Geriatric

Physical Therapy

Description of Specialty Practice

Specialty Council on Geriatric Physical Therapy

American Board of Physical Therapy Specialties

The *Geriatric Description of Specialty Practice* was prepared by the members of a subject matter expert group and members of the Specialty Council on Geriatric Physical Therapy and approved by the American Board of Physical Therapy Specialties of the American Physical Therapy Association.

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Throughout this document, the editors have attempted to use language consistent with the *Guide to Physical Therapist Practice* and universally accepted concepts and terminology, without bias to any particular philosophy or school of thought. The references cited with the case scenarios are given only to help the reader understand the specific examples and are not intended to favor any particular school of thought or philosophy. In addition, these references are *not* intended to be inclusive.

The Specialty Council on Geriatric Physical Therapy encourages your suggestions for improvement of this document. Your input and suggestions will be considered in the development of the next revision. This is a working document and will be modified as necessary.

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Specialty Council on Geriatric Physical Therapy

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Introduction

History of Specialization in Physical Therapy

In 1975, the House of Delegates of the American Physical Therapy Association (APTA) approved the concept of specialization and created the Task Force on Clinical Specialization. The task force was charged with identifying and defining physical therapy specialty practice areas and with developing the structure for and function of a Board-certified process.

The document developed by the task force, "*Essentials for Certification of Advanced Clinical Competence in Physical Therapy*," was adopted by the House of Delegates in 1978. At that time, the House recognized four specialty areas: cardiovascular/pulmonary, neurology, orthopedics, and pediatrics.
In 1979, the House appointed the Commission for the Certification of Advanced Clinical Competence. Specialty councils for each of the four specialty areas were appointed by the commission and charged with the development of competencies unique to the advanced clinician in their respective areas.

In 1980, the Commission became the Board of Certification of Advanced Clinical Competencies (BCACC). The House of Delegates recognized two more specialty areas that same year: sports and clinical electrophysiology. In 1985, the "Essentials for Certification of Advanced Clinical Competence in Physical Therapy" was revised by the House of Delegates and the title was changed to "Essentials for Certification of Physical Therapist Specialists." The BCACC was renamed the American Board of Physical Therapy Specialties (ABPTS), and the first specialty examination was administered in cardiovascular/pulmonary physical therapy that same year. The specialty area of geriatrics was approved in 1989. In June of 2006, the APTA House of Delegates approved Women's Health as the newest area of physical therapist specialty practice.

History of Specialization in Geriatric Physical Therapy

The Section on Geriatrics published its first report on specialization in geriatric physical therapy in 1982.[1] In 1984 Wharton conducted a study that identified advanced-level tasks and the knowledge, skills, and attitudes needed for competent practice by physical therapists who work with geriatric patients.[2] In 1987 the Section on Geriatrics appointed a specialization task force, chaired by Bonnie Teschendorf. In 1989 the APTA House of Delegates accepted the Section on Geriatrics' petition in support of geriatric specialization. Andrew Guccione, PT, PhD, FAPTA, Marybeth Brown, PT, PhD, and Rita Wong, PT, EdD, were appointed as the first members of the Specialty Council on Geriatric Physical Therapy. The council surveyed selected members of the Section on Geriatrics and members of other sections who were considered content experts in the competencies originally identified in the Wharton study and the Teschendorf task force. These survey data were used to fully develop the competencies that were subsequently approved by the American Board of Physical Therapy Specialties (ABPTS) in June 1990. The first geriatrics specialist certification examination was given in February 1992.[3]

The original *Geriatric Physical Therapy Competencies* were based on the work of Wharton and were divided into seven areas: (1) biology, psychology, and sociology of aging; (2) patient care; (3) communication; (4) education; (5) administration; (6) consultation; and (7) scientific inquiry.1 Since 1989 major changes have occurred in the field of geriatrics and gerontology. For example, the science of age-related and pathological changes with aging has increased; the knowledge of physical therapy examinations and interventions has grown; and the settings and regulations in practice have changed. By the mid-1990s these changes were so pervasive that the specialty council felt strongly that the original framework might not be adequate to revalidate geriatric specialty practice. Therefore, a panel of past and current members of the Specialty Council on Geriatric Physical Therapy met in Washington, DC, in April 1996 to discuss a framework for the new *Description of Advanced Clinical Practic*e (DACP). Those who attended this meeting were Rita Wong, Marybeth Brown, Andrew Guccione, Jill Johnson, PT, MS, GCS, Linda Crews, PT, MHS, GCS, and Kathleen Kline Mangione, PT, PhD, GCS. This group constituted the subject matter experts (SME) for the revalidation study. The day-long meeting resulted in a consensus decision that the framework for the DACP would be *A Normative Model of Physical Therapist Professional Education: Version 97*[4] and the *Guide to Physical Therapist Practice*.[5] Laurita Hack, PT, PhD, FAPTA, was the survey consultant.

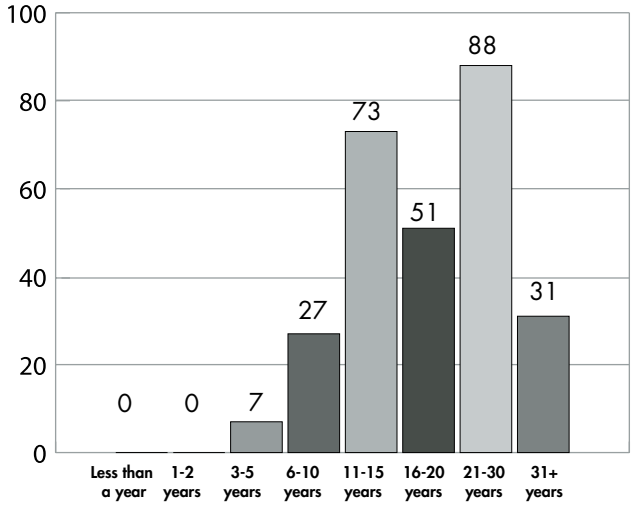
References

1. Greenwald NF. Educational activities related to geriatrics in physical therapy. *Geritopics*. 1982;5(3):9-10.
2. Wharton MA. *Identification of Advanced Level Performance Tasks in Geriatric Physical Therapy* [master's thesis]. Pittsburgh, PA: University of Pittsburgh; 1985.
3. Guccione AA, Brown M, Wong RA. *Geriatric Physical Therapy Specialty Competencies*. Alexandria, VA: American Board of Physical Therapy Specialties; 1990.
4. *A Normative Model of Physical Therapist Professional Education: Version 97*. Alexandria, VA: American Physical Therapy Association; 1997.
5. Guide to Physical Therapist Practice. *Phys Ther*. 1997;77:1163-1650.

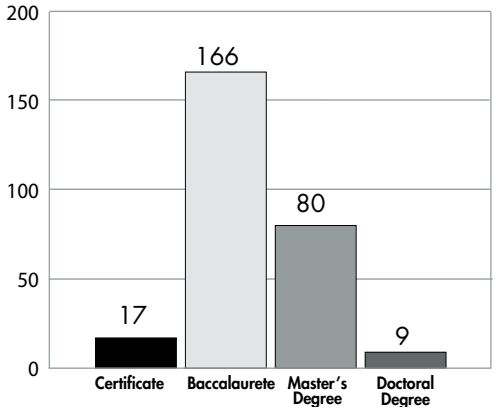
Chapter 1: Description of Board-Certified Specialists in Geriatric Physical Therapy

The practice analysis survey drew responses from 395 practitioners, including 277 Board-certified specialists (GCS) and 118 noncertified Geriatrics Section (GS) members. The following statistical information is based on the GCS survey respondents. While ABPTS collects similar data on all newly board-certified or recertified specialists, this survey sample (51 % response rate) represents the most current descriptive information on geriatric clinical specialists.

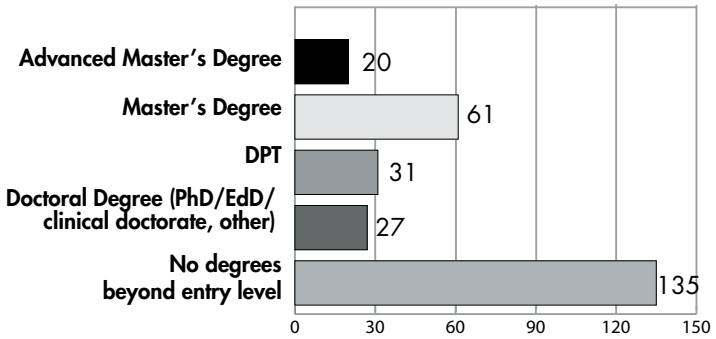
1. Years of practice in physical therapy



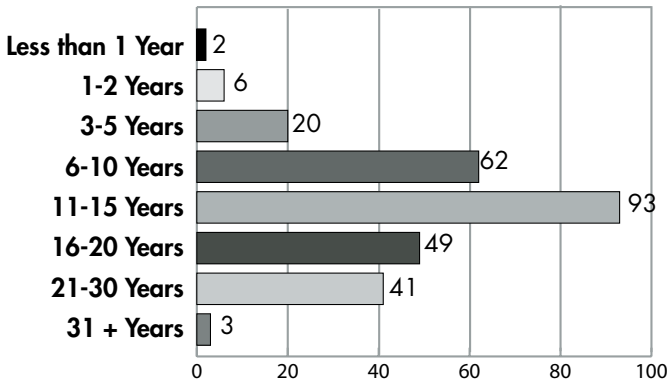
2. Level of education at entry into the profession



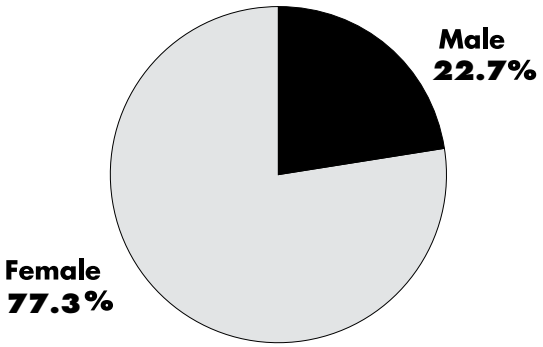
3. Highest-earned academic degree



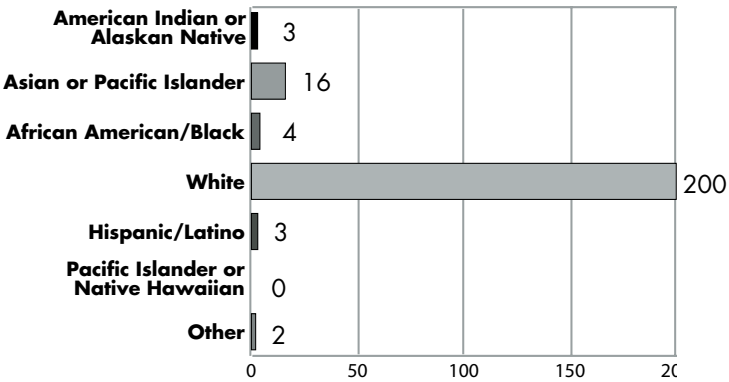
4. Years of practice in geriatric physical therapy



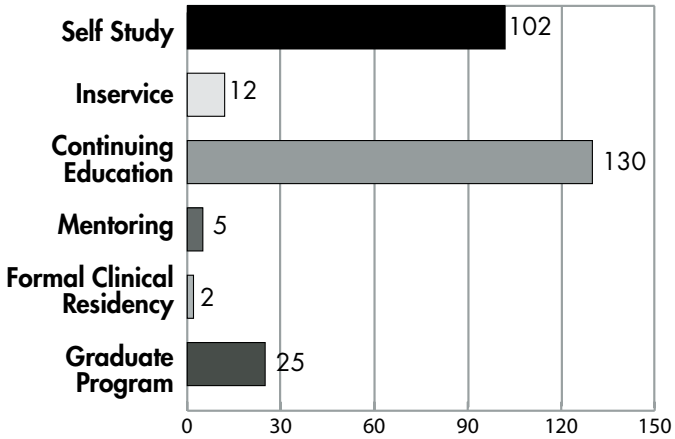
5. Sex



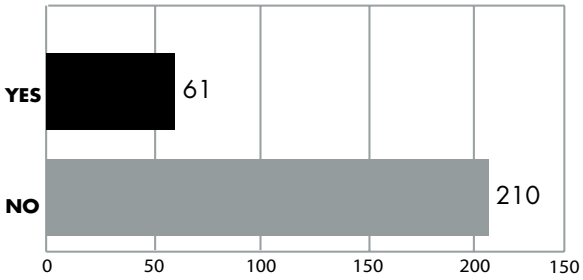
6. Race/ethnic origin



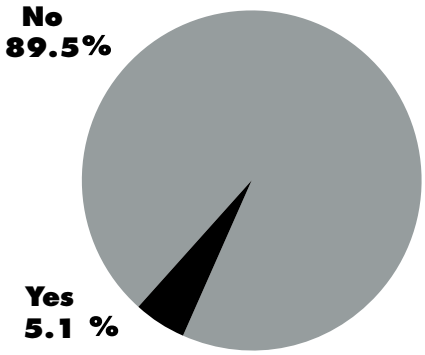
7. Educational method most used to develop geriatric clinical skills



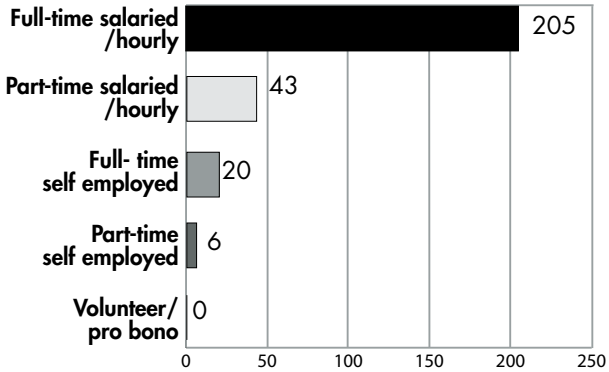
8. Have you been recertified?



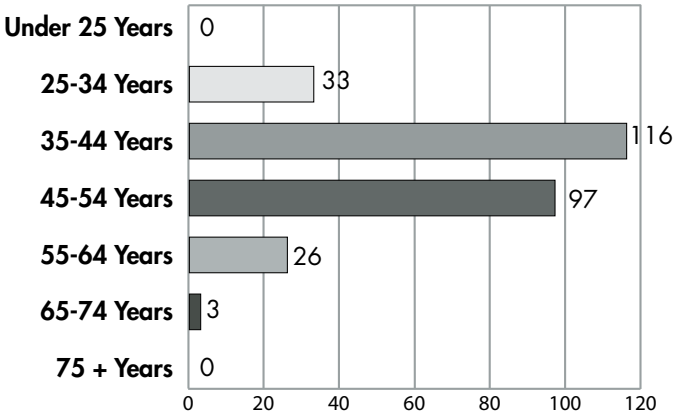
9. Do you have another board certification?



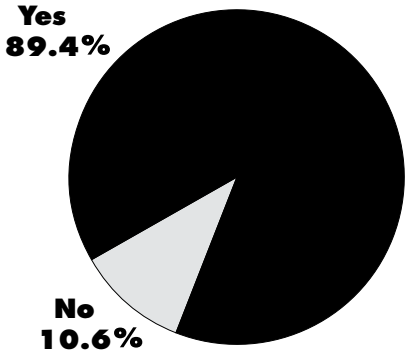
10. What is your primary current employment status?



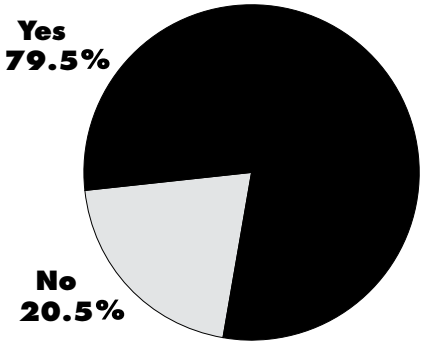
11. Age



12. Are you an APTA member?



13. Are you a member of the Section on Geriatrics?



Chapter 2: Description of Specialty Practice

The Description of Specialty Practice (DSP) describes the practice of geriatric clinical specialists. It is based on the results of a practice analysis survey conducted in 2007. The results of responses from 395 specialist and nonspecialist Section on Geriatrics members are presented in the following document.

The content of the practice analysis survey was based on the *Guide to Physical Therapist Practice*,[1] including the patient/client management model categories of examination, evaluation, diagnosis and prognosis, intervention, and outcomes. In addition, the Professional Roles, Responsibilities, and Values were based on *Professionalism in Physical Therapy: Core Values*[2] as well as the 1999 version of the *Description of Advanced Clinical Practice* (DACP) for geriatrics.[3] The Knowledge Areas section was based on the DACP and *A Normative Model of Physical Therapist Professional Education.*[4]

The DSP represents specialty practice, which includes all elements of practice at entry to the profession. Only the elements considered to be specialty practice, either in frequency, importance, or level of judgment are included here.

I. Knowledge Areas of Geriatric Clinical Specialists

A. Foundation Sciences

- Biology of aging
- Physiology of aging
- Neurophysiology
- Anatomy
- Neuroanatomy
- Pathophysiology
- Cellular biology (eg, phases of soft tissue healing, tissue makeup, changes with aging, response to exercise)

B. Clinical Sciences

- Pharmacology
- Kinesiology
- Pathokinesiology
- Exercise physiology
- Bariatric medicine
- Interpretation of special tests (eg, imaging, lab values)
- Principles of physical therapy evaluation and treatment of geriatric patients with musculoskeletal, neuromuscular, cardiovascular, cardiovascular/pulmonary, integu mentary, or cognitive impairments
- Physical therapy management of healthy elders

C. Behavioral Sciences

- Psychology of aging
- Sociology of aging
- Economics of aging
- Demography
- Epidemiology of chronic disease
- Elements of communication
- Theories of learning
- Principles of adult education
- Teaching methodology
- Management techniques and principles
- Principles of financial management
- Reimbursement mechanisms
- Policy issues in aging
- Consultant role and process
- Roles of interdisciplinary team members
- Program development
- Evidence-based practice

II. Professional Roles, Responsibilities, and Values of Geriatric Clinical Specialists

A. Professional Behavior

The physical therapist practicing as a geriatric clinical specialist exhibits the following behaviors reflecting the core values of a professional by:

- Demonstrating professional behavior in interactions (eg, family meetings, written instructions, end of life discussions, care transitions) with patients, clients, families, caregivers, other health care providers, students, other consumers, and payers.
- Adhering to legal practice standards, including federal, state, and institutional regulations related to patient or client care and fiscal management.
- Practicing ethical decision making that is consistent with the American Physical Therapy Association's Professional Code of Ethics.
- Participating in peer-assessment activities (eg, performance appraisals, student evaluations, chart reviews).
- Demonstrating sensitivity (cultural, religious, and social) in professional interactions.
- Interacting with patients, clients, family members, other health care providers, and community-based organizations for the purpose of coordinating activities to facilitate efficient and effective patient/client care.
- Promoting geriatric physical therapy as an autonomous practice.
- Participating in the advancement of the physical therapy profession.

B. Professional Development

The physical therapist practicing as a geriatric clinical specialist demonstrates professional development by:

- Formulating and implementing a plan for personal and professional development in geriatric physical therapy, based on self-assessment and feedback from others.
- Enhancing knowledge and skill in geriatrics by participating in continuing professional development (eg,

advanced degrees, certification, continuing education seminars, self study, journal clubs, residency education).
- Participating in gathering evidence for practice in geriatrics.

C. Communication

The physical therapist practicing as a geriatric clinical specialist exhibits effective communication by:
- Using active listening.
- Respectfully communicating (written and oral) with patients, clients, family, caregivers, practitioners, consumers, payers, and policy makers.
- Respecting cultural differences during communication.

D. Social Responsibility

The physical therapist practicing as a geriatric clinical specialist demonstrates social responsibility by:
- Displaying generosity as evidenced by the use of time and effort to meet patient or client needs.
- Demonstrating social responsibility, citizenship, and advocacy including community organizations (eg, clubs, Special Olympics, Senior Olympics, Arthritis Foundation).
- Providing physical therapy services to underserved and underrepresented populations to include pro bono work.

E. Leadership

The physical therapist practicing as a geriatric clinical specialist demonstrates leadership by:
- Actively participating in professional organizations and activities related to geriatric physical therapy.
- Maintaining current knowledge of the activities of national and international physical therapy organizations related to geriatrics (eg, AARP, National Osteoporosis Foundation, White House Council on Aging, International Association of Physical Therapists Working with Older People).
- Representing physical therapy and interacting with other professionals and organizations in activities related to physical therapy for geriatric patients (eg, Blueprint on Aging, Fall Free Summit, AARP, American Geriatric Society).
- Promoting development of and participation in clinical residency programs in geriatric physical therapy.

F. Education

The physical therapist practicing as a geriatric clinical specialist demonstrates ability to educate others by:
- Using appropriate teaching methods, and providing evidenced-based geriatric physical therapy educational programs to a variety of audiences including students, other health care professionals, the public, state and nationally elected officials, political groups and political candidates, and third-party payers.
- Mentoring physical therapists, physical therapist assistants, and students by participating in clinical education and research related to geriatric physical therapy.

G. Administration

The physical therapist practicing as a geriatric clinical specialist demonstrates administrative ability by effectively:
- Remaining current in reimbursement and regulatory issues regarding public policy and delivery of services across geriatric care settings.
- Remaining current in changes to economic drivers of health care.

H. Consultation

The physical therapist practicing as a geriatric clinical specialist demonstrates consultation through:
- Promoting successful aging by providing information on wellness, impairment, disease, disability, and health risks related to age, gender, culture, and lifestyle.
- Providing expert consultation about geriatric issues to individuals, businesses, educational institutions, government agencies, legal entities (eg, expert testimony), media outlets, and other organizations.
- Meeting the needs of the geriatric patient/client through active involvement on multidisciplinary teams, while respecting each team member's role.

I. Advocacy

Physical therapist specialists advocate for successful aging through direct patient care interventions, through education, through service, through research, through legislation, and through the development of community resources for geriatric patients/clients. Specifically, physical therapist specialists in geriatrics:
- Assist geriatric patients/clients in obtaining access to health care and physical therapy services.
- Attempt to make the health care delivery system more responsive to the needs of geriatric patients/clients.
- Aid geriatric patients/clients in developing the skills to advocate for themselves.
- Assist geriatric patients/clients in gaining access to all resources to assist in understanding their health condition and managing it.
- Provide health promotion information to patients/clients and the public.
- Disseminate evidence-based information to patients/clients, colleagues, other health care providers, and research agencies.
- Seek opportunities to advocate for geriatric issues with policy and law-making bodies (eg, White House Conference on Aging, Long Term Care Summit, political action committees).

J. Evidence-based Practice

The physical therapist practicing as a geriatric clinical specialist demonstrates evidence-based practice through:

- Critically evaluating new information associated with geriatric physical therapy including techniques and technology, legislation, policy, and environments related to patient/client care.
- Critically evaluating research findings specific to geriatric physical therapy practice.
- Applying principles of evidence-based practice in geriatric physical therapy practice (examination, evaluation, diagnosis, prognosis and intervention).
- Participating in collaborative or independent research to contribute to the science associated with geriatric physical therapy practice.
- Participating in other scholarly activity that advances the practice of geriatric physical therapy (eg, outcomes studies, literature reviews).

III. Practice Expectations for Clinical Specialists in Geriatrics in the Patient/Client Management Model

A. Examination

The physical therapist practicing as a geriatric clinical specialist demonstrates examination by:

- *History*

1. A systematic gathering of data from both the past and the present related to why the patient/client is seeking the services of the physical therapist. Obtain patient history through interview and data from other sources (eg, questionnaires, medical records, test results specific to geriatric patient issues) including:
   a) a medication interview
   b) health status (eg, comorbidity, nutrition, depression, patient's/client's self report, family's or caregiver's report)
   c) social environment (eg, living situation, family structure, abuse)
   d) functional status and activity level
   e) previous therapeutic efforts for this or related problems and their success or failure

- *Systems Review*

1. Assess physiological and anatomical status (eg, cardiovascular/pulmonary, integumentary, musculoskeletal and neuromuscular systems).
2. Appropriately examine communication affect, cognition, language, and learning style of patient/client.

- *Tests and Measures*

1. Select and prioritize tests and measures based on history, systems review, scientific merit, clinical utility, and physiologic or fiscal cost to patient/client relative to criticality of data.
2. Perform tests and measures to include:
   a) Aerobic Capacity/Endurance
      - Aerobic capacity during functional activities (eg, activities of daily living [ADL] scales, indexes, instrumental activities of daily living [IADL] scales, observations)
      - Aerobic capacity during standardized exercise test protocols (eg, ergometry, step tests, time/distance walk/run tests, treadmill tests, oxygen titration, wheelchair tests)
      - Cardiovascular signs and symptoms in response to increased oxygen demand with exercise or activity, including pressures and flow; heart rate, rhythm, and sounds; oximetry; and superficial vascular responses (eg, angina, claudication, and perceived exertion scales; electrocardiography; observations; palpation; sphygmomanometry)
      - Pulmonary signs and symptoms in response to increased oxygen demand with exercise or activity, including breath and voice sounds; cyanosis; gas exchange; respiratory pattern, rate, and rhythm; and ventilatory flow, force, and volume (eg, auscultation, dyspnea and perceived exertion scales, gas analyses, observations, oximetry, palpation, pulmonary function tests)
      - Effects of other medical and pharmacological interventions on aerobic capacity/endurance (eg telemetry, pacemaker, cardiac medications)

   b) Arousal, Attention, and Cognition
      - Arousal and attention (eg, adaptability tests, arousal and awareness scales, profiles, questionnaires)
      - Cognition, including ability to process commands (eg, safety awareness checklists, management of home exercise program, interviews, mental state scales, observations, questionnaires)
      - Communication and language barriers (eg, functional communication profiles, interviews, inventories, observations, questionnaires, assessment of expressive/receptive aphasia)
      - Consciousness, including agitation, dementia, delirium, and coma (eg, clinical signs and symptoms, scales)
      - Motivation and capacity to participate in intervention
      - Orientation to time, person, place, and situation (eg, attention tests, learning profiles, mental state scales)
      - Recall, including memory and retention (eg, assessment scales, interviews, questionnaires)

   c) Assistive and Adaptive Devices

   The physical therapy specialist in geriatrics performs

tests and measures to determine the potential benefits and use of assistive/adaptive devices based on knowledge of ADA guidelines on accessibility and based on patient mobility and ability to perform tasks. These tests and measures include:

- Assistive or adaptive devices and equipment use during functional activities (eg, ADL scales, IADL scales interviews, observations)
- Components, alignment, fit, and ability to care for the assistive or adaptive devices and equipment (eg, interviews, logs, observations, pressure-sensing maps, patient/caregiver reports)
- Remediation of impairments, functional limitations, or disabilities with use of assistive or adaptive devices and equipment (eg, activity status indexes, ADL and IADL scales, aerobic capacity tests, functional performance inventories, health assessment questionnaires, pain scales, videographic assessments, assessments of energy conservation and energy expenditure)
- Safety during use of assistive or adaptive devices and equipment (eg, diaries, fall scales, interviews, logs, observations, patient/caregiver reports)
- Assessment of financial resources/community resources to assist in obtaining devices and equipment and home modification

d) Circulation (Arterial, Venous, Lymphatic)

- Cardiovascular signs, including heart rate, rhythm, and sounds; pressures and flow; and superficial vascular responses (eg, auscultation, electrocardiography, girth measurement, observations, palpation, sphygmomanometry, ankle/brachial index, perceived exertion scales)
- Cardiovascular symptoms (eg, angina, claudication)
- Lymphatic system function (eg, girth and volume measurements, palpation, observation of skin texture)
- Physiological responses to position change, including autonomic responses, central and peripheral pressures, heart rate and rhythm, respiratory rate and rhythm, ventilatory pattern (eg, auscultation, electrocardiography, observations, palpation, skin color changes, sphygmomanometry, pharmacological signs and symptoms)

e) Environmental, Home, and Work (Purposeful Activity) Barriers

- Current and potential barriers (eg, checklists, interviews, observations, questionnaires)
- Physical space and environment (eg, ADA compliance standards, observations, photographic assessments, questionnaires, structural specifications, technology-assisted assessments, videographic assessments)
- Home assessment (eg, standardized tests for home assessment/modification ie. Functional Home Assessment Profile)
- Assessment of willingness to change and fiscal resources to bring about change

f) Ergonomics and Body Mechanics

- Ergonomics related to common diagnoses seen in the geriatric population (eg lighting, seating devices, computer screens with regard to bifocals, deformities and postural changes related to arthritis and ROM changes associated with aging)
- Body mechanics during self-care, home management, work, community, or leisure actions, tasks, or activities (eg, ADL and IADL scales, observations, photographic assessments, technology-assisted assessments, videographic assessments)
- Body mechanics with caregiver activities (eg, observation, environmental assessment, patient handling equipment needs)

g) Gait, Locomotion, and Balance

- Balance during functional activities with or without the use of assistive, adaptive, orthotic, protective, supportive, or prosthetic devices or equipment (eg, ADL scales, IADL scales, observations, videographic assessments, confidence indexes)
- Balance (dynamic and static) with or without the use of assistive, adaptive, orthotic, protective, supportive, or prosthetic devices or equipment (eg, balance scales, dizziness inventories, dynamic posturography, fall scales, motor impairment tests, observations, photographic assessments, postural control tests)
- Gait and locomotion during functional activities on various surfaces with or without the use of assistive, adaptive, orthotic, protective, supportive, or prosthetic devices or equipment, footwear assessment (eg, ADL scales, gait indexes, IADL scales, mobility skill profiles, observations, videographic assessments)
- Gait and locomotion with or without the use of assistive, adaptive, orthotic, protective, supportive, or prosthetic devices or equipment (eg, footprint analyses, gait indexes, mobility skill profiles, gait parameter scales, observations, photographic assessments, technology-assisted assessments, videographic assessments, weight-bearing scales, wheelchair mobility tests)
- Safety during gait, locomotion, and balance (eg, confidence scales, diaries, fall risk assessment scales, functional assessment profiles, logs, reports)

h) Integumentary Integrity
- Activities, positioning, and postures that produce or relieve trauma to the skin (eg, observations, pressure-sensing maps, scales)
- Assistive, adaptive, orthotic, protective, supportive, or prosthetic devices and equipment that may produce or relieve trauma to the skin (eg, observations, pressure-sensing maps, risk assessment scales, techniques and devices used to reduce skin trauma with transfers)
- Skin characteristics, including blistering, continuity of skin color, dermatitis, trophic changes, mobility, sensation, temperature, and turgor (eg, observations, palpation, photographic assessments)

i) Integumentary Integrity/Wound Assessment
- Activities, positioning, and postures that aggravate the wound or scar or that produce or relieve trauma (eg, observations, pressure-sensing maps, pressure relief techniques)
- Signs of infection (eg, cultures, observations, palpation)
- Wound characteristics, including bleeding, contraction, depth, drainage, exposed anatomical structures, location, odor, pigment, shape, size, type, staging and progression, tunneling, and undermining (eg, digital and grid measurement, grading/classification, observations, palpation, photographic assessments, wound tracing)
- Wound scar tissue characteristics, including banding, pliability, sensation, and texture (eg, observations, scar-rating scales)
- Periwound assessment

j) Joint Integrity and Mobility
- Joint integrity and mobility (eg, apprehension, compression and distraction, drawer, glide, impingement, shear, and valgus/varus stress tests; arthrometry; palpation; capsular pattern)
- Joint play movements, including end feel (joints of the axial and appendicular skeletal system) (eg, palpation, accessory movements, special tests)
- Joint movement and functional activities (eg, pain assessment and/or alleviation, quality, substitution, orthotic needs)

k) Motor Function (Motor Control and Motor Learning)
- Dexterity, coordination, and agility (eg, coordination screens, motor impairment tests, motor proficiency tests, observations, videographic assessments)
- Initiation, modification, and control of movement patterns and voluntary postures (eg, activity indexes, gross motor function profiles, neuromotor tests, observations, physical performance tests, postural challenge tests, videographic assessments)

l) Performance (including strength, power and endurance)
- Muscle strength, power, and endurance (eg, dynamometry, manual muscle tests, muscle performance tests, physical capacity tests, technology-assisted assessments, timed activity tests)
- Muscle strength, power, and endurance during functional activities (eg, activities of daily living [ADL] scales, functional muscle tests, instrumental activities of daily living [IADL] scales, observations, videographic assessments)

m) Sensory Integration
- Sensorimotor integration, including postural, equilibrium, and righting reactions (eg, motor and processing skill tests, observations, postural challenge tests, reflex tests, sensory profiles, visual perceptual skill tests)

n) Orthotic, Protective and Supportive Devices
- Components, alignment, fit, and ability to care for the orthotic, protective, and supportive devices and equipment (eg, interviews, logs, observations, pressure-sensing maps, reports)
- Orthotic, protective, and supportive devices and equipment use during functional activities (eg, activities of daily living [ADL] scales, functional scales, instrumental activities of daily living [IADL] scales, interviews, observations, profiles)
- Remediation of impairments, functional limitations, or disabilities with use of orthotic, protective, and supportive devices and equipment (eg, activity status indexes, ADL scales, aerobic capacity tests, functional performance inventories, health assessment questionnaires, IADL scales, pain scales, videographic assessments)
- Safety during use of orthotic, protective, and supportive devices and equipment (eg, diaries, fall scales, interviews, logs, observations, reports)

o) Pain
- Pain, soreness, and nociception (eg, angina scales, analog scales, discrimination tests, pain drawings and maps, provocation tests, verbal and pictorial descriptor tests)
- Pain in specific body parts (eg, pain indexes, pain questionnaires, structural provocation tests)
- Analysis of pain behavior and reaction(s) during specific movements and provocation

p) Posture
- Postural alignment and position (static and dynamic), including symmetry and deviation from midline (eg, grid measurement, inclinometery, observations, height assessment, videographic assessments)

q) Prosthetic Requirements
- Components, alignment, fit, and ability to care for the prosthetic device (eg, interviews, logs, observations, pressure-sensing maps, skin checks, reports)
- Prosthetic device use during functional activities (eg, activities of daily living [ADL] scales, functional scales, instrumental activities of daily living [IADL] scales, interviews, observations)
- Remediation of impairments, functional limitations, or disabilities with use of the prosthetic device (eg, aerobic capacity tests, oximetry, activity status indexes, ADL and IADL scales, functional performance inventories, health assessment questionnaires, fear of falling scales, pain scales, technology-assisted assessments, videographic assessments)
- Residual limb or adjacent segment, including edema, range of motion, skin integrity, and strength (eg, goniometry, muscle tests, observations, palpation, photographic assessments, skin integrity tests, technology-assisted assessments, videographic assessments, volume measurement)
- Safety during use of the prosthetic device (eg, diaries, fall scales, interviews, logs, observations, reports)

r) Self-Care and Home Management (Including ADL and IADL)
- Ability to gain access to home environments (eg, barrier identification, observations, physical performance tests)
- Ability to safely perform self-care and home management activities (eg, ADL scales, aerobic capacity tests, IADL scales, interviews, observations, fall scales)

s) Ventilation and Respiration/Gas Exchange
- Pulmonary signs of respiration/gas exchange, including breath sounds (eg, gas analyses, observations, oximetry)
- Pulmonary symptoms (eg, dyspnea ,perceived exertion, observation, indexes, and scales)

t) Work (Job/School/Purposeful Activity), Community, and Leisure Integration or Reintegration (Including IADL)
- Ability to assume or resume work (purposeful activity), community, and leisure activities with or without assistive, adaptive, orthotic, protective, supportive, or prosthetic devices and equipment (eg, activity profiles, disability indexes, functional status questionnaires, IADL scales, observations, physical capacity tests)
- Ability to gain access to work (purposeful activity), community, and leisure environments (eg, barrier identification, interviews, observations, physical capacity tests, transportation assessments)
- Safety in work (purposeful activity), community, and leisure activities and environments (eg, diaries, fall scales, balance assessment, interviews, logs, observations, dexterity and coordination assessment, videographic assessment, environmental assessments)
- Re-examination

Respond to emerging data from examinations and interventions by performing special tests and measures to evaluate progress, modify or redirect intervention

B. Evaluation

Evaluation is the dynamic process of clinical judgment in interpreting examination data. The physical therapist practicing as a geriatric clinical specialist demonstrates evaluation by:
- Interpreting data from examination (eg, identify relevant, consistent, accurate data; prioritize impairments; assess patient's needs, motivations, and goals)
- Determining when signs and symptoms that indicate referral to a physician or another health care provider is appropriate, based on specialized knowledge of geriatric physical therapy

C. Diagnosis

The physical therapist practicing as a geriatric clinical specialist demonstrates diagnosis by:
- Based on evaluation, organizing data into recognized clusters, syndromes, or categories
- Establishing differential diagnoses based on awareness of diseases, disorders and conditions that affect geriatric patients
- Establishing differential diagnoses based on awareness of diseases, disorders, and conditions that can mimic prevalent practice patterns in geriatric clients and determine the need to refer these clients to other health care providers
- Determining diagnostic practice pattern(s) that guide future patient/client management and are amenable to physical therapy interventions
- Considering physiological changes and atypical presentations with aging that are specific to the diagnostic process

D. Prognosis

Determine the level of optimal improvement that may be attained through intervention and the amount of time required to reach that level. Also includes plan of care. The physical therapist practicing as a geriatric clinical

specialist demonstrates prognostication by:

- Utilizing knowledge of examination, evaluation and diagnosis to determine patient client prognosis
- Considering the long-term prognostic effect of normal age-related changes and comorbidities
- Considering the prognostic effect of medical, social, and occupational history
- Considering the prognostic impact of other medical interventions (eg, implanted devices, pumps, radiation therapy, chemotherapy)
- Considering the prognostic impact of depression, dementia, and other psychosocial issues (eg, grieving, recent loss) when determining prognosis
- Considering the prognostic effect of pharmacological interventions (eg, prescribed medications, over the counter medications, herbal supplements)
- Consideration of the prognostic effect of cultural considerations (eg, values, beliefs, ethnicity, religion, spirituality, sexual orientation, and special populations)
- Considering the patient's personal goals as they relate to the prognosis.
- Developing a plan of care that:
  1. Prioritizes interventions related to the diagnosis, recovery process, patient/client goals, outcomes data, and resources
  2. Takes safety and patient/family/caregiver concerns/living arrangements and financial situation into consideration
  3. Includes achievable patient/client outcomes within available resources and according to the administrative policies and procedures of the practice environment
  4. Considers quality of life in regard to end-of-life wishes, transitions, and advanced directives (eg, quality of life scales)

E. Intervention

The physical therapist practicing as a geriatric clinical specialist demonstrates intervention by:

- *Coordination, Communication, and Documentation*
  1. Interacting with patients, clients, family members, other health care providers, and community-based organizations for the purpose of coordinating activities to facilitate efficient and effective patient or client care
  2. Coordinating the physical therapy patient-management process to include community resources, discharge planning, timely data transmission, and delivery of service
  3. Communicating effectively with patients, clients, family members, caregivers, practitioners, consumers, payers, and policymakers about geriatric issues
  4. Discussing rationale for physical therapy examination and intervention procedures including use of current best evidence with patients/clients and families, other health care professionals, and payers
  5. Collaborating as a health care team member and leader to ensure that physical therapy is a part of an appropriate, culturally competent, comprehensive plan in the care of geriatric patients
  6. Adapting communication to appropriate health literacy levels
  7. Completing thorough, accurate, analytically sound, concise, and timely documentation that follows guidelines and specific documentation formats required by the practice setting(eg, communication with payer sources for maximizing treatment services and resources, legal protection of staff, patient, and/or facility
- *Patient/Client-Related Instruction*
  1. Providing patient/client instruction about diagnosis, prognosis and intervention strategies
  2. Providing patient/client-related instruction to increase patient/client understanding of individual abilities, functional limitations, or disabilities
  3. Providing patient/client-related instruction aimed at risk reduction/prevention as well as health promotion
  4. Assisting patient/client in critically looking at Internet and other information that is available in the community
  5. Adapting instruction for the situation (eg, learning styles, actual practice by the patient or caregiver , use of audio and visual aids, verbal, written, pictorial instruction, culturally sensitive instruction)
  6. Provide patient/client-related instruction in the following specialized areas of geriatric physical therapy (eg, falls prevention, bone health, geriatric athlete, ability enhancement, foot care)
  7. Maintaining a current knowledge base regarding current health indicators as identified by the Department of Health and Center for Disease Control and Prevention in or to provide education to the patient, caregivers, health professionals, and the public on the role of physical therapy interventions
- *Procedural Interventions*
  1. Therapeutic exercise, including, but not limited to:
     a) Aerobic capacity/endurance conditioning or reconditioning (eg, gait/locomotion training, cycles, increased workload over time, treadmills, movement efficiency and energy conservation instruction or training)
     b) Balance, coordination, and agility training (eg, fall risk reduction and education, neuromuscular education or reeducation, perceptual training,

posture awareness training, sensory training or retraining, standardized, programmatic, complementary exercise approaches, task-specific performance training)

c) Vestibular training

d) Body mechanics and postural stabilization (eg, zero lifting techniques for caregivers, postural stabilization activities, posture awareness training)

e) Gait and locomotion training (eg, gait training; implement and device training; perceptual training:, standardized, programmatic, and complementary exercise approaches; powered and non-powered wheelchair mobility training; fall prevention)

f) Neuromotor development training (eg, motor training, movement pattern training, constraint induced movement therapy, neuromuscular education or reeducation)

g) Strength, power, and endurance training for head, neck, limb, pelvic floor, trunk, and ventilatory muscles (eg, active assistive, active, and resistive exercises; aquatic programs; standardized, programmatic, complementary exercise approaches; task-specific performance training)

2. Functional Training in Self-Care and Home Management to include:

a) Barrier accommodations or modifications (eg, environmental modification)

b) Device and equipment use and training (eg, friction reduction devices/lifts, assistive and adaptive device or equipment training during ADL and IADL, orthotic, protective, or supportive device or equipment training during self-care and home management, prosthetic device or equipment training during ADL and IADL)

c) Functional training programs (eg, simulated environments and tasks, transfer training, bed mobility, up from floor, task adaptation)

d) Injury prevention or reduction (eg, self-care and home management, use of devices and equipment, safety awareness training during self-care and home management, zero lift, home safety and energy conservation, fall prevention and education, use of devices to decrease injurious falls)

3. Functional training in work (purposeful activity), community, and leisure integration or reintegration, including but not limited to:

a) Functional training programs (eg, simulated environment and tasks, task adaptation, task training, cardiopulmonary rehabilitation, dexterity/coordination, conditioning/reconditioning training)

b) Injury prevention or reduction (eg, injury prevention education during work, community, and leisure integration or reintegration; injury prevention education with use of devices and equipment; safety awareness training during work, community, and leisure integration or reintegration)

4. Manual therapy techniques, which may include:

a) Manual lymphatic drainage

b) Mobilization/manipulation (eg, soft tissue, spinal and peripheral joints)

5. Prescription, application, and, as appropriate, fabrication of devices and equipment to include:

a) Adaptive devices (eg, environmental controls, hospital beds, raised toilet seats, seating systems, ramps, lifts)

b) Assistive devices (eg, canes, crutches, long-handled reachers, percussors and vibrators, power devices, static and dynamic splints, walkers, wheelchairs)

c) Orthotic devices (eg, braces, casts, shoe inserts, splints)

d) Prosthetic devices (lower-extremity and upper-extremity)

e) Protective devices (eg, braces, cushions, helmets, protective taping)

f) Supportive devices (eg, compression garments, corsets, elastic wraps, mechanical ventilators, neck collars, serial casts, slings, supplemental oxygen, supportive taping)

g) Utilization of financial (individual and community) resources to assist in obtaining appropriate devices

6. Airway clearance techniques, including:

a) Breathing strategies (eg, assisted cough/huff techniques, postural drainage, paced breathing, pursed lip breathing, techniques to maximize ventilation)

b) Manual/mechanical techniques (eg, assistive devices, chest percussion, vibration, and shaking, chest wall manipulation)

c) Positioning (eg, positioning to alter work of breathing, positioning to maximize ventilation and perfusion, pulmonary postural drainage)

7. Integumentary repair and protection techniques:

a) Debridement–nonselective (eg, pulsatile lavage, autolytic, enzymatic or chemical debridement)

b) Debridement–selective (eg, sharp debridement)

c) Dressings (primary and secondary) (eg, hydrogels, alginates, compression wraps)

d) Negative pressure wound therapy

e) Topical antibiotics.

f) Topical agents (eg, cleansers, creams, moisturizers, ointments, sealants)

g) Coordination with other services (hyperbaric

treatment, dialysis, enterostomal therapist, dietician)

h) Positioning, both preventive and post injury

i) Additional healing techniques and tools (eg, special depth shoes, shoe inserts; pressure relieving mattresses, pressure relieving wheelchair cushions)

j) Modalities (eg, whirlpool, pulsatile lavage, electric stimulation, light therapy, ultrasound)

F. Outcomes Assessment

- Assess individual and collective outcomes of patients/clients using valid and credible measures that consider practice setting patient/client culture, and effect of societal factors such as reimbursement
- Choose appropriate outcomes measurement tools for geriatric physical therapy diagnoses based on the patient/client's needs and examination findings (eg, specific impairment tools, patient satisfaction measures, clinical and functional assessment tools, and quality of life scales)

References

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Chapter 3: Linking Practice Dimensions and Professional Responsibilities to Knowledge Areas

I. Introduction

The following chapter uses three case scenarios to link practice expectations to knowledge areas. Each scenario has sample questions followed by explanations. The explanations are keyed to the specific numbered items from Chapter 2 of this document. These scenarios and references are included as examples only and are not intended to be all-inclusive. The terminology used in the scenarios is from the *Guide to Physical Therapist Practice.* Familiarity with the Guide will facilitate the reader's understanding of the cases.

II. Case Scenarios

Case Scenario 1

A 72-year-old female with osteoporosis is referred by her primary care physician to physical therapy for consultation due to recent falls. Her physician is concerned due to significant osteoporosis with T - scores of -3.19 in the right hip and -2.9 in the left hip after 3 years of treatment. Her past medical history is significant for hypertension, hypercholesterolemia, urinary incontinence, degenerative joint disease, gout, and myopia. Patient lives with her spouse in a 2-level home with 5 steps without rails at primary entry and 8 steps indoors with 1 rail to access second floor bedrooms.

Current medications include: alendronate, calcium supplement, Vitamin D, aspirin, furosemide, multivitamin and Lipitor.

She denies any dizziness or syncope. She reports falling twice within the past 2 weeks, primarily when walking outdoors on gravel and on soft ground, sustaining bruising on her arms and hips. No fractures were reported. She reports limited ambulation distance (~30 ft) due to instability and decreased functional endurance; modified independent for other activities of daily living (ADL) with reported difficulty at times with transfers and stepping into tub; and ability to complete activities but she needs time to complete. Patient also reports urinary incontinence of increased frequency within in the last week.

Question 1 for Case Scenario 1

Which of the following standing balance test positions will provide the **MOST** information on the role of visual input?

a. thick foam pad with eyes open
b. level hard surface with eyes open
c. thick foam pad with eyes closed
d. level hard surface with eyes closed

The correct answer is a.

In order to answer this question, the geriatric clinical specialist would incorporate the following knowledge and patient/client management practice expectations:

1.1 Foundation Sciences

1.1.3 neurophysiology
1.1.5 neuroanatomy

1.2 Clinical Sciences

1.2.7 Principles of physical therapy evaluation and treatment of geriatric patients with musculoskeletal, neuromuscular, cardiovascular, integumentary, or cognitive impairments

3.1.5.9 Gait, Locomotion, Balance

3.1.5.9.1 Balance during functional activities with or without the use of assistive, adaptive, orthotic, protective, supportive, or prosthetic devices or equipment (eg, ADL scales, IADL scales, observations, videographic assessments, confidence indexes)

3.1.5.9.2 Balance (dynamic and static) with or without the use of assistive, adaptive, orthotic, protective, supportive, or prosthetic devices or equipment (eg, balance scales, dizziness inventories, dynamic posturography, fall scales, motor impairment tests, observations, photographic assessments, postural control tests)

3.2 Patient/Client Management Expectation: Evaluation

3.2.1 Interpret data from examination. (eg, identify relevant, consistent, accurate data; prioritize impairments; assess patient's needs, motivations, and goals)

The Clinical Test for Sensory Interaction on Balance (CTSIB) is a clinical version of the Sensory Organization Test and uses a stopwatch and visual observation in lieu of sway measures, and a thick foam pad that substitutes for the moving forceplate. The clinician uses the information regarding client response in a variety of environmental conditions to determine involvement of the systems related to balance control and determine intervention management strategies.

To determine the role of visual inputs, condition four of the CTSIB—standing on a thick foam pad—is used. Somatosensory cues are available but inaccurate, so only visual and vestibular cues are most useful. In a typical subject, visual inputs are primarily used. In standing on a thick foam pad with eyes open, visual inputs dominate. Comparing sway in this position with that on a level surface indicates how well the patient is using visual inputs and functionally relates to walking on gravel driveway, beach, and soft sand.[1(p745), 2] Thus the correct answer is **a.**

For the level hard surface with eyes open test condition, input is available from all systems (somatosensory, vestibular, and visual) and does not discriminate which input dominates this test condition. [1(p744), 2] The thick foam pad with eyes closed condition assesses the use of vestibular inputs because vision is absent and somatosensory cues are inaccurate due to the foam pad.[1(p745)]

In the level hard surface condition with eyes closed, somatosensory and vestibular cues are available, but somatosensory inputs will dominate. This test tells how well the patient is using somatosensory inputs for balance. Functional situations include settings with inadequate lighting or visually distracting patterns on carpeting. [1(p744-5)]

References

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2. Gill J, Allum JH, Carpenter MG, et al. Trunk sway measures of postural stability during clinical balance tests. *J Gerontol A Biol Sci Med Sci.* 2001 Jul;56(7):M438-47.

Question 2 for Case Scenario 1

The patient is currently receiving pharmacological management for osteoporosis. Which of the following signs or symptoms is the **MOST** common side effect associated with this treatment?

a. depression
b. gastrointestinal disturbance
c. orthostatic hypotension
d. dizziness

The correct answer is b.

In order to answer this question, the geriatric clinical specialist would incorporate the following knowledge and patient/client management practice expectations:

1.2 Clinical Sciences

1.2.1 pharmacology

3.1 History

3.1.1. Obtain patient history through interview and data from other sources (eg, questionnaires, medical records, tests results, specific to geriatric patient issues including:

3.1.1.1 medication interview

Medications used to prevent or treat osteoporosis include biphosphonates such as alendronate (Fosamax), calcium supplements and vitamin D. Gastrointestinal disturbances such as nausea, diarrhea, vomiting, and stomach pain are common side effects associated with biphosphonates, calcitonin, and calcium supplements in excessive doses. These drugs are all used to control bone mineral homeostasis in the management of osteoporosis.[1(pp467-70), 2] Thus the correct answer is **b**.

Depression (**a**) is a common side effect in drugs such as beta-blockers, antirheumatics, and antiparkinsonian agents. Depression is not a typical side effect associated with bone resorption inhibitors. Orthostatic hypotension (**c**) is a common side effect of drugs that target the cardiovascular system or of drugs such as beta-blockers, vasodilators, antihypertensives, alpha-blockers. and diuretics. It is not typically associated with bone resorption inhibitors. Dizziness (**d**) is a common side effect in drugs that influence the cardiovascular system, such as antianginals, antianemics, vasosodilators, and antihypertensives; however, these are not commonly used in drug management for osteoporosis.

References

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Question 3 for Case Scenario 1

Which of the following interventions is missing from her current plan of care for holistic management of osteoporosis based on AMA guidelines?[1]

a. hormone replacement therapy
b. anti-resorptive therapy
c. lower extremity strength training
d. dietary supplementation with milk

The correct answer is c.

In order to answer this question, the geriatric clinical specialist would incorporate the following knowledge and patient/client management practice expectations:

1.1 Foundation Sciences

1.1.6 pathophysiology

1.2 Clinical Sciences

1.2.1 pharmacology

3.6 Patient/Client Related Instruction

3.6.6 Provide patient/client-related instruction in the following specialized areas of geriatric physical therapy (eg, fall prevention, bone health, geriatric athlete, ability enhancement, foot care)

3.6.7 Maintain a current knowledge base regarding current health indicators as identified by the Department of Health and Center for Disease Control and Prevention in or to provide education to the patient, caregivers, health professionals, and the public on the role of physical therapy interventions.

3.7.1 Therapeutic Exercise Interventions

3.7.1.2 Balance, coordination, and agility training (eg, fall risk reduction and education, neuromuscular education or reeducation, perceptual training, posture awareness training, sensory training or retraining, standardized, programmatic, complementary exercise approaches, task-specific performance training)

According to the American Medical Association (AMA) guidelines postmenopausal individuals with T scores < -2.5 require aggressive therapy with anti-resorptive agents.[1] The patient is postmenopausal and has a < -2.5 T score that requires aggressive therapy including calcium and vitamin D supplementation and the anti-resorptive therapy. The patient is currently on pharmacologic management (anti-resorptive therapy). For years, hormone replacement therapy (HRT) was the gold standard for osteoporosis management; however, with recent research showing increased risk of heart disease, breast cancer, and Alzheimer's with prolonged use, HRT is no longer the primary choice for osteoporosis management.

While nutritional changes are part of osteoporosis management, it is not the best choice for the patient who needs balance intervention.

With the patient's history of falls, there is an increased risk for osteoporosis-related fractures.[2] Lower-extremity muscle weakness has been identified as a risk factor contributing to falls in older people. Research has shown that weakness of the lower extremities, particularly the ankle dorsiflexors, hamstrings, quadriceps is a primary contributing factor to falls.[3] A holistic approach to osteoporosis management incorporates lower extremity strengthening as part of balance intervention in addition to torso stabilization exercises, abdominal, chest, arms and breathing exercises. Therefore, the best answer is **c**, "lower extremity strength training."[4]

References

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3. Robbins AS, Rubenstein LZ, Josephson KR, et al. Predictors of falls among elderly people: results of two population-based studies. *Arch Intern Med.*1989; 149:1628–1633.
4. Daniels, D. *Exercises for Osteoporosis.* New York: Healthy Living Books; 2005.

Question 4 for Case Scenario 1

Which of the following screening questions will BEST determine if the patient has functional incontinence?

a. Do you go more than twice at night?
b. Do you wet your pants when you lift or exercise?
c. Do you have episodes of dribbling during the day?
d. Do you have trouble getting to the toilet in time?

The correct answer is d.

In order to answer this question, the geriatric clinical specialist would incorporate the following knowledge and patient/client management practice expectations:

1.1 Foundation Sciences

1.1.4 anatomy
1.1.6 pathophysiology

3.1 History

3.1.1 Obtain patient history through interview and data from other sources (eg, questionnaires, medical records, tests results, specific to geriatric patient issues including:
3.1.1.2 health status (eg, comorbidity, nutrition, depression, patient's self report, family's or caregiver's report)
3.1.1.4 functional status and activity level

3.2 Patient/Client Management Expectation: Evaluation

3.2.1 Interpret data from examination. (eg, identify relevant, consistent, accurate data; prioritize impairments; assess patient's needs, motivations, and goals)

These screening questions can help determine the type of urinary incontinence the patient is experiencing. Functional incontinence is characterized by one or a combination of the following: inability to get to the bathroom due to physical limitations, or the inability to manage clothing once in the bathroom.[1] A positive response to the screening question "do you have trouble getting to the toilet in time" points towards functional incontinence. This situation occurs is when the bladder is normal but mobility and access deficits such as use of a walker or confinement to a wheel chair cause problems in timing. Weakness, altered mentation or psychological factors may cause this type of incontinence as well. Thus the correct response is **d**.

A positive response to the screening question, "Do you go more than twice at night?" would indicates either an overactive bladder or urge incontinence which is the involuntary contraction of the detrusor muscle with a strong desire to void (urgency) as soon as the urge is felt. A positive response to "Do you wet your pants when you lift or exercise?" would indicate stress incontinence. Pressure applied to the bladder during physical exertion or from laughing, sneezing, or coughing increases abdominal pressure leading to urine loss. A positive response to "Do you have episodes of dribbling during the day?" would indicate overflow incontinence. This occurs with over distention of the bladder and the inability to completely empty the bladder. Urine leaks out or dribbles so the patient has no sensation of fullness or emptying.

References

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2. Lewis C, Bottomley J. *Geriatric Rehabilitation*. 3rd edition. Upper Saddle River, NJ: Prentice Hall; 2008:91.

Question 5 for Case Scenario 1

Which of the following tests would be BEST to assess for fall risk and both static and dynamic balance?

a. Berg Balance Scale
b. Timed Up and Go Test
c. Four Square Step Test
d. Functional Reach Test

The correct answer is a.

In order to answer this question, the geriatric clinical specialist would incorporate the following knowledge and patient/client management practice expectations:

1.3 Foundation Sciences

1.1.3 neurophysiology
1.1.5 neuroanatomy

1.4 Clinical Sciences

1.2.7 principles of physical therapy evaluation and treatment of geriatric patients with musculoskeletal, neuromuscular, cardiovascular cardiovascular, integumentary, or cognitive impairments

3.1.5.9 Gait, Locomotion, Balance

3.1.5.9.1 Balance during functional activities with or without the use of assistive, adaptive, orthotic, protective, supportive, or

prosthetic devices or equipment (eg, ADL scales, IADL scales, observations, videographic assessments, confidence indexes)

3.1.5.9.2 Balance (dynamic and static) with or without the use of assistive, adaptive, orthotic, protective, supportive, or prosthetic devices or equipment (eg, balance scales, dizziness inventories, dynamic posturography, fall scales, motor impairment tests, observations, photographic assessments, postural control tests)

3.2 Patient/Client Management Expectation: Evaluation

3.2.1 Interpret data from examination. (eg, identify relevant, consistent, accurate data; prioritize impairments; assess patient's needs, motivations, and goals)

The Berg Balance Scale assesses balance rather than gait and has been shown to have the best sensitivity and specificity for healthy community dwelling elderly.[1,2,3] The scale assesses both static and dynamic balance during the performance of 14 distinctive tasks and is designed to measure balance in older adults and to predict fallers. The Timed Up and Go test is good for fall risk assessment but does not assess balance function.[2] The Four Square Step test is fairly new; it is a reliable and valid tool for measuring the ability to perform multidirectional movements in individuals with deficits secondary to vestibular disorders.[4] The Functional Reach test can detect balance impairment and change in performance over time. It is part of the Berg Balance Scale, but in itself provides a limited picture of the patient's deficits. The Berg Balance Scale assesses balance rather than gait and has been shown to have the best sensitivity and specificity for healthy community dwelling elderly. The scale assesses both static and dynamic balance during the performance of 14 distinctive tasks and is designed to measure balance in older adults and to predict fallers. Thus **a**, "Berg Balance Scale," is the best answer.

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Case Scenario 2

The patient is a 66-year-old Hispanic male who is an illegal immigrant and who lives in local shelters or on the streets. He believes he last saw a doctor over 20 years ago. He was admitted to the hospital in a coma with a blood glucose measure of 423 and diagnosed with diabetes type 2. Twelve hours after admission and stabilization of blood glucose levels he developed vomiting, suffered a seizure and experienced tachycardia, hypertension and hallucinations. These symptoms cleared after 2 days. He is referred to physical therapy for gait and transfer training. Nursing reports that he has been moderate assist for all gait and transfers. He also has an open wound on the top of his right foot. The wound bed is pale and the skin surrounding it is shiny and tight with no hair.

Question 1 for Case Scenario 2

The patient's seizures, vomiting and hallucinations were most likely caused by:

a. acute alcohol withdrawal
b. epilepsy
c. Parkinson disease
d. prolonged hyperglycemia

The correct answer is a.

In order to answer this question, the geriatric clinical specialist would incorporate the following knowledge and patient-client management practice expectations:

1.1 Foundation Science

1.1.2 physiology of aging
1.1.6 pathophysiology

3.2 Patient/Client Management Expectation: Evaluation

3.2.1 Interpret data from examination. (eg, identify relevant, consistent, accurate data; prioritize impairments; assess patient's needs, motivations, and goals)

3.2.2 Determine when signs and symptoms that indicate referral to a physician or another health care provider is appropriate, based on specialized knowledge of geriatric physical therapy.

This patient has presented with classic symptoms of acute alcohol withdrawal (deliriums tremens) which usually onsets 6-12 hours after the last drink and will last up to 72 hours.1 Thus a is the best answer. Epilepsy is possible due to the seizure but, given his overall presentation and the timing of the onset of symptoms, one has to suspect that the underlying cause of the seizure would be more likely due to something such as acute alcohol withdrawal than to a chronic disease such as epilepsy. Delirium could onset in an elderly patient with Parkinson disease under this kind of stress.[2,3] But seizure is not a typical symptom, and so this is not the best choice. Finally, hyperglycemia is incorrect as the typical symptoms are increased thirst, headache, difficulty concentrating, and blurred vision.[3]

References

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3. Goodman CC, Fuller KS. *Pathology: Implications for the Physical Therapist*. 3rd Ed. Philadelphia, PA: Elsevier; 2008:20-25.

Question 2 for Case Scenario 2

Examination shows that he has balance deficits. Which of the following impairments/diagnoses is he MOST likely to exhibit based on his medical history?

a. decreased vibratory sensation in the feet
b. loss of strength in the large muscles of the legs and arms

c. loss of bone mineral density
d. tightness of bilateral hamstrings

The correct answer is a.

In order to answer this question, the geriatric clinical specialist would incorporate the following knowledge and patient-client management practice expectations:

1.1 Foundation Science

1.1-3 neurophysiology
1.1-6 pathophysiology
1.3behavioral sciences
1.3.5 epidemiology of chronic disease

3.1 History

3.1.1.2 health status (eg, comorbidity, nutrition, depression, patient's self report, family's or caregiver's report)
3.1.2. Perform a systems review to assess physiological and anatomical status (eg, cardiovascular/ pulmonary, integumentary, musculoskeletal and neuromuscular systems,)
3.1.5.24 Respond to emerging data from examinations and interventions by performing special tests and measures to evaluate progress, modify or redirect intervention.

3.3 Patient/Client Management Expectation: Diagnosis

3.3.2 Establish differential diagnoses based on awareness of diseases, disorders and conditions that affect geriatric patients.

The patient is most likely to exhibit loss of vibratory sensation due to his diabetes and probable alcoholism. The most common form of diabetic neuropathy is a sensory polyneuropathy which usually affects the hands and feet. The patient's balance deficits are related directly related to the diabetes and balance deficits which makes a the best answer.

Loss of bone mineral density or osteoporosis risk increases with diabetes and alcoholism.[1] Ostoeporosis is more common in those with type 1 diabetes and studies of bone mineral density in type 2 diabetes have been conflicting.[2] Male gender somewhat lessens the risk of osteoporosis and thus makes the loss of proprioceptive sensation a better choice. Also, balance issues are not directly linked to osteoporosis but are directly linked to loss of proprioceptive sensation/vibratory sensory testing.[3] While strength and flexibility losses are possible in any patient there is nothing in the stem of this question to indicate that these impairments would be any more likely in this patient than any other problem.

References

1. Goodman CC, Fuller KS. Pathology: Implications for the Physical Therapist, 3rd Edition. Philadelphia, PA: Elsevier; 2008:321-2,344-63,1158-9.
2. Bottomley J, Lewis C. *Geriatric Rehabilitation: A Clinical Approach.* 3rd ed. Upper Saddle River, NJ: Pearson Prentice Hall; 2008:220-225.
3. Oyer DS, Saxon D, Shah A. Quantitative assessment of diabetic peripheral neuropathy with use of the clanging tuning fork test. *Endocrine Practice* . 2007;13(1):5-10.

Question 3 for Case Scenario 2

Which of the following would be the best intervention for the wound on his right foot?

a. use pressure garments and elevation
b. use vacuum assisted closure
c. apply a moist dressing, keep wound bed very moist
d. keep extremity cool at all times

The correct answer is b.

In order to answer this question, the geriatric clinical specialist would incorporate the following knowledge and patient-client management practice expectations:

1.1 Foundation Science

1.1.7 cellular biology - (eg. Phases of soft tissue healing, tissue makeup, changes with aging, response to exercise)

3.4 Patient/Client Management Expectations: Prognosis

3.4.9.1 Prioritizes interventions related to the diagnosis, recovery process, patient/client goals, outcomes data, and resources.

3.7 Procedural Interventions

3.7.2.6 Injury prevention or reduction (eg, self-care and home management, use of devices and equipment, safety awareness training during self-care and home management, zero lift, home safety and energy conservation, fall prevention and education, use of devices to decrease injurious falls)
3.7.5.1Manual lymphatic drainage
3.7.7.3 Positioning (eg, positioning to alter work of breathing, positioning to maximize ventilation and perfusion, pulmonary postural drainage)
3.7.8.3 Dressings (primary and secondary) (eg, hydrogels, alginates, compression wraps)
3.7.8.8 Positioning, both preventive and post injury
3.7.8.9 Additional Healing Techniques and Tools (eg, special depth shoes, shoe inserts; pressure relieving mattresses, pressure relieving wheelchair cushions)
3.7.8.10 Modalities (eg, whirlpool, pulsatile lavage, electric stimulation, light therapy, ultrasound)

The key to answering this question is realizing that the described wound is an arterial wound, as it is pale and dry with shiny tight skin around it. In contrast, one would expect a red wound bed with a large amount of exudates if it were a venous wound. The best treatment for arterial wounds is to increase blood flow to the area.[1] Compression garments are the treatment of choice for venous wounds but would be contraindicated in an arterial wound.[2] Using a moist dressing and keeping the wound bed "very moist" is not appropriate for arterial wounds; a moist wound bed could lead to tissue degradation and create an environment for infection. Keeping the leg "cool" is clearly not going to increase blood flow to the area and is not a treatment listed in any texts or other reference materials. Using a vacuum pump for vacuum-assisted closure is a non-surgical method for increasing blood flow to the area. This is a well-accepted treatment method for arterial wounds of the lower extremity.[1] Thus **b** is the best answer.

References

1. Hirsch AT, et al. ACC/AHA 2005 Practice Guidelines for the management of patients with peripheral arterial disease (lower extremity, renal, mesenteric, and abdominal aortic): a collaborative report from the American Association for Vascular Surgery/Society for Vascular Surgery, Society for Cardiovascular Angiography and Interventions, Society for Vascular Medicine and Biology, Society of Interventional Radiology, and the ACC/AHA Task Force on Practice Guidelines (Writing Committee to Develop Guidelines for the Management of Patients With Peripheral Arterial Disease): endorsed by the American Association of Cardiovascular and Pulmonary Rehabilitation; National Heart, Lung, and Blood Institute; Society for Vascular Nursing; TransAtlantic Inter-Society Consensus; and Vascular Disease Foundation. *Circulation*. 2006;113(11):463-654.
2. Goodfield M. Optimal management of chronic leg ulcers in the elderly. *Drugs and Aging.* 1997;10(5):341-8.

Question 4 for Case Scenario 2

The patient is being discharged. As his physical therapist is concerned that he continues with an exercise program to improve strength and mobility as well as assist in managing his blood glucose levels. The best recommendation for his home program is:

a. an aquatics program 20–30 minutes, 3 times per week
b. a 30-minute walking program based on city blocks, 3-4 times per week
c. treadmill walking for 20 minutes, 3 times a week
d. exercise with cuff weights and stationary bike 3 times per week

The correct answer is b.

In order to answer this question, the geriatric clinical specialist would incorporate the following knowledge and patient-client management practice expectations:

2.4 Social Responsibility

2.4.3 Providing physical therapy services to underserved and underrepresented populations to include pro bono work.

2.9 Advocacy

2.9.4 Assist geriatric clients in gaining access to all resources to assist in understanding their health condition and managing it

2.9.5 Provide health promotion information to patients, clients, and the public

2.9.6 Disseminate evidence-based information to clients, colleagues, other health care providers, and research agencies

3.6 Patient/Client Related Instruction

3.6.3 Provide patient/client-related instruction aimed at risk reduction/prevention as well as health promotion

The key to answering this question is to recognize the importance of considering cultural and social issues when planning treatment interventions. The patient is homeless and living on the streets and is thus very unlikely to have access to resources such as treadmills, stationary bikes, or pool therapy. Despite his patient being homeless, the therapist should continue to be an advocate for the patient to achieve and maintain optimal health.[1,2 3] In this role it would be the therapist's job to create a home exercise program that is feasible for the patient's situation. A walking program is free and available to anyone.[4]

According to Chakravarthy[5], "Physical inactivity increases the risk of many chronic disorders. Numerous studies have convincingly demonstrated that undertaking and maintaining moderate levels of physical activity (eg, brisk walking 3 hours a week) greatly reduces the incidence of developing many chronic health conditions, most notably type 2 diabetes mellitus, obesity, cardiovascular disease, and many types of cancers…. Although changing an individual's ingrained behavior is commonly perceived to be difficult, encouraging evidence suggests that intensive and repeated counseling by health care professionals can cause patients to become more physically active. Therefore, counseling patients to undertake physical activity to prevent chronic health conditions becomes a primary prevention modality."[5]

References

1. Bottomley J, Lewis C. *Geriatric Rehabilitation: A Clinical Approach*. 3rd ed. Upper Saddle River, NJ: Pearson Prentice Hall; 2008:463.
2. Goodman CC, Fuller KS. *Pathology: Implications for the Physical Therapist.* 3rd Ed. Philadelphia, PA: Elsevier; 2008.
3. Applewhite SL. Homeless veterans: perspectives on social services use. *Social Work.* 1997;42(1):19-30.
4. Fitzpatrick SE, et al. Physical activity and physical function improved following a community-based intervention in older adults in Georgia senior centers. *Journal of Nutrition for the Elderly.* 2008;27(1-2):135-54.
5. Chakravarthy MV, Joyner MJ, Booth FW. An obligation for primary care physicians to prescribe physical activity to sedentary patients to reduce the risk of chronic health conditions." *Mayo Clinic proceedings*. Mayo Clinic. 2002;77(2):165-73.

Case Scenario 3

The patient is an 80-year-old female with a history of osteoarthritis in bilateral hips, knees, and shoulders. She has had total joint arthroplasties for both hips and her right knee. She was diagnosed with a torn rotator cuff in the left shoulder 3 years ago and opted not to have it surgically repaired. She complains of severe osteoarthritic pain and limited motion in her right shoulder. She also has hypertension which is managed with low dose diuretics and a beta blocker. She takes tramadol for her osteoarthritis. Six weeks ago she had to have her right hip prosthesis replaced. She now has a referral for home health physical therapy. She lives alone in a two-story home. She has adapted it so that she has a bedroom on the first floor and only has to negotiate stairs to do laundry in the basement and to enter and exit her home. There is a railing on the basement stairs and on the stairs entering the home from her garage.

Question 1 for Case Scenario 3

The patient feels that ibuprofen would help decrease her arthritis pain better than the tramadol she is taking. You are concerned she might do this and so educate her that the reason her doctor has not put her on ibuprofen is most likely because:

a. ibuprofen is contraindicated in those with hypertension
b. beta blockers and ibuprofen combined causes liver damage
c. tramadol slows and reverses joint damage caused by osteoarthritis

d. ibuprofen provides minimal pain relief post- joint replacement

The correct answer is a.

In order to answer this question, the geriatric clinical specialist would incorporate the following knowledge and patient-client management practice expectations:

1.2 Clinical Sciences

1.2.1 pharmacology

1.2.7 principles of physical therapy evaluation and treatment of geriatric patients with musculoskeletal, neuromuscular, cardiovascular, cardiopulmonary, integumentary, or cognitive impairments

3.0 History

3.1.1.1 medication interview

3.6 Patient/Client Related Instruction

3.6.3 Provide patient/client-related instruction aimed at risk reduction/prevention as well as health promotion.

Ibuprofen causes spikes in blood pressure and so is not recommended for those with HTN and, if used, must be monitored closely. Ibuprofen has been shown to decrease the effects of beta blockers. Therefore the best answer is **a.**

"Beta blockers and ibuprofen combined causes liver damage".is not the correct response. Although ibuprofen is metabolized in the liver and kidneys, not all beta blockers are metabolized by the liver. The scenario does not state which beta blocker she is taking, so it is inaccurate to state that both drugs combined cause liver damage. Tramadol is a central-acting analgesic used to treat moderate to severe pain and is available by prescription only. It is not locally acting, and it does not slow or reverse joint damage. Concerning the amount of pain relief ibuprofen would give post total joint arthroplasty, ibuprofen is indicated for moderate pain relief and is available in variable dosages, which may or may not approach the level of pain relief of central nervous system-acting Tramadol. But most important, d does not address the fact that ibuprofen is contraindicated in those with HTN and could actually cause harm to the patient with HTN.

References

1. Olson J. Anti-inflammatory and Immunomodulating Agents. In: *Clinical Pharmacology Made Ridiculously Simple.* 2nd ed. Miami, FL: MedMaster Inc; 2001:133-137.
2. Aschenbrenner D, Venable S. Analgesic and Anti-inflammatory Drugs. In: *Drug Therapy in Nursing*. 3rd ed., Baltimore, MD: Lippincott Williams &Wilkins; 2008:412-413.

Question 2 for Case Scenario 3

Which of the following ADLs is she most likely to be unable to regain the ability to perform and will require long-term assistance or a compensatory technique?

a. climbing stairs
b. toilet transfers
c. cooking in the oven
d. reaching dishes above shoulder level

The correct answer is d.

In order to answer this question, the geriatric clinical specialist would incorporate the following knowledge and patient-client management practice expectations:

1.1.1 Foundation Sciences

1.1.2 physiology of aging

1.1.4 anatomy

1.2.7 Principles of physical therapy evaluation and treatment …

3.0 History

3.1.1.3 social environment (eg. living situation, family structure, abuse)

3.1.1.4 functional Status and activity level

3.4.2 Consider the long term prognostic effect of normal age related changes

3.5 Patient/Client Management Expectations: Prognosis

The scenario describes an elderly woman diagnosed with a torn rotator cuff in the left shoulder 3 years ago who opted not to have it surgically repaired. She also reports severe osteoarthritic pain and limited motion in the right shoulder. Both impairments would definitely affect her ability to reach overhead.1 Therefore the best response is **d**, "reaching dishes above shoulder level."

"Climbing stairs" is not the correct response because she currently manages the stairs independently and has already modified her lifestyle to decrease the frequency of stair usage. "Toilet transfers" is incorrect because the patient has already been independent for weeks since she has been home. There is no reason to expect her to decrease in functional independence with home physical therapy.[2] "Cooking in the oven" is not the best answer for a number of reasons. Many ovens are set below the stove top and require some degree of bending to reach into the oven. However we do not know how tall she is and she may not be forward-bending over 90˚ to access the oven. In addition, some ovens are set in the wall at waist height. There are simply too many unknowns to confidently answer **c**.

References

1. Moore KL, Dalley A. Lower Limb, Chapter 6-Upper Limb, In: *Clinical Oriented Anatomy*. 4th ed. Philadelphia, PA: Lippincott Williams & Wilkins; 1999:607-615,697-699.
2. Bottomley JM, Lewis CB. Orthopaedic Treatment Considerations. In: *Geriatric Physical Therapy: A Clinical Approach*. East Norwalk, CT: Appleton and Lange; 1994:327-352.

Question 3 for Case Scenario 3

What will be the best home exercise to give the patient given limited compliance?

a. squats with bilateral upper extremity in support
b. shoulder pulley into flexion and abduction
c. long arc quads, bilateral
d. adapted sit-to-stand exercise

The correct answer is d.

In order to answer this question, the geriatric clinical specialist would incorporate the following knowledge and patient-client management practice expectations:

1.1.1. Foundation Sciences

1.1.2 physiology of aging

1.1.4 anatomy

1.2.7 Principles of physical therapy evaluation and treatment…

1.3.8 Principles of adult education

3.7.1 Therapeutic Exercise Interventions

3.7.1.7 Strength, power, and endurance training

Choice **d** includes retraining function and addresses relevant impairments, making it the best choice.[1] At this time there should not be any hip precautions; however, if necessary it would be easy to modify this exercise to be done within hip precautions. Sit-to-stand exercises will strengthen all muscles of the lower extremities while retraining function.[2] The other choices are all appropriate exercises but will only affect one or two muscle groups and do not retrain function; therefore **d** is the best choice.

References

1. Bottomley JM, Lewis CB. Orthopaedic Treatment Considerations. In: *Geriatric Physical Therapy: A Clinical Approach*. East Norwalk, CT: Appleton and Lange; 1994:327-352.
2. Kisner C, Colby LA. The Hip. In: *Therapeutic Exercise: Foundations and Techniques.* 3rd ed, Philadelphia, PA: F.A. Davis; 1996:386-401.

Chapter 4: Examination Content Outline and List of Medical Conditions Seen by Specialists

The examination blueprint is based on approximately 200 questions in the exam. Additionally, questions will be written to avoid use of negative stems. Questions may include graphics. Examination questions can represent both a practice expectation and a knowledge area associated with that expectation.

A case scenario may have more than one question; however, the questions are written independently so that incorrectly answering one question should not jeopardize answering the next question correctly.

The following is a summary including the percent of exam questions for each of the major components of the DSP.

Examination Content Domains

	Percent
I. Knowledge Areas:	15%
A. Foundation Sciences	5
B. Clinical Sciences	5
C. Behavioral Sciences	5
II. Practice Expectations:	85%
A. Professional Roles and Responsibilities	
1. Professional Behavior	2
2. Professional Development	2
3. Communication	2
4. Social Responsibility	2
5. Leadership	2
6. Education/Advocacy	2
7. Administration/Consultation	2
8. Evidence Based Practice	2
B. Patient/Client Management	
1. Examination	23
2. Evaluation/Diagnosis/Prognosis	14
3. Intervention	27
4. Outcomes	5
TOTAL:	100%

Medical Conditions

The medical conditions that may be represented on the examination include (but are not limited to) the following:

- **Musculoskeletal**
  - fractures
  - TJR
  - OA
  - all other (sprains, strains, etc)
  - osteoporosis
  - spine problems
- **Cardiovascular/pulmonary**
- **Diabetes**
- **Falls**
- **Acute Infections**
- **Peripheral Circulation Compromise**
  - amputation
  - lymphedema
  - peripheral vascular and wounds
- **Neurologic**
  - stroke
  - PD
  - dementia/mental illness
- **Other**
  - frailty
  - includes others such as obesity, cancer, and autoimmune disease

Chapter 5: Executive Summary of the Geriatric Practice Analysis

I. Introduction

A practice analysis is a systematic study of professional practice behaviors and content knowledge that specialty practice comprises. The purpose of a practice analysis is to collect data that will describe what clinical geriatric specialist practitioners do and what skills and knowledge bases enable them to perform specialist practice. The data are then used to describe specialty practice in clinical geriatric physical therapy. This description of specialty practice (DSP) defines the content areas for the clinical geriatric specialist certification examination. This chapter summarizes the practice analysis research of the clinical specialization in clinical geriatric physical therapy resulting in this DSP.

A nationwide analysis of clinical geriatric specialty practice was conducted in 2007 to revalidate/revise the existing Geriatric Description of Advanced Clinical Practice (DACP). This analysis was based on the 1999 document describing clinical geriatric specialist practice1 and input from a 6-member subject matter expert (SME) group. The focus of this group was to identify changes in practice over the past 10 years. Notable changes included *Guide to Physical Therapist Practice*[2] and increasing emphasis on evidence-based practice. ABPTS funded the revalidation process.

II. Methods

A. Survey Instrument

The framework and format for the survey was developed by consensus of the SME group. Contributing documents included the *Guide to Physical Therapist Practice*[2] and its patient/client management model, the existing 1999 *Description of Advanced Clinical Competencies in Clinical Geriatric Physical Therapy*[1] and work by Sackett et al[3,4] on evidence-based medicine. Design and administration of the survey was based on Dillman's Total Design Method.[5]

The survey contained four sections. Section 1 addressed new (within the past 10 years) Knowledge Areas Expected of the Geriatric Specialist. Items were rated on: Frequency on a 5-point Likert-type scale with 0 being "never" and 4 being "daily"; Importance on a 4-point Likert-type scale with 0 being "not important" and 3 being "very important"; and Level of Judgment on a similar 4-point scale with 0 as "do not use" and 3 as "analysis." Section 2 was Professional Roles and Responsibilities, and Section 3 was Practice Expectations. Both sections 2 and 3 were rated on the same scale of Frequency as well as Level of Mastery, which was a 4-point Likert-type scale with 1 as "advanced beginner skill level" and 4 as "expert skill level." Section 4 collected demographic information.

B. Pilot Surveys

A convenience sample of 35 physical therapists was used for pilot testing. Respondents were clinical geriatric specialists, both certified and non-certified, who were professional colleagues of SME group members. The SME members observed the respondents as they completed the survey and were available to answer any questions and get immediate feedback and suggestions. The SME members completed a separate observation form with each pilot survey administration. The observation forms recorded time to complete and specific comments/questions the respondents had.

Feedback from respondents on the pilot was very positive. Average time to complete the survey was 60-90 minutes. Respondents had very few comments or questions about the scales. In general, most comments were editorial in nature. Other than appropriate editorial changes, there were no substantive changes to the actual survey.

III. Final Survey Administration

The initial plan was to administer the survey completely on line through the Research component of APTA. All board-certified clinical geriatric specialists received an e-mail invitation to participate. A list of potential non–board-certified specialists was generated from the Section on Geriatrics membership list. Section members were sent an e-mail asking if they were doing clinical geriatric practice and if so, if they would be willing to participate in the survey. From these 2 e-mails, 517 GCS and 317 non-GCS Section members responded that they were willing to participate. These 834 therapists were e-mailed the link to the survey, which included instructions to potential respondents to complete the survey within 2 weeks. A second e-mail/postcard reminder went out after 2 weeks with an extension of the deadline by an additional 2 weeks, and a final email/postcard was sent just prior to the final deadline date for surveys completion. After 1 month, the response rates were disappointingly low, with 11% for GCS and 22% for non-GCS. Another reminder and a new survey link were sent to non-respondents with the survey being available for an additional 2 weeks. The final response rates were 16% for GCS and 26% for non-GCS and a total response rate of 20%. The SME group and the Geriatric Specialty Council (GSC) felt that the primary issue with the low response rate was the length of time to complete the survey. ABPTS together with the GSC and the SME group decided to move from an electronic survey to a mailed, hard copy survey. Additionally, they split the survey so that each respondent completed Sections 1 and 4. Additionally, each respondent received one of the following: Section 2, the first part of Section 3, or the second half of Section 3. The abbreviated surveys were sent out by USPS with a request for returns within 2 weeks. The final combined response rate (electronic surveys, mail surveys, and pilot surveys for GCS) was 50.6% for GCS, 37.2% for non-GCS, and 45.7% combined.

Respondents were given the opportunity to call or e-mail the project coordinator if they had questions about the survey. Only 6 potential respondents sent questions, which were related to either eligibility or to completing the survey.

IV. Data Analysis

The ordinal data were analyzed descriptively. The decision rules for defining specialty practice derived from the Frequency, Importance, and Level of Judgment ratings (Section 1) and from the Frequency and Level of Mastery ratings (Sections 2 and 3). In Section 1 (Knowledge Areas), items were included if at least 65% of respondents rated the item on Importance at a 2 or 3 ("moderately important" or "very important") and on Level of Judgment at a 2 or 3 ("application" or "analysis"). For Sections 2 and 3 (Professional Roles/Responsibilities and Practice Expectations), items were included in the DSP if at least 65% of the respondents rated the item on Level of Mastery at a 2 or 3 ("proficient" or "expert"). Concerning frequency, items were included if at least 65% of respondents rated them higher than 0 ("never").

The group addressed frequency ratings specific to the individual items. Most items scored very high on frequency as well as criticality/mastery. If the level of mastery or judgment/ importance was high, lower frequency was of less concern. In the event of discrepancy such as importance rating at 65% and level of criticality at less than 65%, the SME would compare the responses for GCS with responses from non-GCS. In all close cases, the SME group came to consensus about keeping the item or eliminating the item.

V. Results

Since the changes from the pilot survey to the final survey were minimal, the pilot surveys also were included in the analysis. The final combined response rate (electronic surveys, mail surveys, and pilot surveys for GCS) was 50.6% (277/547) for GCS, 37.2% (118/317) for non-GCS, and 45.7% (395/864) combined. The responses and demographic characteristics for these two groups were very similar.

Data from the first three sections of the survey are the basis for the description of clinical geriatric specialty practice shown in Chapter 2. According to the decision rules agreed upon and subsequent consensus of the SME group, 1 item was eliminated from Section 1, none from Section 2, and 37 from 3 of the survey. Categorically the items eliminated were identified as not performed at the specialist level. The SME Group determined that the survey responses driving these decisions reflected change in practice patterns over the past 10 years. Again, eliminating an item from the DSP does not mean that clinical geriatric specialists do not use that intervention, but rather that the intervention is not performed significantly differently by specialists.

Data from Section 4 of the survey was reported in Chapter 1 as Demographics of Board-Certified Geriatric Specialists. As noted, the demographics for the non–board-certified respondents were very similar.

The SME group set the levels for Chapter 5 of this DSP, Examination Test Specifications. These decisions were based on the survey responses as well as the previous 1999 test blueprint.

VI. Conclusions

The demographic information shown in Chapter 1 is the most current on clinical geriatric certified specialists. The description of specialty practice for clinical geriatric physical therapy in Chapter 2 is based on the patient/client management model in the *Guide to Physical Therapist Practice*[2] with emphasis on the knowledge areas and procedures that distinguish a clinical geriatric specialist from a non-specialist. This description of practice was validated through a survey of clinical geriatric specialists. Chapter 2 also can serve as a self-assessment tool for prospective board-certified clinical geriatric specialists from which to develop a study guide to prepare for the certification examination. The case scenarios in Chapter 3 are presented to help explain the connections between the Knowledge Areas and Procedures and the Practice dimensions and to familiarize prospective clinical geriatric specialists with the certification examination question format. The case scenarios include examples of the levels of knowledge and reasoning expected of specialists. Chapter 4 is the exam blueprint. Chapter 5 presents this technical report describing the practice analysis and the development of the DSP. This is a working document and will continue to be revisited on a recurring basis for review and revalidation based on changes in practice patterns over time.

References

1. Clinical Geriatric Physical Therapy: *Description of Advanced Clinical Practice*, APTA, 1999.
2. Guide to Physical Therapist Practice, 2nd Ed. *Phys Ther.* 2005;81:9-744.
3. Sackett DL, Richardson WS, Rosenberg W, Haynes RB. *Evidence-based Medicine: How to Practice and Teach EBM*. New York, Churchhill Livingstone, 1997.
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E-45

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Description of Specialty Practice: Geriatrics

Assessment Tool for Physical Therapy: Geriatrics is based on the Geriatric Physical Therapy Description of Specialty Practice (2009) prepared by the members of a subject matter expert (SME) group and members of the Specialty Council on Geriatric Physical Therapy. The DSP was approved by and used with permission of the American Board of Physical Therapy Specialties (ABPTS).

ABPTS states that: "Individuals who are considering applying for specialist certification may find use of assessment tools a valuable way of determining readiness for specialist certification. Use of the assessment tool does not guarantee success on the specialist certification examination."

Assessment Tool for Physical Therapy: Geriatrics will help physical therapists (and their clinical supervisors or mentors) evaluate their current level of knowledge and skills in the practice of geriatric physical therapy against a set of nationally accepted advanced clinical competencies.

Assessment Tool for Physical Therapists

Description of Specialty Practice: Geriatrics

TABLE OF CONTENTS

How to Use the Assessment Tool

Directions:

Read each competency statement.

1. Assess the performance of the clinician being assessed for each competency by placing an (×) in the box that BEST describes the behavior (unsatisfactory, satisfactory, or superior performance) on this aspect of the competency.

2. After marking each item associated with the competency, calculate the cumulative rating for each knowledge-based area or clinical practice expectation and record in the provided summary box: 1 point for each "Unsatisfactory Performance" rating, 2 points for each "Satisfactory Performance" rating, and 3 points for each "Superior Performance" rating. Please note, the maximum number of possible rating points is provided in each knowledge area/clinical practice expectation summary box.

3. Once you have completed the entire assessment tool, copy each rating into the Summary Form on page 27. You will then have a global perspective for each competency and the description of specialty practice.

Here is a sample of how to use this assessment tool:

Assessment Tool for Physical Therapists **Description of Specialty Practice: Geriatrics** **SAMPLE ASSESSMENT**				
Directions: Place an "×" in the box that BEST describes behavior observed for aspect of the competency.	Unsatisfactory Performance 1	Satisfactory Performance 2	Superior Performance 3	
1. Ability to identify the educational needs of the learner/client.				
a) Identifies what the learner needs to know.		×		2
a) Identifies what the learner needs to be able to do.			×	3
Calculate the cumulative rating for this section and record here ➔				5 / 6

Assessment Tool for Physical Therapists

Description of Specialty Practice: Geriatrics

The Guide to Physical Therapist Practice (Guide) describes the patient/client management model, which includes patient/client examination (history, systems review, tests, and measures), evaluation, diagnosis, prognosis, intervention, and outcomes. Based on the development of the Guide and previous specialty practice surveys, the elements of this patient/client management model are the accepted standard for all physical therapist practice, including specialty practice. A Description of Specialty Practice (DSP) does not include all the items covered in the Guide, but rather highlights those elements of practice that clinical specialists utilize or perform at an advanced level compared with non-specialists.

This DSP includes competency statements about knowledge-based areas and clinical practice expectations related to geriatric physical therapy. The clinical practice expectations consist of competency in the area of professional roles, responsibilities and values, and competency in patient/client management. The competency statements reflect the wording used on the survey instrument.

Directions: Place an "×" in the box that BEST describes behavior observed for aspect of the competency.	Unsatisfactory Performance 1	Satisfactory Performance 2	Superior Performance 3	Rating
I. Knowledge Areas of Geriatrics Clinical Specialists				
A. Foundation Sciences				
1. Is knowledgeable about the biology of aging.				
2. Is knowledgeable about the physiology of aging.				
3. Is knowledgeable about neurophysiology.				
4. Is knowledgeable about anatomy.				
5. Is knowledgeable about neuroanatomy.				
6. Is knowledgeable about pathophysiology.				
7. Is knowledgeable about cellular biology (eg, phases of soft tissue healing, tissue makeup, changes with aging, response to exercise).				
Calculate the cumulative rating for this section and record here ➔				21
B. Clinical Sciences				
1. Is knowledgeable about pharmacology.				
2. Is knowledgeable about kinesiology.				
3. Is knowledgeable about pathokinesiology.				
4. Is knowledgeable about exercise physiology.				
5. Is knowledgeable about bariatric medicine.				
6. Is knowledgeable about the interpretation of special tests (eg, imaging, lab values)				
7. Is knowledgeable about principles of physical therapy evaluation and treatment of geriatric patients with musculoskeletal, neuromuscular, cardiovascular, cardiovascular/pulmonary, integumentary, or cognitive impairments.				
8. Is knowledgeable about physical therapy management of healthy elders.				
Calculate the cumulative rating for this section and record here ➔				24

Assessment Tool for Physical Therapists

Description of Specialty Practice: Geriatrics

Directions: Place an "×" in the box that BEST describes behavior observed for aspect of the competency.	Unsatisfactory Performance 1	Satisfactory Performance 2	Superior Performance 3	Rating
C. Behavioral Sciences				
1. Is knowledgeable about the psychology of aging.				
2. Is knowledgeable about the sociology of aging.				
3. Is knowledgeable about the economics of aging.				
4. Is knowledgeable about demography.				
5. Is knowledgeable about the epidemiology of chronic disease.				
6. Is knowledgeable about elements of communication.				
7. Is knowledgeable about theories of learning.				
8. Is knowledgeable about principles of adult education.				
9. Is knowledgeable about teaching methodology.				
10. Is knowledgeable about management techniques and principles.				
11. Is knowledgeable about principles of financial management.				
12. Is knowledgeable about reimbursement mechanisms.				
13. Is knowledgeable about policy issues in aging.				
14. Is knowledgeable about the consultant role and process.				
15. Is knowledgeable about the roles of interdisciplinary team members.				
16. Is knowledgeable about program development.				
17. Is knowledgeable about evidence-based practice.				
Calculate the cumulative rating for this section and record here ➔				51

Assessment Tool for Physical Therapists

Description of Specialty Practice: Geriatrics

Directions: Place an "×" in the box that BEST describes behavior observed for aspect of the competency.	Unsatisfactory Performance 1	Satisfactory Performance 2	Superior Performance 3	Rating
II. Professional Roles, Responsibilities, and Values of Geriatrics Clinical Specialists				
A. Professional Behavior				
1. Demonstrates professional behavior in interactions (eg, family meetings, written instructions, end of life discussions, care transitions) with patients, clients, families, caregivers, other health care providers, students, other consumers, and payers.				
2. Adheres to legal practice standards, including federal, state, and institutional regulations related to patient or client care and fiscal management				
3. Practices ethical decision making that is consistent with the American Physical Therapy Association's Professional Code of Ethics.				
4. Participates in peer-assessment activities (eg, performance appraisals, student evaluations, chart reviews).				
5. Demonstrates sensitivity (cultural, religious, and social) in professional interactions.				
6. Interacts with patients, clients, family members, other health care providers, and community-based organizations for the purpose of coordinating activities to facilitate efficient and effective patient/client care.				
7. Promotes geriatric physical therapy as an autonomous practice.				
8. Participates in the advancement of the physical therapy profession.				
Calculate the cumulative rating for this section and record here ➔				24
B. Professional Development				
1. Formulates and implements a plan for personal and professional development in geriatric physical therapy.				
2. Enhances knowledge and skill in geriatrics by participating in continuing professional development (eg, advanced degrees, certification, continuing education seminars, self study, journal clubs, residency education).				
3. Participates in gathering evidence for practice in geriatrics.				
Calculate the cumulative rating for this section and record here ➔				9

Assessment Tool for Physical Therapists

Description of Specialty Practice: Geriatrics

Directions: Place an "×" in the box that BEST describes behavior observed for aspect of the competency.	Unsatisfactory Performance 1	Satisfactory Performance 2	Superior Performance 3	Rating
C. Communication				
1. Uses active listening.				
2. Respectfully communicates (written and oral) with patients, clients, family, caregivers, practitioners, consumers, payers, and policy makers.				
3. Respects cultural differences during communication.				
Calculate the cumulative rating for this section and record here ➔				9
D. Social Responsibility				
1. Displays generosity as evidenced by the use of time and effort to meet patient or client needs.				
2. Demonstrates social responsibility, citizenship, and advocacy including community organizations (eg, clubs, Special Olympics, Senior Olympics, Arthritis Foundation).				
3. 3Provides physical therapist services to underserved and underrepresented populations to include pro bono work.				
Calculate the cumulative rating for this section and record here ➔				9
E. Leadership				
1. Actively participates in professional organizations and activities related to geriatric physical therapy.				
2. Maintains current knowledge of the activities of national and international physical therapy organizations related to geriatrics (eg, AARP, National Osteoporosis Foundation, White House Council on Aging, International Association of Physical Therapists Working with Older People).				
3. Represents physical therapy and interacts with other professionals and organizations in activities related to physical therapy for geriatric patients (eg, Blueprint on Aging, Fall Free Summit, AARP, American Geriatric Society).				
4. Promotes development of and participation in clinical residency programs in geriatric physical therapy.				
Calculate the cumulative rating for this section and record here ➔				12

Assessment Tool for Physical Therapists

Description of Specialty Practice: Geriatrics

Directions: Place an "×" in the box that BEST describes behavior observed for aspect of the competency.	Unsatisfactory Performance 1	Satisfactory Performance 2	Superior Performance 3	Rating
F. Education				
1. Uses appropriate teaching methods, and provides evidenced-based geriatric physical therapy educational programs to a variety of audiences including students, other health care professionals, the public, state and nationally elected officials, political groups and political candidates, and third-party payers.				
2. Mentors physical therapists, physical therapist assistants, and students by participating in clinical education and research related to geriatric physical therapy.				
Calculate the cumulative rating for this section and record here ➔				6
G. Administration				
1. Remains current in reimbursement and regulatory issues regarding public policy and delivery of services across geriatric care settings.				
2. Remains current in changes to economic drivers of health care.				
Calculate the cumulative rating for this section and record here ➔				6
H. Consultation				
1. Promotes successful aging by providing information on wellness, impairment, disease, disability, and health risks related to age, gender, culture, and lifestyle.				
2. Provides expert consultation about geriatric issues to individuals, businesses, educational institutions, government agencies, legal entities (eg, expert testimony), media outlets, and other organizations.				
3. Meets the needs of the geriatric patient/client through active involvement on multidisciplinary teams, while respecting each team member's role.				
Calculate the cumulative rating for this section and record here ➔				9
I. Advocacy				
1. Assists geriatric patients/clients in obtaining access to health care and physical therapy services.				
2. Attempts to make the health care delivery system more responsive to the needs of geriatric patients/clients.				
3. Aids geriatric patients/clients in developing the skills to advocate for themselves.				

Assessment Tool for Physical Therapists

Description of Specialty Practice: Geriatrics

Directions: Place an "×" in the box that BEST describes behavior observed for aspect of the competency.	Unsatisfactory Performance 1	Satisfactory Performance 2	Superior Performance 3	Rating
I. Advocacy (cont'd)				
4. Assists geriatric patients/clients in gaining access to all resources to assist in understanding their health condition and managing it.				
5. Provides health promotion information to patients/clients and the public.				
6. Disseminates evidence-based information to patients/clients, colleagues, other health care providers, and research agencies.				
7. Seeks opportunities to advocate for geriatric issues with policy and law-making bodies (eg, White House Conference on Aging, Long-Term Care Summit, political action committees).				
Calculate the cumulative rating for this section and record here ➔				21
J. Evidence-Based Practice				
1. Critically evaluates new information associated with geriatric physical therapy including techniques and technology, legislation, policy, and environments related to patient/client care.				
2. Critically evaluates research findings specific to geriatric physical therapy practice.				
3. Applies principles of evidence-based practice in geriatric physical therapy practice (examination, evaluation, diagnosis, prognosis and intervention).				
4. Participates in collaborative or independent research to contribute to the science associated with geriatric physical therapy practice.				
5. Participates in other scholarly activity that advances the practice of geriatric physical therapy (eg, outcomes studies, literature reviews).				
Calculate the cumulative rating for this section and record here ➔				15

Assessment Tool for Physical Therapists

Description of Specialty Practice: Geriatrics

Directions: Place an "×" in the box that BEST describes behavior observed for aspect of the competency.	Unsatisfactory Performance 1	Satisfactory Performance 2	Superior Performance 3	Rating
III. Practice Expectations for Geriatrics Clinical Specialists in the Patient/Client Management Model				
A. Examination				
History				
1. Systematically gathers data from both the past and the present related to why the patient/client is seeking the services of the physical therapist. Obtains patient history through interview and data from other sources (eg, questionnaires, medical records, test results specific to geriatric patient issues) including: a) a medication interview b) health status (eg, comorbidity, nutrition, depression, patient's/client's self report, family's or caregiver's report) c) social environment (eg, living situation, family structure, abuse) d) functional status and activity level e) previous therapeutic efforts for this or related problems and their success or failure				
Calculate the cumulative rating for this section and record here ➔				3
Systems Review				
1. Assesses physiological and anatomical status (eg, cardiovascular/pulmonary, integumentary, musculoskeletal and neuromuscular systems).				
2. Appropriately examines communication affect, cognition, language, and learning style of patient/client.				
Calculate the cumulative rating for this section and record here ➔				6
Tests and Measures				
1. Selects and prioritizes tests and measures based on history, systems review, scientific merit, clinical utility, and physiologic or fiscal cost to patient/client relative to criticality of data.				
2. Performs tests and measures to include: a) Aerobic Capacity/Endurance • Aerobic capacity during functional activities (eg, activities of daily living [ADL] scales, indexes, instrumental activities of daily living [IADL] scales, observations)				

Assessment Tool for Physical Therapists **Description of Specialty Practice: Geriatrics**				
Directions: Place an "×" in the box that BEST describes behavior observed for aspect of the competency.	Unsatisfactory Performance 1	Satisfactory Performance 2	Superior Performance 3	Rating
Tests and Measures (cont'd)				
• Aerobic capacity during standardized exercise test protocols (eg, ergometry, step tests, time/distance walk/run tests, treadmill tests, oxygen titration, wheelchair tests) • Cardiovascular signs and symptoms in response to increased oxygen demand with exercise or activity, including pressures and flow; heart rate, rhythm, and sounds; oximetry; and superficial vascular responses (eg, angina, claudication, and perceived exertion scales; electrocardiography; observations; palpation; sphygmomanometry) • Pulmonary signs and symptoms in response to increased oxygen demand with exercise or activity, including breath and voice sounds; cyanosis; gas exchange; respiratory pattern, rate, and rhythm; and ventilatory flow, force, and volume (eg, auscultation, dyspnea and perceived exertion scales, gas analyses, observations, oximetry, palpation, pulmonary function tests) • Effects of other medical and pharmacological interventions on aerobic capacity/endurance (eg telemetry, pacemaker, cardiac medications)				
b) Arousal, Attention, and Cognition • Arousal and attention (eg, adaptability tests, arousal and awareness scales, profiles, questionnaires) • Cognition, including ability to process commands (eg, safety awareness checklists, management of home exercise program, interviews, mental state scales, observations, questionnaires) • Communication and language barriers (eg, functional communication profiles, interviews, inventories, observations, questionnaires, assessment of expressive/receptive aphasia) • Consciousness, including agitation, dementia, delirium, and coma (eg, clinical signs and symptoms, scales) • Motivation and capacity to participate in intervention • Orientation to time, person, place, and situation (eg, attention tests, learning profiles, mental state scales) • Recall, including memory and retention (eg, assessment scales, interviews, questionnaires)				

Assessment Tool for Physical Therapists

Description of Specialty Practice: Geriatrics

Directions: Place an "×" in the box that BEST describes behavior observed for aspect of the competency.	Unsatisfactory Performance 1	Satisfactory Performance 2	Superior Performance 3	Rating
Tests and Measures (cont'd)				
c) Assistive and Adaptive Devices: The physical therapy specialist in geriatrics performs tests and measures to determine the potential benefits and use of assistive/adaptive devices based on knowledge of ADA guidelines on accessibility and based on patient mobility and ability to perform tasks. These tests and measures include: • Assistive or adaptive devices and equipment use during functional activities (eg, ADL scales, IADL scales interviews, observations) • Components, alignment, fit, and ability to care for the assistive or adaptive devices and equipment (eg, interviews, logs, observations, pressure-sensing maps, patient/caregiver reports) • Remediation of impairments, functional limitations, or disabilities with use of assistive or adaptive devices and equipment (eg, activity status indexes, ADL and IADL scales, aerobic capacity tests, functional performance inventories, health assessment questionnaires, pain scales, videographic assessments, assessments of energy conservation and energy expenditure) • Safety during use of assistive or adaptive devices and equipment (eg, diaries, fall scales, interviews, logs, observations, patient/caregiver reports) • Assessment of financial resources/community resources to assist in obtaining devices and equipment and home modification				
d) Circulation (Arterial, Venous, Lymphatic) • Cardiovascular signs, including heart rate, rhythm, and sounds; pressures and flow; and superficial vascular responses (eg, auscultation, electrocardiography, girth measurement, observations, palpation, sphygmomanometry, ankle/brachial index, perceived exertion scales) • Cardiovascular symptoms (eg, angina, claudication) • Lymphatic system function (eg, girth and volume measurements, palpation, observation of skin texture) • Physiological responses to position change, including autonomic responses, central and peripheral pressures, heart rate and rhythm, respiratory rate and rhythm, ventilatory pattern (eg, auscultation, electrocardiography, observations, palpation, skin color changes, sphygmomanometry, pharmacological signs and symptoms)				

Assessment Tool for Physical Therapists **Description of Specialty Practice: Geriatrics**				
Directions: Place an "×" in the box that BEST describes behavior observed for aspect of the competency.	Unsatisfactory Performance 1	Satisfactory Performance 2	Superior Performance 3	Rating
Tests and Measures (cont'd)				
e) Environmental, Home, and Work (Purposeful Activity) Barriers • Current and potential barriers (eg, checklists, interviews, observations, questionnaires) • Physical space and environment (eg, ADA compliance standards, observations, photographic assessments, questionnaires, structural specifications, technology-assisted assessments, videographic assessments) • Home assessment (eg, standardized tests for home assessment/modification ie.Functional Home Assessment Profile) • Assessment of willingness to change and fiscal resources to bring about change				
f) Ergonomics and Body Mechanics • Ergonomics related to common diagnoses seen in the geriatric population (eg lighting, seating devices, computer screens with regard to bifocals, deformities and postural changes related to arthritis and ROM changes associated with aging) • Body mechanics during self-care, home management, work, community, or leisure actions, tasks, or activities (eg, ADL and IADL scales, observations, photographic assessments, technology-assisted assessments, videographic assessments) • Body mechanics with caregiver activities (eg, observation, environmental assessment, patient handling equipment needs)				
g) Gait, Locomotion, and Balance • Balance during functional activities with or without the use of assistive, adaptive, orthotic, protective, supportive, or prosthetic devices or equipment (eg, ADL scales, IADL scales, observations, videographic assessments, confidence indexes) • Balance (dynamic and static) with or without the use of assistive, adaptive, orthotic, protective, supportive, or prosthetic devices or equipment (eg, balance scales, dizziness inventories, dynamic posturography, fall scales, motor impairment tests, observations, photographic assessments, postural control tests)				

Assessment Tool for Physical Therapists

Description of Specialty Practice: Geriatrics

Directions: Place an "×" in the box that BEST describes behavior observed for aspect of the competency.	Unsatisfactory Performance 1	Satisfactory Performance 2	Superior Performance 3	Rating
Tests and Measures (cont'd)				
• Gait and locomotion during functional activities on various surfaces with or without the use of assistive, adaptive, orthotic, protective, supportive, or prosthetic devices or equipment, footwear assessment (eg, ADL scales, gait indexes, IADL scales, mobility skill profiles, observations, videographic assessments) • Gait and locomotion with or without the use of assistive, adaptive, orthotic, protective, supportive, or prosthetic devices or equipment (eg, footprint analyses, gait indexes, mobility skill profiles, gait parameter scales, observations, photographic assessments, technology-assisted assessments, videographic assessments, weight-bearing scales, wheelchair mobility tests) • Safety during gait, locomotion, and balance (eg, confidence scales, diaries, fall risk assessment scales, functional assessment profiles, logs, reports)				
h) Integumentary Integrity • Activities, positioning, and postures that produce or relieve trauma to the skin (eg, observations, pressure-sensing maps, scales) • Assistive, adaptive, orthotic, protective, supportive, or prosthetic devices and equipment that may produce or relieve trauma to the skin (eg, observations, pressure-sensing maps, risk assessment scales, techniques and devices used to reduce skin trauma with transfers) • Skin characteristics, including blistering, continuity of skin color, dermatitis, trophic changes, mobility, sensation, temperature, and turgor (eg, observations, palpation, photographic assessments)				
i) Integumentary Integrity/Wound Assessment • Activities, positioning, and postures that aggravate the wound or scar or that produce or relieve trauma (eg, observations, pressure-sensing maps, pressure relief techniques) • Signs of infection (eg, cultures, observations, palpation) • Wound characteristics, including bleeding, contraction, depth, drainage, exposed anatomical structures, location, odor, pigment, shape, size, type, staging and progression, tunneling, and undermining (eg, digital and grid measurement, grading/classification, observations, palpation, photographic assessments, wound tracing) • Wound scar tissue characteristics, including banding, pliability, sensation, and texture (eg, observations, scar-rating scales) • Periwound assessment				

Assessment Tool for Physical Therapists **Description of Specialty Practice: Geriatrics**				
Directions: Place an "×" in the box that BEST describes behavior observed for aspect of the competency.	Unsatisfactory Performance 1	Satisfactory Performance 2	Superior Performance 3	Rating
Tests and Measures (cont'd)				
j) Joint Integrity and Mobility • Joint integrity and mobility (eg, apprehension, compression and distraction, drawer, glide, impingement, shear, and valgus/varus stress tests; arthrometry; palpation; capsular pattern) • Joint play movements, including end feel (joints of the axial and appendicular skeletal system) (eg, palpation, accessory movements, special tests) • Joint movement and functional activities (eg, pain assessment and/or alleviation, quality, substitution, orthotic needs)				
k) Motor Function (Motor Control and Motor Learning) • Dexterity, coordination, and agility (eg, coordination screens, motor impairment tests, motor proficiency tests, observations, videographic assessments) • Initiation, modification, and control of movement patterns and voluntary postures (eg, activity indexes, gross motor function profiles, neuromotor tests, observations, physical performance tests, postural challenge tests, videographic assessments)				
l) Performance (including strength, power and endurance) • Muscle strength, power, and endurance (eg, dynamometry, manual muscle tests, muscle performance tests, physical capacity tests, technology-assisted assessments, timed activity tests) • Muscle strength, power, and endurance during functional activities (eg, activities of daily living [ADL] scales, functional muscle tests, instrumental activities of daily living [IADL] scales, observations, videographic assessments)				
m) Sensory Integration • Sensorimotor integration, including postural, equilibrium, and righting reactions (eg, motor and processing skill tests, observations, postural challenge tests, reflex tests, sensory profiles, visual perceptual skill tests)				

Assessment Tool for Physical Therapists

Description of Specialty Practice: Geriatrics

Directions: Place an "×" in the box that BEST describes behavior observed for aspect of the competency.	Unsatisfactory Performance 1	Satisfactory Performance 2	Superior Performance 3	Rating
Tests and Measures (cont'd)				
n) Orthotic, Protective and Supportive Devices • Components, alignment, fit, and ability to care for the orthotic, protective, and supportive devices and equipment (eg, interviews, logs, observations, pressure-sensing maps, reports) • Orthotic, protective, and supportive devices and equipment use during functional activities (eg, activities of daily living [ADL] scales, functional scales, instrumental activities of daily living [IADL] scales, interviews, observations, profiles) • Remediation of impairments, functional limitations, or disabilities with use of orthotic, protective, and supportive devices and equipment (eg, activity status indexes, ADL scales, aerobic capacity tests, functional performance inventories, health assessment questionnaires, IADL scales, pain scales, videographic assessments) • Safety during use of orthotic, protective, and supportive devices and equipment (eg, diaries, fall scales, interviews, logs, observations, reports)				
o) Pain • Pain, soreness, and nociception (eg, angina scales, analog scales, discrimination tests, pain drawings and maps, provocation tests, verbal and pictorial descriptor tests) • Pain in specific body parts (eg, pain indexes, pain questionnaires, structural provocation tests) • Analysis of pain behavior and reaction(s) during specific movements and provocation				
p) Posture • Postural alignment and position (static and dynamic), including symmetry and deviation from midline (eg, grid measurement, inclinometery, observations, height assessment, videographic assessments)				
q) Prosthetic Requirements • Components, alignment, fit, and ability to care for the prosthetic device (eg, interviews, logs, observations, pressure-sensing maps, skin checks, reports) • Prosthetic device use during functional activities (eg, activities of daily living [ADL] scales, functional scales, instrumental activities of daily living [IADL] scales, interviews, observations)				

Assessment Tool for Physical Therapists **Description of Specialty Practice: Geriatrics**				
Directions: Place an "×" in the box that BEST describes behavior observed for aspect of the competency.	Unsatisfactory Performance 1	Satisfactory Performance 2	Superior Performance 3	Rating
Tests and Measures (cont'd)				
• Remediation of impairments, functional limitations, or disabilities with use of the prosthetic device (eg, aerobic capacity tests, oximetry, activity status indexes, ADL and IADL scales, functional performance inventories, health assessment questionnaires, fear of falling scales, pain scales, technology-assisted assessments, videographic assessments) • Residual limb or adjacent segment, including edema, range of motion, skin integrity, and strength (eg, goniometry, muscle tests, observations, palpation, photographic assessments, skin integrity tests, technology-assisted assessments, videographic assessments, volume measurement) • Safety during use of the prosthetic device (eg, diaries, fall scales, interviews, logs, observations, reports)				
r) Self-Care and Home Management (Including ADL and IADL) • Ability to gain access to home environments (eg, barrier identification, observations, physical performance tests) • Ability to safely perform self-care and home management activities (eg, ADL scales, aerobic capacity tests, IADL scales, interviews, observations, fall scales)				
s) Ventilation and Respiration/Gas Exchange • Pulmonary signs of respiration/gas exchange, including breath sounds (eg, gas analyses, observations, oximetry) • Pulmonary symptoms (eg, dyspnea ,perceived exertion, observation, indexes, and scales)				
t) Work (Job/School/Purposeful Activity), Community, and Leisure Integration or Reintegration (Including IADL) • Ability to assume or resume work (purposeful activity), community, and leisure activities with or without assistive, adaptive, orthotic, protective, supportive, or prosthetic devices and equipment (eg, activity profiles, disability indexes, functional status questionnaires, IADL scales, observations, physical capacity tests) • Ability to gain access to work (purposeful activity), community, and leisure environments (eg, barrier identification, interviews, observations, physical capacity tests, transportation assessments)				

Assessment Tool for Physical Therapists

Description of Specialty Practice: Geriatrics

Directions: Place an "×" in the box that BEST describes behavior observed for aspect of the competency.	Unsatisfactory Performance 1	Satisfactory Performance 2	Superior Performance 3	Rating
Tests and Measures (cont'd)				
• Safety in work (purposeful activity), community, and leisure activities and environments (eg, diaries, fall scales, balance assessment, interviews, logs, observations, dexterity and coordination assessment, videographic assessment, environmental assessments)				
u) Reexamination • Respond to emerging data from examinations and interventions by performing special tests and measures to evaluate progress, modify or redirect intervention				
Calculate the cumulative rating for this section and record here ➔				63

Assessment Tool for Physical Therapists

Description of Specialty Practice: Geriatrics

Directions: Place an "×" in the box that BEST describes behavior observed for aspect of the competency.	Unsatisfactory Performance 1	Satisfactory Performance 2	Superior Performance 3	Rating
B. Evaluation (the dynamic process of clinical judgment in interpreting examination data)				
1. Interprets data from examination (eg, identifies relevant, consistent, accurate data; prioritizes impairments; assesses patient's needs, motivations, and goals).				
2. Determines when signs and symptoms that indicate referral to a physician or another health care provider is appropriate, based on specialized knowledge of geriatric physical therapy.				
Calculate the cumulative rating for this section and record here ➔				6
C. Diagnosis				
1. Based on evaluation, organizes data into recognized clusters, syndromes, or categories.				
2. Establishes differential diagnoses based on awareness of diseases, disorders, and conditions that affect geriatric patients.				
3. Establishes differential diagnoses based on awareness of diseases, disorders, and conditions that can mimic prevalent practice patterns in geriatric clients and determines the need to refer these clients to other health care providers.				
4. Determines diagnostic practice pattern(s) that guide future patient/client management and are amenable to physical therapy interventions.				
5. Considers physiological changes and atypical presentations with aging that are specific to the diagnostic process.				
Calculate the cumulative rating for this section and record here ➔				15
D. Prognosis (determines the level of optimal improvement that may be attained through intervention and the amount of time required to reach that level; including plan of care)				
1. Uses knowledge of examination, evaluation and diagnosis to determine patient client prognosis.				
2. Considers the long-term prognostic effect of normal age-related changes and comorbidities.				
3. Considers the prognostic effect of medical, social, and occupational history.				
4. Considers the prognostic impact of other medical interventions (eg, implanted devices, pumps, radiation therapy, chemotherapy).				
5. Considers the prognostic impact of depression, dementia, and other psychosocial issues (eg, grieving, recent loss) when determining prognosis.				

Assessment Tool for Physical Therapists

Description of Specialty Practice: Geriatrics

Directions: Place an "×" in the box that BEST describes behavior observed for aspect of the competency.	Unsatisfactory Performance 1	Satisfactory Performance 2	Superior Performance 3	Rating
D. Prognosis (cont'd)				
6. Considers the prognostic effect of pharmacological interventions (eg, prescribed medications, over the counter medications, herbal supplements).				
7. Considers the prognostic effect of cultural considerations (eg, values, beliefs, ethnicity, religion, spirituality, sexual orientation, and special populations).				
8. Considers the patient's personal goals as they relate to the prognosis.				
9. Develops a plan of care that: • Prioritizes interventions related to the diagnosis, recovery process, patient/client goals, outcomes data, and resources • Takes safety and patient/family/caregiver concerns/ living arrangements and financial situation into consideration • Includes achievable patient/client outcomes within available resources and according to the administrative policies and procedures of the practice environment • Considers quality of life in regard to end-of-life wishes, transitions, and advanced directives (eg, quality of life scales).				
Calculate the cumulative rating for this section and record here ➔				27
E. Intervention				
Coordination, Communication, and Documentation				
1. Interacts with patients, clients, family members, other health care providers, and community-based organizations for the purpose of coordinating activities to facilitate efficient and effective patient or client care.				
2. Coordinates the physical therapy patient-management process to include community resources, discharge planning, timely data transmission, and delivery of service.				
3. Communicates effectively with patients, clients, family members, caregivers, practitioners, consumers, payers, and policymakers about geriatric issues.				
4. Discusses rationale for physical therapy examination and intervention procedures including use of current best evidence with patients/clients and families, other health care professionals, and payers.				

Assessment Tool for Physical Therapists

Description of Specialty Practice: Geriatrics

Directions: Place an "×" in the box that BEST describes behavior observed for aspect of the competency.	Unsatisfactory Performance 1	Satisfactory Performance 2	Superior Performance 3	Rating
Coordination, Communication, and Documentation (cont'd)				
5. Collaborates as a health care team member and leader to ensure that physical therapy is a part of an appropriate, culturally competent, comprehensive plan in the care of geriatric patients.				
6. Adapts communication to appropriate health literacy levels.				
7. Completes thorough, accurate, analytically sound, concise, and timely documentation that follows guidelines and specific documentation formats required by the practice setting (eg, communication with payer sources for maximizing treatment services and resources, legal protection of staff, patient, and/ or facility.				
Calculate the cumulative rating for this section and record here ➔				21
Patient/Client-Related Instruction				
1. Provides patient/client instruction about diagnosis, prognosis and intervention strategies.				
2. Provides patient/client-related instruction to increase patient/client understanding of individual abilities, functional limitations, or disabilities.				
3. Provides patient/client-related instruction aimed at risk reduction/prevention as well as health promotion.				
4. Assists patient/client in critically looking at Internet and other information that is available in the community.				
5. Adapts instruction for the situation (eg, learning styles, actual practice by the patient or caregiver, use of audio and visual aids, verbal, written, pictorial instruction, culturally sensitive instruction).				
6. Provides patient/client-related instruction in the following specialized areas of geriatric physical therapy (eg, falls prevention, bone health, geriatric athlete, ability enhancement, foot care).				
7. Maintains a current knowledge base regarding current health indicators as identified by the Department of Health and Center for Disease Control and Prevention in or to provide education to the patient, caregivers, health professionals, and the public on the role of physical therapy interventions.				
Calculate the cumulative rating for this section and record here ➔				21

Assessment Tool for Physical Therapists

Description of Specialty Practice: Geriatrics

Directions: Place an "×" in the box that BEST describes behavior observed for aspect of the competency.	Unsatisfactory Performance 1	Satisfactory Performance 2	Superior Performance 3	Rating
Procedural Interventions				
1. Provides therapeutic exercise, including, but not limited to: a) Aerobic capacity/endurance conditioning or reconditioning (eg, gait/locomotion training, cycles, increased workload over time, treadmills, movement efficiency and energy conservation instruction or training) b) Balance, coordination, and agility training (eg, fall risk reduction and education, neuromuscular education or reeducation, perceptual training, posture awareness training, sensory training or retraining, standardized, programmatic, complementary exercise approaches, task-specific performance training) c) Vestibular training d) Body mechanics and postural stabilization (eg, zero lifting techniques for caregivers, postural stabilization activities, posture awareness training) e) Gait and locomotion training (eg, gait training; implement and device training; perceptual training:, standardized, programmatic, and complementary exercise approaches; powered and non-powered wheelchair mobility training; fall prevention) f) Neuromotor development training (eg, motor training, movement pattern training, constraint induced movement therapy, neuromuscular education or reeducation) g) Strength, power, and endurance training for head, neck, limb, pelvic floor, trunk, and ventilatory muscles (eg, active assistive, active, and resistive exercises; aquatic programs; standardized, programmatic, complementary exercise approaches; task-specific performance training)				
2. Provides functional training in self-care and home management to include: a) Barrier accommodations or modifications (eg, environmental modification) b) Device and equipment use and training (eg, friction reduction devices/lifts, assistive and adaptive device or equipment training during ADL and IADL, orthotic, protective, or supportive device or equipment training during self-care and home management, prosthetic device or equipment training during ADL and IADL) c) Functional training programs (eg, simulated environments and tasks, transfer training, bed mobility, up from floor, task adaptation) d) Injury prevention or reduction (eg, self-care and home management, use of devices and equipment, safety awareness training during self-care and home management, zero lift, home safety and energy conservation, fall prevention and education, use of devices to decrease injurious falls)				

Assessment Tool for Physical Therapists **Description of Specialty Practice: Geriatrics**				
Directions: Place an "×" in the box that BEST describes behavior observed for aspect of the competency.	Unsatisfactory Performance 1	Satisfactory Performance 2	Superior Performance 3	Rating
Procedural Interventions (cont'd)				
3. Provides functional training in work (purposeful activity), community, and leisure integration or reintegration, including but not limited to: a) Functional training programs (eg, simulated environment and tasks, task adaptation, task training, cardiopulmonary rehabilitation, dexterity/coordination, conditioning/reconditioning training) b) Injury prevention or reduction (eg, injury prevention education during work, community, and leisure integration or reintegration; injury prevention education with use of devices and equipment; safety awareness training during work, community, and leisure integration or reintegration)				
4. Uses manual therapy techniques, including: a) Manual lymphatic drainage b) Mobilization/manipulation (eg, soft tissue, spinal and peripheral joints)				
5. Prescribes, applies, and, as appropriate, fabricates devices and equipment to include: a) Adaptive devices (eg, environmental controls, hospital beds, raised toilet seats, seating systems, ramps, lifts) b) Assistive devices (eg, canes, crutches, long-handled reachers, percussors and vibrators, power devices, static and dynamic splints, walkers, wheelchairs) c) Orthotic devices (eg, braces, casts, shoe inserts, splints) d) Prosthetic devices (lower-extremity and upper-extremity) e) Protective devices (eg, braces, cushions, helmets, protective taping) f) Supportive devices (eg, compression garments, corsets, elastic wraps, mechanical ventilators, neck collars, serial casts, slings, supplemental oxygen, supportive taping) g) Utilization of financial (individual and community) resources to assist in obtaining appropriate devices				

Assessment Tool for Physical Therapists

Description of Specialty Practice: Geriatrics

Directions: Place an "×" in the box that BEST describes behavior observed for aspect of the competency.	Unsatisfactory Performance 1	Satisfactory Performance 2	Superior Performance 3	Rating
Procedural Interventions (cont'd)				
6. Uses airway clearance techniques, including: a) Breathing strategies (eg, assisted cough/huff techniques, postural drainage, paced breathing, pursed lip breathing, techniques to maximize ventilation) b) Manual/mechanical techniques (eg, assistive devices, chest percussion, vibration, and shaking, chest wall manipulation) c) Positioning (eg, positioning to alter work of breathing, positioning to maximize ventilation and perfusion, pulmonary postural drainage)				
7. Uses integumentary repair and protection techniques: a) Debridement–nonselective (eg, pulsatile lavage, autolytic, enzymatic or chemical debridement) b) Debridement–selective (eg, sharp debridement) c) Dressings (primary and secondary) (eg, hydrogels, alginates, compression wraps) d) Negative pressure wound therapy e) Topical antibiotics. f) Topical agents (eg, cleansers, creams, moisturizers, ointments, sealants) g) Coordination with other services (hyperbaric treatment, dialysis, enterostomal therapist, dietician) h) Positioning, both preventive and post injury i) Additional healing techniques and tools (eg, special depth shoes, shoe inserts; pressure relieving mattresses, pressure relieving wheelchair cushions) j) Modalities (eg, whirlpool, pulsatile lavage, electric stimulation, light therapy, ultrasound)				
Calculate the cumulative rating for this section and record here ➔				21
F. Outcomes Assessment				
1. Assesses individual and collective outcomes of patients/clients using valid and credible measures that consider practice setting patient/client culture, and effect of societal factors such as reimbursement				
2. Chooses appropriate outcomes measurement tools for geriatric physical therapy diagnoses based on the patient/client's needs and examination findings (eg, specific impairment tools, patient satisfaction measures, clinical and functional assessment tools, and quality of life scales)				
Calculate the cumulative rating for this section and record here ➔				6

Description of Specialty Practice: Geriatrics
SUMMARY FORM

Use this summary to gain an overview of the ratings you recorded for each behavior. Copy each rating you recorded to this page. You will then have a global perspective for each competency.

I. Knowledge Areas of Geriatrics Clinical Specialists	Score	Summary Score
A. Foundation Sciences	21	
B. Clinical Sciences	24	
C. Behavioral Sciences	51	
Cumulative Rating for Section I		**96**
II. Professional Roles, Responsibilities, and Values of Geriatrics Clinical Specialists	Score	Summary Score
A. Professional Behavior	24	
B. Professional Development	9	
C. Communication	9	
D. Social Responsibility	9	
E. Leadership	12	
F. Education	6	
G. Administration	6	
H. Consultation	9	
I. Advocacy	21	
J. Evidence-Based Practice	15	
Cumulative Rating for Section II		**120**

Description of Specialty Practice: Geriatrics
SUMMARY FORM (cont'd)

III. Practice Expectations for Geriatrics Clinical Specialists in the Patient/ Client Management Model	Score	Summary Score
A. Examination		
1) History	3	
2) Systems Review	6	
3) Tests and Measures	63	
B. Evaluation	6	
C. Diagnosis	15	
D. Prognosis	27	
E. Intervention		
1) Coordination, Communication, and Documentation	21	
2) Patient/Client-Related Instruction	21	
3) Procedural Interventions	21	
F. Outcomes Assessment	6	
Cumulative Rating for Section III		**189**
Total Cumulative Rating		**405**

Description of Specialty Practice: Geriatrics
ACTION PLAN

After you have reviewed the summary form, identify (by highlighting) the competency aspects that you scored the weakest. These are the competency aspects that may need to be improved. An action plan may be developed to increase knowledge and/or skills for each of the competency aspects that have been highlighted. An action plan can help to organize and prioritize professional development needs.

It is simple to develop an action plan.

1. Identify the **competency aspect** that needs to be improved.
2. Assign a professional development **priority** to the competency aspect using a scale of 1 to 5 with 1 being the lowest priority and 5 the highest priority.
3. Identify **when** (timeframe for implementation of the action item) each professional development need can be satisfied.
4. Indicate **how** (eg, continuing education course, college/university class, mentor, clinical residency, supervised clinical practice) each professional development need will be satisfied.
5. Identify **what** resources (eg, time off, registration fee, contact with possible mentors, application for clinical residency, etc.) are needed.
6. Choose the **method** that will be used to demonstrate that each professional development need has successfully been met (eg, certificate of completion, passing grade, mentor feedback, satisfactory completion of residency, etc.)

Here is a sample action plan to consider:

BEHAVIOR	PRIORITY 1 = lowest 5 = highest	WHEN	HOW	WHAT	METHOD
I am able to identify the educational needs of the learner/client.	4	by 6/04	CE course	1. time off 2. registration fee 3. travel funds 4. shift coverage	1. certificate of completion 2. peer review
I am able to reevaluate treatment or goals	2	by 12/04	mentor	1. agreement with department director	1. mentor feedback 2. peer review

For additional professional development information, visit www.APTA.org/CareersEducation.

Assessment Tool for Physical Therapists

Description of Specialty Practice: Geriatrics
EVALUATION FORM

Please take a few minutes to give us feedback on the Assessment Tool for Physical Therapists: Geriatrics. Fill in this evaluation form (use back for additional comments), and return it by mail to APTA, Postprofessional Certification & Credentialing Department, 1111 North Fairfax Street, Alexandria, VA 22314-1488, Attn: Performance Evaluation, or return by fax to 703/706-8186.

(Please print)

I. Name _____

First Last

II. APTA Membership APTA member number _____ **(___) nonmember**

Circle your response 5=excellent 4=good 3=average 2=fair 1=poor

III. Clarity

1. The Assessment Tool for Physical Therapists: Geriatrics met my needs.

5 4 3 2 1 N/A

COMMENTS _____

2. The Assessment Tool for Physical Therapists: Geriatrics was clearly presented and easily understandable.

5 4 3 2 1 N/A

COMMENTS _____

3. The instructions for completion of the Assessment Tool for Physical Therapists: Geriatrics were clear and precise.

5 4 3 2 1 N/A

COMMENTS _____

IV. Format

4. The Assessment Tool for Physical Therapists: Geriatrics was easy to follow.

5 4 3 2 1 N/A

COMMENTS _____

5. The format was appropriate for the assessment of clinical practice.

5 4 3 2 1 N/A

COMMENTS _____

V. User Friendly

6. The Assessment Tool for Physical Therapists: Geriatrics was user-friendly.

5 4 3 2 1 N/A

COMMENTS _____

Thank You!