental illness the opportunity to achieve and maintain their highest level of function.

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Neely Sullivan has worked with residents living with behavioral and mental illness in a variety of clinical settings including skilled nursing and outpatient facilities and CCRCs/ILFs/ALFs. This experience and numerous courses have allowed her to treat and develop patient care programs for clients living with depression, posttraumatic stress disorder, dementia, bipolar disorder, schizophrenia, etc. She has also served in multiple levels of regional and corporate management positions. In these positions, Neely has developed policies and worked closely with interdisciplinary teams to ensure that clients living with behavioral and mental illness have the opportunity to attain their highest level of function and quality of life. She currently provides educational support to 6000 therapists nationwide as Director of Education for Select Rehabilitation.

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I have had a fall...

I CAN get up

1. Ease yourself up onto your elbows
2. Move onto your hands and knees
3. Hold onto a firm surface for support and pivot your bottom around
4. Slide into the chair and rest before trying to move

I CAN'T get up

- Can I attract attention?
 - Shout and bang something
 - Press your emergency pendant
 - Use the telephone if you can
- Can I get comfortable?
 - Find a nearby pillow, cushion or rolled up item of clothing to put under your head
- Can I keep warm?
 - Cover yourself with clothing, a tablecloth or rug
- Can I keep moving?
 - Move position to avoid getting pressure sores
 - Move joints to avoid stiffness and help circulation
 - Roll away from a damp area if your bladder "lets go"

Inform your doctor or health care professional about your fall as soon as you can

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NATIONAL FALL PREVENTION DAY

Mariana Wingood, DPT, PT, GCS, CEEAA

The first day of fall (September 22, 2016 this year) marks the 9th National Fall Prevention Day (FPAD). The purpose of the event is to raise awareness about how to prevent fall-related injuries among older adults. This year's event theme is Ready, Steady, Balance: Prevent Falls in 2016.¹ The event seeks to unite health care professionals, caregivers, and producers to work together and raise awareness and prevent falls in the older adult. Last year more than 70 organizations across 48 states participated.¹ This includes the Balance and Falls Special Interest Group as well as federal agencies that comprise the Falls Free Initiative.

For those who have participated in the past, it is time to start thinking and planning for FPAD 2016! For those who have never been involved, please reach out to your State Geriatric Advocate or the States Falls Free Coalition.

To find your State Advocates contact information online at www.geriaticsppt.org. Select "Members" tab, then "Contact Your State Advocate." If you are interested in being your State Advocate, or want more info about the program, contact the AGPT State Advocate Coordinator, Beth Black, PT, GCS, at BBlackPT@gmail.com

The following link brings you to your Falls Free Coalition: <https://www.ncoa.org/map/ncoa-map/> and choose falls prevention coalitions to find yours on the map.

Here are some ideas that have been done in the past:

- Fall Prevention Screening: Using the Center of Disease Control (CDC) Stop Elderly Accidents, Deaths, and Injury (STEADI) Screening Tool
- Attending Health Fares
- Presentations for the Community Dwelling Older Adults
- In-services: For Nursing Home Staff, Assisted Living Facilities, and Hospital Staff
- Informational Table Set Up at Your Clinic/Hospitals Entrance

- Table Set Up Within the Community
- Educate Local Doctors, Physician Assistants, and Nurses About the CDC STEADI Screening Tool
- Tai Chi Demonstrations

This year's goals:

- increase collaboration with PT/PTA students;
- increase interdisciplinary collaboration with OTs, COTAs, RN, Pharmacists, Podiatrists, and any other health care professionals; and
- educate primary care providers about the CDC STEADI Toolkit.

Resources

- National Council on Aging (NCOA)
—<https://www.ncoa.org/healthy-aging/falls-prevention/>
—NCOA's National Falls Prevention Resource Center supports the implementation of evidence-based falls prevention programs and serves as a national clearinghouse of tools and best practices
- CDC-STEADI Screening Tool and Educational Material
—<http://www.cdc.gov/steady/>
—STEADI's tools and educational materials will help you to:
 - identify patients at low, moderate, and high risk for a fall;
 - identify modifiable risk factors; and
 - offer effective interventions.
—Free Webinar: <http://www.cdc.gov/steady/webinar.html>
- Fall Prevention Center of Excellence
—<http://stopfalls.org/news-events/fall-prevention-awareness-week/>
—Identifies best practices in fall prevention and to help communities offer fall prevention programs to older people who are at risk of falling
—Has a great list and resources for planning a National Fall Prevention Day
- Balance and Falls Special Interest Group

- <http://geriatricspt.org/members/special-interest-groups/>
- Interdisciplinary letter templates that will help you contact your local health care professionals and invite them to join you in this effort
- Many more balance and falls resources

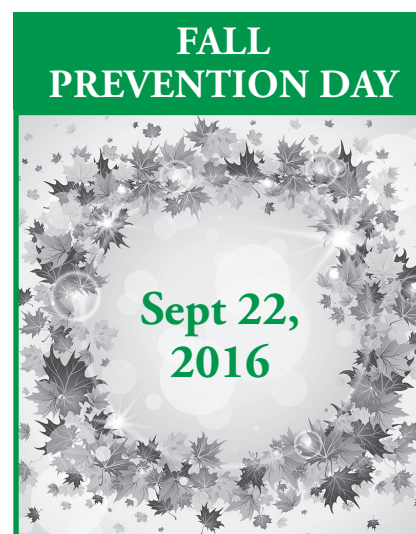
If you have any questions or comments, feel free to contact Mariana Wingood at mariana.wingood@outlook.com.

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Mariana Wingood is a physical therapist at University of Vermont Medical Center Inpatient Rehab. She is also the Balance and Falls SIG Chair and Vermont's State Advocate.



MEET JEREMY FOSTER, PTA

Michele Stanley, PT, DPT, GCS, CEEAA



A long time APTA member of the Academy of Geriatric Physical Therapy, Home Health Section, and newly elected PTA member at large of the Acute Care Academy, Jeremy Foster, PTA, has had a distinguished career while achieving advanced proficiencies in areas of Geriatrics, Integumentary, and Acute Care. "I believe that by working towards these Advanced Proficiencies I have gained much knowledge ...that has helped me provide evidence-based PT with a variety of different patients." He notes that being credentialed as a Clinical Instructor has also been very beneficial to both him and the students that he has supervised.

After high school, Jeremy worked as an orderly at a long-term care facility while going to college and taking classes toward a nursing degree. After a stint in the Desert Storm activated Army National Guard, he spent 3 years working as a Rehab Tech. Jeremy credits "working with a PT who had many years of experience who was willing to share his knowledge regarding the many benefits of PT and the joy that he had found in his career of helping people" as the guidance that he needed to switch courses

to physical therapy. He graduated from Salt Lake Community Colleges PTA Program in 1996.

He started his physical therapy career working for Professional Placement Resources, a contract company in Jacksonville Beach, Florida. He worked for one year with them and has only positive comments about that experience but then "PPS hit and the market dried up." Grenada Lake Medical Center, a 157-bed hospital in Mississippi, was his employer from 1998-2014 although during 1999-2011 he also worked at a local skilled nursing facility, Grace Health and Rehab. He was able to do this because hospital staff worked a 7 on and 7 off schedule. North Sunflower Medical Center, a 25 bed Critical Access Hospital in Ruleville, MS, became his alternate employer in 2011. Two years ago, for a different experience, Jeremy began to work for Mississippi Homecare doing home health. "All of these settings have assisted me in becoming a more knowledgeable PTA, helping me understand all the different settings in which PT is performed," he says.

What is his favorite work setting among so many experiences? "I can honestly say that I do not have a favorite work setting," Jeremy says. "Each work setting provides its own challenges and rewards. For instance, I really enjoy the one on one patient care in Home Health, but driving down a gravel road for 20 miles is no fun. "Jeremy says that irrespective of work setting, he teaches basic pelvic floor exercises to all of his patients: hip adduction with ball squeezes and gluteal squeezes, always coaching them to breathe during every exercise and smile as much as they can."

Olivia, age 7, and Abigail, 2, provide non-work experiences in Jeremy's life (along with wife, Gwen) as does playing tennis 2 to 3 times/week, run-

ning, and letting the computer beat him at chess. Jeremy is active in his faith community, enjoys sharing details of his financial recovery using the Dave Ramsey plan, and travels back to Gwen's native Philippines for several weeks every other year or so.

"I would like for every PT and PTA to think about how powerful of an organization we could become if we were all members of the APTA. I am not always in agreement with APTA policies, but I continue to be a member because overall the APTA is the voice for PT. We need to increase our membership to increase our ability to promote the profession and to fight the Washington battles."



Michele Stanley is a clinical education specialist for Evergreen Rehabilitation and staff physical therapist at St. Mary's Hospital in Madison, WI. Dr.

Stanley has practiced in the areas of acute care, home health, skilled nursing, and private practice.

PTAs MOVING FORWARD IN THEIR CAREERS: THE NEW AND MOST EXCITING PATHWAYS TO THE FUTURE!

Ann Lowrey, PTA; Marangela Prysiazny Obispo, PT, DPT, GCS

There is exciting news for the future of the Physical Therapist Assistant! The American Physical Therapy Association (APTA) is moving forward with the Advanced Proficiency Pathways (APP) program and The Academy of Geriatric Physical Therapy (AGPT) is developing a new course: *Advances in Exercise for the Aging Adult: A PTA Focus Course*.

The APP program for PTAs is now the post-graduation program to promote PTAs' career development and proficiency. This program is a step above the former APTA PTA Advanced Proficiency Program. As an APP program participant, the PTA will be assigned a program mentor by APTA to work with a Physical Therapist clinic mentor and complete content specific courses specially geared towards advanced proficiency. The PTA will work closely with the program mentor to ensure that course work is in-depth and beyond entry-level. The courses completed in the APP program will be required to have a posttest or be an onsite course that is accepted by the APTA. The program mentor will help determine which core courses will be accepted in the chosen content area. Skills assessments will be conducted by the Physical Therapist clinic mentor in which the PTA will have the opportunity to demonstrate clinical competence. The APP program is designed to be completed in 3 to 5 years and the available content specific areas include Geriatrics, Acute Care, Cardiopulmonary, Oncology, Orthopaedics, Pediatrics, and Wound Management. The PTAs have asked the following questions, *I don't work with a geriatric specialist to be my clinic mentor; can I still participate? I work in home health and don't see my clinic mentor every day; can I still enroll? I may move or change jobs in the middle of the program; will I need to start over?* The answer is, No worries! The APTA provides the clinic mentor with all the tools necessary for

skills assessments. In case the program participant needs to change jobs or relocate to a different area, the APTA will re-assign a new mentor and bring them up to speed. The next APP application cycle will open May 1, 2016. Please visit www.apta.org/APP for an enrollment application and more information.

The Academy of Geriatric Physical Therapy has a number of continuing education courses for the PTA to use towards the APP. The PTAs can purchase the Geriatric Focus 2012 and Topics 1-6 for the PTA (LMSK-0008) via the APTA Learning Center at www.apta.org. Topics 1-6 modules cover Geriatric Rehabilitation, Musculoskeletal System, Neuromuscular System, Cardiovascular & Cardiopulmonary Systems, Integumentary System, and Diabetes & Endocrine System. In addition, PTAs may also participate in the new onsite course currently being developed by AGPT that is specifically designed for the Physical Therapist Assistant. *Advances in Exercise for the Aging Adult: A PTA Focus Course* is "a 2-day course that will focus on the Physical Therapist Assistant's (PTA) use of exercise as an advanced rehabilitation intervention for the aging adult. Several common functional outcome measures will be actively performed by participants or demonstrated by instructors. The physical stress theory regarding proper exercise intensity will be presented. PTAs will learn how to utilize this concept in exercise programs for aging adults, as indicated by the physical therapy (PT) plan of care (POC), for aerobic conditioning, balance, gait, and strength training. A variety of diagnoses commonly treated in aging adults will be reviewed and discussed relative to the application of exercise principles, treatment progression, and precautions. A discussion of barriers and motivation strategies to assist the aging adult in achieving goals will be included. The course will include both lecture and

hands-on practical lab activities" (AGPT PTA Course Development Committee). This course will be launched soon!

The American Physical Therapy Association and the Academy of Geriatric Physical Therapy work continuously to create opportunities for PTAs to move forward in their career. Being a member of the professional association will provide the PTA with the right tools for advancement, which makes PTA membership so valuable. We encourage all PTAs to participate in the APP program and to stay tuned for more information about the new onsite course, *Advances in Exercise for the Aging Adult: A PTA Focus Course*.



Ann Lowrey works full time in a private owned outpatient clinic in Franklin, PA, and per-diem for Aegis Therapies in Oil City, PA. She currently serves as the PTA Advocate with the Academy of Geriatric Physical Therapy and PTA Advanced Proficiency Work Group Co-coordinator. She can be reached via e-mail at annlowreypta@gmail.com.



Marangela Prysiazny Obispo is PTA Program Director at Keiser University Miami Campus. She is also an adjunct faculty for the Post-Professional Geriatric Physical Therapy Residency Program at St. Catherine's Rehabilitation Hospitals in Miami, Florida. She currently serves as PTA Advanced Proficiency Work Group Co-coordinator. She can be reached via e-mail at mobispo@keiseruniversity.edu.

ESSAY FOR THE AGPT GERINOTES

March 11, 2016

Jillian Tanych, SPT, EP-C
University of Vermont DPT
Class of 2017
APTA Student Assembly Board of
Directors Secretary
APTA Brand Champion
aptasa.secretary@gmail.com

This year's APTA Combined Sections Meeting (CSM) took place in Anaheim, California. As a member of the APTA Student Assembly Board of Directors (SABoD), I had the honor of attending CSM with the purpose of representing our Student Assembly of physical therapy and physical therapy assistant students. My position on the board is that of Secretary as well as the SABoD liaison to the Academy of Geriatric Physical Therapy and the Education Section. As the Secretary and section liaison, my duties include organizational responsibilities such as following formal protocols for minutes and organizing tasks but more importantly, engaging students within the APTA through communication on involvement opportunities.

My primary responsibility at CSM was to represent the SABoD at the APTA Student Neighborhood, which involved educating students on involvement opportunities on the national, state, chapter, and section levels. Our goal of the SABoD is to help students find a home within the APTA through membership, advocacy, communication, and involvement opportunities. At CSM I was able to attend the following events: Component Leadership Meeting, ABPTS Opening Ceremony, CSA Meeting for delegates, Student Assembly Board of Directors Meeting, and the Student Assembly Forum on communication. These events allowed myself and my fellow board members to make long-lasting connections with leaders of our profession. Our Board of Directors has also been making progress with our SABoD Strategic Plan and

has been successful in connecting with students to discover the best ways in which the APTA may communicate information with them.

The geriatric population has always held special importance to me. Because of my love for this population, I was appointed the SABoD liaison to the AGPT. At CSM I had the pleasure of attending some of the AGPT events as mentioned above. At the Opening Ceremony, I was able to congratulate the newly recognized Geriatric Clinical Specialist while also considering attending a Geriatric Residency program post-graduation. At the AGPT Breakfast, I was able to continue recognizing Geriatric Clinical Specialists and gain inspiration from our AGPT leaders while also meeting other AGPT members. Lastly, at the AGPT Member's Meeting & Awards Ceremony, I had the honor of meeting many more students, clinicians, and leaders who are passionate about the geriatric population including AGPT President Bill Staples, PT, DHSc, DPT, GCS, CEEAA.

One moment that stuck out to me was at the AGPT Member's Meeting & Awards Ceremony when Tamara N. Gravano, PT, DPT, GCS, CEEAA, received her award. I had originally met Tamara at the APTA National Student Conclave 2014 after being encouraged by other students to network with those who share similar interests. Tamara has indirectly and positively impacted my desire to work with the geriatric population and to be involved with leadership in the future through her accomplishments as a Geriatric Certified Specialist, the former Chair of the Membership Committee, and the current Chair of the Residency & Fellowship SIG. I hope that at the upcoming National Student Conclave 2016 (Miami, FL), as well as CSM and NEXT, students will have the same opportunities to network with AGPT members and leaders in order to form

those lasting relationships that are vital for us to advance the profession while providing the best care for our patients.

CSM 2016 simply ignited the spark for my professional development in clinical care and leadership. To say the least, this conference inspired me to pursue further education and leadership within the realm of the AGPT. Each and every AGPT leader and member has become a role model for not only myself, but many other students as well. On behalf of the Student Assembly, I thank you for reaching out to us, including us in your meetings and events, sponsoring us to attend APTA events, and creating countless opportunities for us to be involved with the geriatric population.



Jillian Tanych is a second year student physical therapist from Lyndonville, VT. She attends the University of Vermont and is the representative of her DPT class. Jillian is the APTA Student Assembly Board of Directors Secretary and serves as the Board's liaison to the Academy of Geriatric Physical Therapy.

FIGHTING FRAILITY: A CALL TO ACTION

*Katie Fandrey, PT, DPT, CLT; Joshua Mewwisen, PT, DPT;
Kristen Reed, PT, DPT; LaDora V. Thompson, PhD, PT*

INTRODUCING FRAILITY

Benjamin Franklin once said, “An ounce of prevention is worth a pound of cure.” Historically, America’s health care system focuses on curing diseases and disabilities. However, physical activity and exercise have the power to prevent many of the primary diseases and disabilities that concern Americans. Physical therapists are the movement and exercise specialists of the health care world. This places us in a unique position to lead the way on preventative care. In the push for preventative care, we are calling all physical therapists working in geriatrics to consider placing their focus on identifying and treating frailty in older adults.

Frailty is a clinical syndrome that is defined as “a late-life vulnerability to adverse health outcomes.”^{1(p185)} Frail individuals have a reduced capacity to cope with everyday stressors, or a lack of resiliency. It occurs along a continuum of severity: at one end is a pre-frail condition and at the other is an end-stage condition.² Pre-frailty is a condition in which an individual is transitioning from a robust state to one of frailty.³ End-stage frailty is a condition that presages death.² An individual with end-stage frailty is unable to cope with even the smallest stressors. Frailty often leads to acute illness, decreased functional mobility, falls, delirium, and institutionalization.⁴ In other words, frailty is a gateway to the negative outcomes that health care professionals are working to treat. Fortunately, frailty might be reversible, or at least attenuated, by physical therapy interventions.⁵ Therefore, it is vital to the preventative care movement that physical therapists be able to identify pre-frail and frail individuals.

Although often misused, frailty is distinctly different from the terms sarcopenia, comorbidity, and disability. Sarcopenia is defined as age-related decline in muscle mass that contributes to disability, frailty, and falls.⁶ Frailty is a broader term than sarcopenia. It address-

es muscle loss as well as other physiological factors such as weakness, weight loss, exhaustion, low activity, and slowness.⁷ Comorbidity is defined as the presence of two or more chronic medical conditions such as arthritis, hypertension, or diabetes.⁷ A comorbid individual may not experience any of the symptoms of frailty. For example, an individual could have well-controlled hypertension and diabetes. Since both are well controlled, the individual is not more vulnerable to stressors than those without comorbidities. Disability is defined as difficulty in activities of daily living.⁷ An individual with a spinal cord injury who is wheelchair bound may have difficulty with activities of daily living, but otherwise be perfectly healthy and no more vulnerable to stressors than those without a disability. A study by Fried et al⁷ suggested that disability, comorbidity, and frailty are distinct by demonstrating that 26.6% of frail individuals are neither comorbid nor disabled.

In the push for preventative care, we are calling all physical therapists working in geriatrics to consider placing their focus on identifying and treating frailty in older adults.

It is important that physical therapists are able to distinguish between frailty and other terms. Correctly defining the terms will help to develop the optimal plan of care for all patients. Physical therapy intervention for sarcopenia will focus on progressive resistance exercise to build muscle mass. Intervention for disability will emphasize task training. Intervention for comorbidities will be specific to the comorbidities. However, a plan of care that addresses frailty will be more comprehensive. It must include strengthening to reduce weakness, endurance training to reduce fatigue, creating a home exercise program to increase daily physical activity, and gait training

to increase walking speed. A comprehensive treatment plan that addresses all the components of frailty has the power to reduce an individual’s vulnerability to stressors and preserve overall health and physical function.

Physical therapists working in geriatrics will undoubtedly see frail individuals in their practice. We need to be able to define and recognize frailty in order to treat it. The prevalence of frailty in the United States is between 4% and 17%. Furthermore, it is more prevalent in persons older than 80.⁵ According to the Center for Disease Control and Prevention, frailty is as, or more, prevalent in the United States than congestive heart failure (1.5%),⁸ diabetes (9.3%),⁹ and Alzheimer’s disease (1.5%).¹⁰ Thus, it is a relevant diagnosis in older adults that warrants our attention. Despite its prevalence in old age, it is important to note that is not an unavoidable consequence of aging. Between two-thirds and three-quarters of individuals who are 85 years and older are not frail.⁴

In addition to being prevalent, frailty is a costly medical diagnosis. Robinson et al¹¹ found that total medical expenses for 6 months following an elective colorectal surgery increased with advancing frailty. In their study, individuals classified as frail spent \$110,702 ± \$67,705 in the 6 months following colorectal surgery. Pre-frail individuals spent \$51,650 ± \$21,569. And, non-frail individuals spend \$33,543 ± \$17,870.¹¹ This demonstrates that frail individuals have difficulty coping with a stressor such as colorectal surgery; therefore, they require additional medical attention that skyrockets the medical costs and hinders quality of life.

QUANTIFYING FRAILITY

Historically, frailty has been quantified into 3 primary frameworks: a phenotype, a deficit accumulation index, and biological markers. The Cardiovascular Health Study (CHS) developed and operationalized the first framework:

the phenotype of frailty. It is a prospective, observational study of 5,317 older adults.⁷ The authors classified frailty as the presence of 3 or more of the following components: weight loss, weakness, poor endurance, slowness, and low physical activity level. For clarity, Fried et al⁷ defined each of these components. Weight loss is an unintentional loss of 10 or more pounds, or 5% or more of body weight, in the prior year. Weakness is determined based on assessing grip strength. In order to be considered weak, grip strength must be in the lowest 20% at baseline after being adjusted for gender and body mass index. Poor endurance is indicated by a self-report of exhaustion as identified by two questions from the CES-D scale. Slowness is based on walking speed. An individual must be in the slowest 20% of the population after being adjusted for gender and height. And finally, low physical activity level is a weighted kilocalorie score based on the amount of kilocalories expended per week at the individual's baseline.

The second primary framework is the Frailty and Deficit Accumulation Index. This index counts deficits in individuals. According to Rockwood and Mitnitski,¹² the deficits are determined based on symptoms, signs, laboratory abnormalities, diseases, and disabilities based on the Comprehensive Geriatric Assessment (FI-CGA). The FI-CGA facilitates the identification of health issues and appropriate interventions based on the following: cognitive and emotional status, motivation, health attitude, communication (hearing, speech, vision), strength, mobility, balance, elimination, nutrition, activities of daily living (ADLs), instrumental activities of daily living (IADLs), sleep, social engagement, home environment, and caregiver relationship. The total number of items that can be used in the frailty index is 80. The frailty index score is calculated by dividing the number of deficits by the total number of deficits considered.¹¹ According to the authors, an individual is more at risk for adverse health outcomes and an increased risk of death if a higher number of deficits are accumulated. They also determined that individuals who obtained a frailty index score of greater than 0.55 have a median survival rate that is much lower than the average person.

The third primary framework uses biological markers of ageing to define frailty. Mitnitski et al¹³ examined a biomarker-based frailty index (FI-B). The authors analyzed baseline data and mortality (up to 7 years) in the Newcastle 85+ Study. The FI-B combines 40 different biomarkers of cellular ageing, inflammation, hematology, and immunosenescence. The FI-B is based on a score from 0 to 1. According to Mitnitski et al,¹³ if FI equals zero, then the individual has no deficits present. If FI equals one, then every deficit is present. An FI-B greater than the median score of 0.33 is strongly associated with 7-year mortality. Interestingly, researchers found that the FI-B was more powerful than any individual biomarker in predicting mortality.¹²

Each of the 3 primary frameworks quantifies frailty through a unique lens when assessing individuals. However, they all quantify frailty as a multifactorial clinical syndrome. A diagnosis of frailty will lead to the need for a comprehensive treatment plan in order to prevent a lack of resiliency and decline in function.

As physical therapists, we hold an optimal position to screen our patients for frailty. In contrast to the 3 primary frameworks, the following screening tools have been shown to be simple, validated, and quick to assess: simple "FRAIL" questionnaire screening tool, CHS frailty screening measure (Fried scale), clinical frailty scale, and the Gerontopole Frailty Screening tool. The simple "FRAIL" questionnaire consists of 5 simple questions that can easily be incorporated into an initial evaluation. Each question gains information on a patient's fatigue, resistance, ambulation, illness, and weight loss.⁵ In order to be categorized as frail the patient must report "yes" to 3 or more questions. An individual who answers "no" to one or two questions would be categorized as pre-frail.⁵

The CHS frailty screening measure also consists of 5 criteria. These include exhaustion, unintentional weight loss, grip strength, walking speed, and energy expenditure.⁵ The criteria for categorizing an individual as pre-frail or frail is the same as the simple "FRAIL" questionnaire. According to Morley et al,⁵ the CHS screening measure dem-

onstrates predictive validity. Clinicians may use this scale to identify frailty, risk for falls, hospitalizations, disability, and death. Research has shown that the CHS screening measure may identify frail older adults across the continuum of care from those who are hospitalized to community-dwelling populations.

The Clinical Frailty Scale is based primarily on clinical judgment. When applying the Clinical Frailty Scale, the clinician places the individual on an 8-point scale from very fit (1) to terminally ill (9) based on a patient's diagnosis and current function.⁵ The Clinical Frailty Scale is also the only screening measure that includes descriptions of where an individual may fall on the frailty scale based on their degree of dementia.

Finally, the Gerontopole Frailty Screening Tool consists of 6 "yes/no" questions that include an individual's living situation, weight loss, fatigue, mobility, memory, and gait speed.⁵ If the individual answers "yes" to any of the questions, then the clinician classifies the individual as frail based on their clinical judgment.

As physical therapists it is our duty to screen older adults for frailty. Each of the screening tools has been shown to be a valid measure for screening frailty. They are quick and easily incorporated into an older adult's initial evaluation. Screening for frailty will help physical therapists to determine the appropriate course of action and allow for optimal health and quality of life in our patients.

FRAILTY AND THE FUTURE OF PHYSICAL THERAPY PRACTICE

Historically, physical therapists are very well branded in rehabilitation. This is because of the professional areas of expertise, the level of education, and the conditions and environments under which physical therapists practice. While it is a role that is legitimate and fitting, rehabilitation is reactionary by nature. Since 2011 in the United States, 10,000 individuals turn 65 years old on a daily basis.¹⁴ Physical therapists are in an optimal position to expand our roles as *proactive* health care providers, allowing us to ease the current and projected demands of an aging population on the health care system.

Frailty is one area where future physical therapists can become more

proactive providers and ease the burden of a major health problem facing the aging American population. When it comes to fighting frailty, physical therapists have the tools, expertise, and the ability to make a difference in the lives of older adults. In order to be successful against frailty, health care providers *must* be proactive and cannot afford to be reactive. Once an individual crosses over the threshold into the realm of frailty, returning to a functional, self-sustaining level of existence can be a significant struggle and even impossible in some instances.

Advocating for earlier access to physical therapy services will help lessen the steepness of the curve of decline that faces our pre-frail older adults. It would be beneficial for physical therapists to spend time and resources (eg, financial or physical) to keep individuals as active and independent as long as possible. Alternatively, letting individuals continue down the slippery slope of aging without having been screened for frailty by a qualified physical therapist results in worse outcomes, increased physical decline, increased financial and caregiver burden, and impaired quality of life. Imagine a situation where an individual's main goal is to be able to return to walking after relying on a wheelchair for locomotion for two years. Muscular and neuromuscular deconditioning, as well as cardiovascular and other organ system decline, takes time and significant physical resources to improve in individuals who are not frail. If an individual crosses over the threshold into frailty, then the physical resources it will take to regain lost functional abilities make recovery an even greater challenge. Timely physical therapy intervention is a far more effective and efficient tool to prevent this individual from having to rely on a wheelchair in the first place, curbing the descent to frailty before it becomes too late.

Fortunately, the aforementioned screening tools are very accessible and can be easily implemented into a physical therapy evaluation. This paper is a challenge to physical therapists to consider including gait speed, grip strength, weight loss, and activity and/or exhaustion questionnaires into evaluations to screen older adults for frailty. These measures are time efficient, research supported measures for markers of frailty

and pre-frailty. Once an individual is identified as pre-frail or frail, patient-specific physical therapy interventions can target impairments to improve patients' functional independence. Furthermore, physical therapists can market health and wellness programs to prevent further functional decline.

We encourage physical therapists to consider screening for frailty across the continuum of function. The need to screen for frailty may be more apparent in someone who has suffered a stroke; however, as a profession we can keep community dwelling older adults independent, mobile, and healthy for as long as possible by performing routine, time-efficient screens and delivering timely interventions. Education regarding the importance of screening for frailty will benefit clinicians, patients, and community dwelling older adults.

Even an individual who is a resident of a more intensive care facility can be educated about the benefit of transitioning from an "illness" model of managing their symptoms and guiding their recovery to a "wellness" model through community fitness and/or regular exercise. Education may include the importance of continuing to remain active in order to stave off frailty as long as possible. Exercise is an essential part of improving quality of life and facilitating resilience, which can be addressed through physical therapy intervention.

It is important that current and future physical therapists are aware of the impact of frailty on negative health outcomes, decreasing independence, quality of life, and mortality. Identifying and appropriately treating pre-frail individuals has the power to add years of independence and improve the quality of life for older adults. Screening and treating the underlying factors that can lead to frailty are ways that we, as physical therapists, are able to live out the APTA's vision statement. The APTA also lists guiding principles that can help us, as a profession, to achieve this vision. These guiding principles are very applicable to clinicians working against frailty. By providing accessible, consumer-centric, inter-disciplinary, and innovative care and screening, we can optimize movement and improve the human experience in our patients who require our help and attention the most. We encourage physical therapists to be

in the business of vitality. We have a unique skill-set and educational background that can facilitate conversation and intervention to make a positive difference in the lives of older adults.

Physical therapists have a duty to optimize movement to improve the health of society. The APTA's vision statement is: "transforming society by optimizing movement to improve the human experience."¹⁵ For physical therapists working in geriatrics, this means addressing frailty. Frailty is a major barrier in the overall health and quality of life in America's older adults. Physical therapists have the expertise to fight frailty and improve the human experience for our generation of older adults.

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ADDRESSING FALL PREVENTION IN FRAIL ELDERS WITH PT LEAD GROUPS IN PACE

Susan Musicant, DPT

PACE

First, what is PACE (Program of All-inclusive Care for the Elderly)?

It is Medicare Advantage 2016 version, which began as federal program in 1990. Yes, but it is more and also less.

More because PACE offers a comprehensive interdisciplinary team (IDT) of medical professionals (social worker, OT and PT and ST, physician, home health nurse, clinic nursing, activity program, and transportation) all housed in one place—a day center with full medical and rehab clinic. PACE provides and pays for all services of Medicare A, B, and D and a number of other features and services that are not provided by those payment sources.

Less because only “qualified seniors” can join. Qualifications include over 55 years old, “nursing home eligible,” safe community (non-SNF) housing, and generally both Medicare and Medicaid eligible. If not Medicaid eligible, participants are required to pay a monthly fee out of pocket—an amount comparable to SNF costs.

The PACE mission is to provide comprehensive integrated services as described above, thereby supporting frail elders to remain living in the community.¹

I have been working in PACE for the past 20 years. I consider myself very fortunate, privileged, even. I can treat our patients (we call them “participants”) on an ongoing basis even if they are not improving but need skilled PT to maintain their current level of function.² Productivity is not measured in minutes. Goals are not measured in only “objective” measurements. In addition to skilled treatment, we have an ongoing maintenance exercise program run by in-house trained and therapist-supervised rehab aides. Rehab therapists are required to re-evaluate each participant every 6 months. And last but not least,

the rehab therapist collaborates with the IDT in transitions from acute hospitalizations, to SNF rehab placements and home again, greatly enhancing continuity of care which maximizes outcomes significantly.

The power of working in groups to achieve physical therapy goals:

Human beings are social. Elders are frequently deprived of social interaction and support, resulting in depression and all the detrimental physical responses to depression: collapsed posture, decreased activity, increased problems with chronic pain, vicious cycle of falls, and fear of falls. The circular reinforcement of social isolation and all these other mutually reinforcing problems is profound. Skilled physical therapy group work can address these issues and help elders to rise out of the sense that these problems are inevitably part of aging. Here the skills and knowledge of a physical therapist can provide exercise and education perhaps more than other professional that works with frail elders to address risk for falls.⁵ It is key that each participant in the group is evaluated a head of time by the physical therapist, so that the therapist can enhance safe participation.

Individuals with acute musculoskeletal issues need to be guided to avoid painful or provocative positions but still feel their participation, however limited, will enhance their over all well-being and ability to remain independent. Using progressive balance challenges, high intensity resistive exercise, posture and breathing retraining, music and a home exercise program pamphlet supplementation we can see real improvement in balance outcome measures such as functional reach, TUG, and fall frequencies.⁴ Additionally we see social interaction and mutual empowerment of participants that can powerfully address the vicious cycle of falls and fear of falls.

A Fall Prevention Exercise Group in PACE: Center for Elders Independence, Oakland, California:

In a PACE setting, there is the opportunity for physical therapist lead exercise groups. This author has been running an exercise group for several years with a focus on fall prevention. The group is conducted in the “activities” room, since there is not another large enough space in the center. Even in this less controlled environment, in PACE, this is possible, and amazingly valuable. Randomly controlled studies done have shown the value of this format for treatment of balance impairments and fall risk in frail elders.³

At Center for Elders Independence, PACE Oakland “I’ll Never Fall Again” a PT Lead Fall Prevention Exercise Group:

Here is a window into the group the authors runs every Wednesday at our PACE center in Oakland, California—“Center for Elders Independence.” The original impetus for the group was through a grant from county program on aging. The grant was for teaching *caregivers* how to teach an exercise group for fall prevention using evidence-based methods. (*It was clear to me that activity aides or other support staff could not easily learn to lead this kind of group, that is when I started doing this.*) The grant required pretests of TUG and a 4-meter walk test to get baseline measures. These assessments were then repeated after 8 weeks of a one time per week group exercise program using the recommended exercises and techniques to facilitate group work. The author chose Wednesday because there was a large group of Hispanic women on that day and the author thought it would be a cohesive group.

It was immediately evident that the social support the participant’s received from each other enhanced their participation in and benefit from the exercises. Though the project for the grant ended

after 8 weeks, the enthusiasm for the group grew and attracted more people. It was clear our rehab department was too small. We moved into the activities room with a larger and less homogenous group.

Two years later, the author still leads this group every Wednesday, same time and same place. A pamphlet was created by the author for participants to take home from photos taken of participants doing the exercises and reinforcing the exercises and basic fall prevention strategies — in English and Spanish, “I’ll Never Fall Again”**. I set up additional smaller groupings to present the pamphlet and reinforce the concepts presented there.

The format is basically the same for each session. The author always starts the group with a focus on dynamic posture. In sitting, it is the preference for participants to place their hands on their chest which facilitates lifting their chest (creating increased thoracic extension) with inhalation. The author conveys with her movement, her voice, and her connection with each participant the “joy of movement”...from deepened relaxed breathing, to opening their posture to enable increased unimpinged shoulder range of motion to high intensity resistance band exercises of upper and lower extremities. During the half hour we have for the group, we progress from posture/breathing to high intensity exercise of key muscle groups done in sitting (rotator cuff, ankle eversion, as well as basic large muscles involved in stand balance and ambulation), to standing exercises focused on dynamic balance and standing endurance. It is a physically and emotionally energetic session enhanced by my personal and physical knowledge of each person and the power of a positive well-run group.

Not every individual present in our day center wants to or can participate. But surprisingly that is a small percentage of people. Retrospectively looking at the Timed Up and Go (TUG) scores that is part of every 6 months physical therapy evaluation for each participant in our program, a positive trend is evident, providing some objective measure of the value of this half hour once a week, with a home exercise component (Table). And beyond that there is the testimony of participants and their eager participation.

Table. Results of Retrospective Assessment

Number of participants	At initial grouping 4/8/14 - 6/2/14	Group in day center begun ~ 9/15 - 2/20/16
	8 (all women)	27 (6 men, 21 women)
Ages of participants	67-89	66-89
Total number of falls in this period (falls with fractures)	12 (3 with fractures)	29 (5 with fractures)
Changes in TUG score*	+19 sec	+9 sec
Changes in FR score*	+8"	-4"
Approximate number of sessions (weekly)	90 weeks	70 weeks

Abbreviations: TUG, Timed Up and Go; FR, functional reach

*Changes in TUG and FR scores based on simple addition of “changes” for all participants

Another Fall Prevention Dance-Based Therapy/Group Exercise Program in PACE: Alexian Brothers, St. Louis, Missouri:

A 6 week, 3 time per week pilot program was begun using a dance intervention model called The Lebed Method (TLM). From the write up of their RCT study published in *Nursing Administration Quarterly*,⁴ they note that there is evidence-based research suggesting dance based therapy for fall prevention. They used “participant specific music.” They customized the “steps” to speak to the history and interests of the participants as well as address the “specific balance and mobility outcomes” they were aiming for. Using fall risk (FR) and TUG they showed “positive trends” at the end of the 6 weeks. Since the completion of this pilot study, this PACE center has “expanded their program to all participants.” This study has been recognized in University of Missouri-Columbia Health Sciences Research Symposium, 2009. Of note here, their exercise group leaders are not all therapists but have been trained in a 3-day TLM certification course.

PT Group Treatment Outside of PACE:

Unfortunately studies show gains made in individualized treatment are often not carried over posttreatment.^{6,7}

In addition, opportunities for physical therapist lead groups exercise for frail elders are very limited because of Medicare and Medicaid reimbursement policy. This is an unmet need. In other parts of the world, there are more government sponsored exercise and fall prevention programs for seniors. These include PT lead group exercise programs with high quality outcome studies showing their efficacy.⁸ In the United States, unfortunately, most frail elders do not receive comprehensive services like these which could prevent or delay institutionalization.

Annotated bibliography

See below an annotated bibliography of “fall prevention in community dwelling frail elders:” including informative literature about PACE, highest level evidence-based fall prevention strategies, and dealing with the challenges of exercise adherence in this population.

**“I’ll Never Fall Again,” pamphlet created by this author from photos of participants in exercise fall prevention group at CEI 2014-2015.

Please feel free to contact me if this an area of PT you are interested, either group exercise programs or PACE — or if you have experiences with programs like this you want to share.

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PACE is a unique model of care begun in 1971. As of 1997 PACE is a permanent Medicare provider throughout the country and rapidly growing. This program provides integrated and comprehensive geriatric care and financing, helping frail elders maintain community housing with family or in assistive living facilities.

2. Drummond-Dye R. Dispelling the myth of maintenance care: Jimmo v Sebelius: the implications of a court ruling on the “improvement standard.”. *PT in Motion*. v.5, no.8, 2013;5(8):44.

This article addresses a court ruling on Medicare “improvement standard” that has been the basis for denying treatment for continued therapy if there is no evidence of improvement. In this ruling, if it can be shown that “skilled treatment” is necessary to maintain or prevent decline, “then those reasonable and necessary services shall be covered” — to begin no later than January 2014.

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This systematic review (based on 10 studies) compares outcomes of group-based exercise with various control groups (3 of the studies compared with therapist prescribed home exercise programs as their control) demonstrates there is preliminary evidence that group programs have better compliance and better outcomes in fall rate, balance, and fear of falling.

4. Krampe J, Rantz MJ, Dowell L, Schamp R, Skubic M, Abbott C. Dance-based therapy in a program of all-inclusive care for the elderly: an integrative approach to decrease fall risk. *Nurs Adm Q*. 2010;34(2):156-161. doi: 10.1097/NAQ.0b013e3181d91851.

At a PACE program in St. Louis, Missouri (Alexian Brothers Community Services PACE), they carried out a longitudinal study of a group exercise program (based on a particular type of “therapeutic dance” called Lebed Method) done 3 times per week for 6 weeks. Their outcome measures of Functional Reach, and Timed up and Go, demonstrated a positive trend in improved function from their small sample.

5. Sherrington C, Tiedemann A, Close JC, Lord SR, Exercise and Sports Science Australia. Exercise and Sports Science Australia position statement on exercise and falls prevention in older people. *J Sci Med Sport*. 2011;14(6):489-495. doi: 10.1016/j.jsams.2011.04.001. Epub 2011 May 14.

This position paper gives an excellent summary of results of contemporary studies relevant to fall prevention for older adults: Role of exercise is known to be the single intervention that by itself is most effective for preventing falls. The most effective exercise is found to be balance retraining. Dosage has been studied and recommended: Obviously it must be ongoing and 2 hours per week. Issue of adherence is crucial. Factors such as social interaction, strong leadership and positive health message encourage compliance.

6. Forkan T, Pumper B, Smyth N, Wirkkala H, Ciol MA, Shumway-Cook A. Exercise adherence following physical therapy intervention in older adults with impaired balance. *Phys Ther*. 2006;86(3):401-410.

This study looked at 556 older adults. 90% received a HEP. 37% reported no longer doing it. This study based on a survey looks at factors involved in these outcomes such as lack of belief in exercise safety, lack of social support,

depression, to name some of the factors cited here.

7. Jack K, McLean SM, Moffett JK, Gardiner E. Barriers to treatment adherence in physiotherapy outpatient clinics: a systematic review. *Man Ther*. 2010;15(3):220-228. doi: 10.1016/j.math.2009.12.004. Epub 2010 Feb 16.

This systematic review attempts to identify barriers to exercise adherence for outpatient PT programs. Their conclusion is that those that need it the most (low levels of physical activity, low self-efficacy, depression, poor social support) are the most likely to benefit the least.

8. Iliffe S, Kendrick D, Morris R, et al. Multicentre cluster randomised trial comparing a community group exercise programme and home-based exercise with usual care for people aged 65 years and over in primary care. *Health Technol Assess*. 2014;18(49):vii-xxvii, 1-105. Doi: 10.3310/hta18490..

The outcome of a large scale population study in England run for 24 months and followed up for an additional 24 months had as a primary outcome “achievement of the current physical activity recommendations” with secondary outcomes of improvement in number of falls and reduced fear of falls.



Susan Musicant graduated in the last Physical Therapy class from Stanford University in 1985. I have been working in a PACE for the last 20 years. Program of

All-inclusive Care of the Elderly is a dual eligible (Medicare and Medicaid), capitated, all-inclusive care program. It is supported and regulated under Medicaid “Community Based Long-Term Services & Supports.” Last year I completed a DPT at Rocky Mountain University of Health Professions.

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