

AMERICAN BOARD OF PHYSICAL THERAPY RESIDENCY AND FELLOWSHIP EDUCATION

Description of Residency Practice
Geriatrics
June 2017

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Preamble

The American Board of Physical Therapy Residency and Fellowship Education (ABPTRFE), a board-appointed group of the American Physical Therapy Association (APTA), has created the following Description of Residency Practice (DRP) to reduced unwarranted curriculum variability; provide residents minimum consistency in learning experiences for that area of practice; and streamline the accreditation process for reporting.

This DRP is the product of collaborative work by ABPTRFE and the APTA Physical Therapy Outcomes Registry staff, and is based on feedback received from members of the American Board of Physical Therapist Specialties (ABPTS) and directors of residency programs. Feedback was analyzed and incorporated into the DRP as ABPTRFE refined the document.

While all programs are required to meet the comprehensive curriculum and program requirements as outlined within the *ABPTRFE Quality Standards for Clinical Physical Therapist Residency and Fellowship Programs*, the purpose of the DRP is to: (1) establish a consistent curriculum expectation for residency programs within the same specialty area, and (2) provide consistency in program reporting for accreditation processes. The DRP allows flexibility for programs to incorporate additional learning experiences unique to the program's environment that are beyond the minimum standard expectations.

The DRP for each residency area will undergo revalidation at least once every 10 years. The process for revalidation will be a collaborative process with ABPTS, for specialty areas recognized by ABPTS, and will occur as part of the revalidation of that specialty area by ABPTS.

I. Type of Program

Geriatrics is a clinical area of practice.

II. Learning Domain Expectations

A residency program must have a curriculum inclusive of the learning domains identified within that area's current validated analysis of practice.

The following information is extracted directly from chapter 2 of the *Geriatric Description of Specialty Practice*.¹

A. Knowledge Areas of Geriatric Practice

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)

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, integumentary, or cognitive impairments
- Physical therapy management of healthy elders

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

B. Professional Competencies of Geriatric Physical Therapists

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.

¹Geriatric Physical Therapy Description of Specialty Practice. 3rd ed. Alexandria, VA: American Physical Therapy Association; 2009. Reproduced with permission. © 2009 American Physical Therapy Association. All rights reserved.

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- 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.

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.

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.

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.

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.

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.

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.

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.

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 clients, colleagues, other health care providers, and research agencies.
- Seek opportunities to advocate for geriatric issues with policy and lawmaking bodies (eg, White House Conference on Aging, Long Term Care Summit, political action committees).

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).

C. Psychomotor Skills of Geriatric Physical Therapists in the Patient/Client Management Model

Examination

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

1. History
 - 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, tests results, specific to geriatric patient issues) including:
 - A medication review
 - Health status (eg, comorbidity, nutrition, depression, patient's/client's self-report, family's or caregiver's report)
 - Social environment (eg, living situation, family structure, abuse)
 - Functional status and activity level
 - Previous therapeutic efforts for this or related problems and their success or failure

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2. Systems Review

- Perform a systems review to assess physiological and anatomical status (eg, cardiovascular/pulmonary, integumentary, musculoskeletal and neuromuscular systems).
- Appropriately examine communication affect, cognition, language, and learning style of patient/client.

3. Test and Measures

- 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.
- Perform tests and measures to include:
 - 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).
- 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).
- 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).

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- 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.
- Circulation (Aterial, 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).
- 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.
- 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).

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- 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).
- 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).
- 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.
- Joint Integrity and Mobility
 - Joint integrity and mobility (eg, apprehension, compression and distraction, drawer, glide,

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- 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).
- 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).
- 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).
- 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).
- 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).
- 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.
- Posture

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- Postural alignment and position (static and dynamic), including symmetry and deviation from midline (eg, grid measurement, inclinometry, observations, height assessment, videographic assessments).
 - 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).
 - 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).
 - 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).
 - 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).
4. Reexamination
- Respond to emerging data from examinations and interventions by performing special tests and measures to evaluate progress, modify or redirect intervention.

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.

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.

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:
 - 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).

Intervention

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

1. Coordination, Communication, and Documentation
 - 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.

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- Coordinating the physical therapy patient-management process to include community resources, discharge planning, timely data transmission, and delivery of service.
 - Communicating effectively with patients, clients, family members, caregivers, practitioners, consumers, payers, and policymakers about geriatric issues.
 - 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.
 - 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.
 - Adapting communication to appropriate health literacy levels.
 - 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).
2. Patient/Client-Related Instruction
- Providing patient/client instruction about diagnosis, prognosis and intervention strategies.
 - Providing patient/client-related instruction to increase patient/client understanding of individual abilities, functional limitations, or disabilities.
 - Providing patient/client-related instruction aimed at risk reduction/prevention as well as health promotion.
 - Assisting patient/client in critically looking at Internet and other information that is available in the community.
- 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).
 - 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).
 - 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.
3. Procedural Interventions
- Therapeutic exercise, including, but not limited to:*
- Aerobic capacity/endurance conditioning or reconditioning (eg, gait/locomotion training, cycles, increased workload over time, treadmills, movement efficiency and energy conservation instruction or training).
 - 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).
 - Vestibular training.
 - Body mechanics and postural stabilization (eg, zero lifting techniques for caregivers, postural stabilization activities, posture awareness training).
 - 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).

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

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

- Barrier accommodations or modifications (eg, environmental modification).
- 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).
- Functional training programs (eg, simulated environments and tasks, transfer training, bed mobility, up from floor, task adaptation).
- 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).

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

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

- 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).

Manual therapy techniques, which may include:

- Manual lymphatic drainage.
- Mobilization/manipulation (eg, soft tissue, spinal and peripheral joints).

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

- Adaptive devices (eg, environmental controls, hospital beds, raised toilet seats, seating systems, ramps, lifts).
- Assistive devices (eg, canes, crutches, long-handled reachers, percussors and vibrators, power devices, static and dynamic splints, walkers, wheelchairs).
- Orthotic devices (eg, braces, casts, shoe inserts, splints).
- Prosthetic devices (lower-extremity and upper-extremity).
- Protective devices (eg, braces, cushions, helmets, protective taping).
- Supportive devices (eg, compression garments, corsets, elastic wraps, mechanical ventilators, neck collars, serial casts, slings, supplemental oxygen, supportive taping).
- Utilization of financial (individual and community) resources to assist in obtaining appropriate devices.

Airway clearance techniques, including:

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

- Manual/mechanical techniques (eg, assistive devices, chest percussion, vibration, and shaking, chest wall manipulation).
- Positioning (eg, positioning to alter work of breathing, positioning to maximize ventilation and perfusion, pulmonary postural drainage).

Integumentary repair and protection techniques:

- Debridement–nonselective (eg, pulsatile lavage, autolytic, enzymatic or chemical debridement).
- Debridement–selective (eg, sharp debridement).
- Dressings (primary and secondary) (eg, hydrogels, alginates, compression wraps).
- Negative pressure wound therapy.
- Topical antibiotics.
- Topical agents (eg, cleansers, creams, moisturizers, ointments, sealants).
- Coordination with other services (hyperbaric treatment, dialysis, enterostomal therapist, dietician).
- Positioning, both preventive and post injury.
- Additional healing techniques and tools (eg, special depth shoes, shoe inserts; pressure relieving mattresses, pressure relieving wheelchair cushions).
- Modalities (eg, whirlpool, pulsatile lavage, electric stimulation, light therapy, ultrasound).

Outcomes Assessment

- Assess individual and collective outcomes of patients/clients using valid & 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).

III. Practice Settings

The clinical curriculum of all accredited residency

programs must include a variety of practice settings, as noted below. A resident should experience a minimum of 5% of their time in each setting, as required by the *ABPTRFE Quality Standards for Clinical Physical Therapist Residency and Fellowship Programs*.

If a residency program is unable to provide each participant with an opportunity to engage in patient care activities within these settings, the program must provide additional learning opportunities (eg, observation, didactic, journal club, research) related to patient care within these settings for the minimum required hours noted above.

The minimum required practice settings for geriatric residency programs are:

- Acute care facility
- Outpatient facility
- Patient's home/home care
- Skilled nursing facility

IV. Patient Populations

The clinical curriculum of all accredited residency programs must include a variety of patient populations, specific to sex and age group as listed below, for a minimum of 5% of the program hours required by the *ABPTRFE Quality Standards for Clinical Physical Therapist Residency and Fellowship Programs*.

If a residency program is unable to provide each resident with an opportunity to engage in patient care activities within these populations, the program must provide additional learning opportunities (eg, observation, didactic, journal club, research) related to patient care within these populations for the minimum required hours noted above.

The minimum required patient populations for geriatric residency programs are:

Age:

- Geriatrics (60 years of age to end of life)

Note: ABPTRFE is aware that patients younger than 60 years of age may be appropriate to be included

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Description of Residency Practice Geriatrics

within a geriatric residency program. Situations when this might occur include when a patient's condition is more likely found in older persons who have multiple diseases, disabilities, and/or mental problems.

Sex:

- Female
- Male

V. Primary Health Conditions

The clinical curriculum of all accredited residency programs must include a variety of primary health conditions associated with the program's area of practice (see below list).

If a residency program is unable to provide each resident with an opportunity to engage in patient care

activities within the majority of these populations, the program must provide additional learning opportunities (eg, observation, didactic, journal club, research) related to patient care within these conditions.

The following template must be used when logging resident-patient encounters as part of the residency curriculum. Patients evaluated, treated, or managed by the resident as part of the resident's education throughout the course of the residency program should be included within the template. The patient's primary health condition is only counted during the first patient encounter. **Patient encounters beyond the initial visit should not be included in the frequency count.**

Name of Resident:	
Primary Health Conditions Geriatrics	Number of Patients Evaluated, Treated, or Managed by the Resident as Part of the Program's Curriculum
CARDIOVASCULAR SYSTEM	
Congestive heart failure	
Myocardial Infarction (eg, CABG, valve replacement)	
PULMONARY SYSTEM	
Chronic obstructive pulmonary disease	
Peripheral vascular disease	
Pneumonia	
Respiratory failure	
ENDOCRINE SYSTEM	
Dehydration	
Diabetes (debility from)	
Electrolyte imbalance	
INTEGUMENTARY SYSTEM	
Anemia	
Wound disorder	
NERVOUS SYSTEM	
Acquired brain injury (eg, traumatic brain injury)	

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Cerebrovascular accident	
Dementia (eg, Alzheimer's and other types)	
Diabetic neuropathy	
Encephalopathy (toxic, metabolic, anoxic)	
Neurologic disorders, progressive (eg, ALS, MS, Huntington's disease)	
Parkinson's disease	
Peripheral neuropathy	
Vestibular disorders	
MUSCULOSKELETAL SYSTEM	
Bone density below reference range (eg, osteopenia/osteoporosis)	
Fractures	
Frailty/deconditioning/debility	
Joint Replacement	
Musculoskeletal pain, strain, or sprain	
Myopathies (eg, critical illness myopathy)	
Osteoarthritis	
Spinal stenosis	
INVOLVEMENT OF MULTIPLE SYSTEMS	
Acute infectious disease (eg, cellulitis, UTI, C-diff)	
Falls	
Malignant neoplastic disease (eg, cancer, failure to thrive)	
Organ transplant (heart, lung, kidney, liver)	
Renal failure syndrome (acute/chronic) *do not log transplants here	
Sepsis	
OTHER	