ABPTRFE
American Board of Physical Therapy
Residency & Fellowship Education

Description of Residency Practice: Geriatrics

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DRP Geriatrics

Preamble

The American Board of Physical Therapy Residency & Fellowship Education, a board-appointed group of the American Physical Therapy Association, has created the following "Description of Residency Practice" to reduce 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 American Board of Physical Therapist Specialties through the practice analysis for specialty revalidation.

While all programs are required to meet the comprehensive curriculum and program requirements as outlined within "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 area of practice. 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.

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 Physical Therapy "Description of Specialty Practice."[1]

A. Knowledge Areas of Geriatric Practice

- **Foundation Sciences**
  - Anatomy.
  - Biology of aging.
  - Cellular biology, including phases of soft tissue healing, tissue makeup, changing with aging and response to exercise.
  - Neuroanatomy.
  - Neurophysiology.
  - Pathophysiology.

[1] "Geriatric Physical Therapy Description of Specialty Practice." 3rd ed. Alexandria, VA: American Physical Therapy Association; 2020. Reproduced with permission. © 2021 American Physical Therapy Association. All rights reserved.

- Physiology of aging.

- **Clinical Sciences**
  - Exercise physiology.
  - Interpretation of special tests, including imaging and lab values.
  - Movement science/kinematic and kinetic analysis of movement systems.
  - Pathokinesiology.
  - Pharmacology.
  - Prevention, wellness, and health promotion in older adults.

- **Behavioral Sciences**
  - Adult teaching, learning, and communication.
  - Consultancy.
  - Critical inquiry for evidence-based practice.
  - Cultural competence.
  - Health literacy.
  - Interprofessional collaboration.
  - Patient management and advocacy.
  - Psychology, psychopathology, and psychosocial issues of aging,
  - Theories of aging, including frailty.

B. Professional Competencies of Geriatric Physical Therapists

The physical therapist practicing as a geriatric clinical specialist should demonstrate all the skills developed as an entry level practitioner. These include:

- Accurate and timely documentation.
- Acting as a consultant.
- Adherence to administrative policies.
- Advocating for the older adult and successful aging.
- Appropriate professional behavior.
- Demonstrating evidence-based practice.
- Educating and mentoring to other stakeholders.
- Effective communication skills
- Growing leadership responsibility.
- Ongoing professional development.
- Social responsibility.

Specific to practice as a geriatric clinical specialist, the physical therapist should additionally demonstrate the following:

- Aiding the older adult in developing the skills to advocate for themselves.
- Applying legal practice standards, including federal, state, and institutional regulations related to patient or client care and fiscal management.
- Assisting older adult in gaining access to resources to manage their health condition.
- In the process of working with the older adult, the physical therapist practicing as a geriatric clinical specialist will have responsibility for the following:
  - Addressing caregiver burden
  - Awareness of total health status, including comorbidity, nutrition, depression, patient's/client's self-report, family's or caregiver's report.
  - Coordinating the physical therapy patient/client management process to include community resources, discharge planning, and delivery of service with patients, clients, family members, other health care providers, and community-based organizations.
  - Discussion and/or defending rationale for physical therapy management using best available evidence with the patient/client, their family, other health care professionals and payers.
  - Mindfulness of the older adults' social environment, including living situation, family structure, and above.

- Utilize financial (individual and community) resources to assist in obtaining appropriate assistive technology.

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:

  - 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 (e.g., questionnaires, medical records, test results specific to geriatric patient issues) including:
      - A medication review and reconciliation.
      - Health status (e.g., living situation, family structure, recognizing abuse).
      - Recognition of caregiver burden.
      - Body structures and previous functional status and activity level.

  - Systems Review
    - Assess physiologic and anatomical status (e.g., cardiovascular/pulmonary, integumentary, musculoskeletal, and neuromuscular systems).
    - Appropriately examine communication affect, cognition, language, and learning style of patient/client.

  - Tests 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.
    - Choose appropriate outcomes measures that are reliable, valid, responsive, and feasible across the ICF domains based on acuity, diagnosis, prognosis, and practice settings.
    - Perform tests and measures to include:

      - Aerobic Capacity/Endurance
        - 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 (e.g., angina, claudication, and perceived exertion scales; electrocardiography; observations; palpation; sphygmomanometry).
        - Pulmonary signs and symptoms in response to increased oxygen demand with exercise or activity. This includes observations of respiratory rate, pattern and rhythm, breath and voice sounds, gas exchange and cyanosis. Assessments include ventilatory flow, force and volume, auscultation, oximetry, palpation, pulmonary function tests and gas analyses, and use of dyspnea and perceived exertion scale.
        - Effects of other medical and pharmacological interventions on aerobic capacity/endurance (e.g., telemetry, pacemaker, cardiac medications).

      - Assistive Technology (Assistive Devices, Adaptive Devices, and Prosthetics and Orthotics)
        The physical therapy specialist in geriatrics perform 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:
        - Management of impairments, activity limitations, or participation restrictions with use of assistive technology related to movement and function.

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

- Circulation (Arterial, Venous, Lymphatic)
  - Cardiovascular signs, including heart rate, rhythm, and sounds; pressures and flow; and superficial vascular responses (e.g., auscultation, electrocardiography, girth measurement, observations, palpation, sphygmomanometry, ankle/brachial index, perceived exertion scales).
  - Cardiovascular symptoms (e.g., angina, claudication).
  - Lymphatic system function, including girth, volume and edema measurements, palpation and 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 (e.g., auscultation, electrocardiography, observations, palpation, skin color changes, sphygmomanometry, pharmacological signs and symptoms).

- Environmental Factors (Home and Work Barriers)
  - Assessment of current and potential barriers in living and work environment, including physical, psychosocial, attitudinal, and financial.

- Ergonomics and Body Mechanics
  - Ergonomics related to common adaptations for the geriatric population in living and work environment, including lighting, seating, and technology (e.g., lighting, seating devices, computer screens regarding bifocals, deformities and postural changes related to arthritis and ROM change associated with aging).
  - Body mechanics of patient and caregiver during activities in the home and work environment (e.g., ADL and IADL scales, observations, and technology-assisted assessments).

- Gait and Locomotion, Ambulator and Non-ambulatory Mobility (biomechanical, kinematic, kinetic, temporal-spatial characteristics)

- Integumentary Integrity
  - Activities, positioning, postures, and assistive, adaptive, orthotic, protective, supportive, or prosthetic devices and equipment that produce or relieve trauma to the skin.
  - Skin characteristics, including blistering, continuity of skin color, dermatitis, trophic changes, mobility, sensation, temperature, and turgor (e.g., observations, palpation, photographic assessments).

- Integumentary Integrity/Wound Assessment
  - Signs of infection (e.g., cultures, observations, palpation).
  - Wound characteristics including location, dimensions and shape, exposed anatomical structures, contraction, staging and progression, tunneling and undermining, drainage and bleeding, odor and pigment.
  - Wound scar tissue characteristics, including banding, pliability, sensation, and texture (e.g., observations, scar-rating scales).

- Joint Integrity and Mobility
    - Joint play movements, including end feel (joints of the axial and appendicular skeletal system) (e.g., palpation, accessory movements, special tests).
    - Joint movement and functional activities (e.g., pain assessment and/or alleviation, quality, substitution, orthotic needs).

- Mental Functions (Arousal, Attention, and Cognition)
    - Cognition, including ability to process commands (e.g., safety awareness checklists, management of home exercise program, interviews, mental state scales, observations, questionnaires).
    - Consciousness, including agitation, dementia, delirium, and coma (e.g., clinical signs and symptoms, scales).
    - Motivation and self-efficacy.

- Motor Function (Motor Control and Motor Learning)
    - Dexterity, coordination, and agility (e.g., coordination screens, motor impairment tests, motor proficiency tests, observations, videography assessments).
    - Control of voluntary postures and movement patterns.
    - Task and motion analysis.

- Motor Performance (including strength, power and endurance)
    - Muscle strength, power, endurance and length measurement (e.g., dynamometry, manual muscle tests, muscle performance tests, physical capacity tests, technology-assisted assessments, timed activity tests).

- Pain
    - Analysis of pain behavior and reaction(s) during specific movements and provocation.

- Posture
    - Postural alignment and position (static and dynamic), including symmetry and deviation from midline (e.g., grid measurement, inclinometer, observations, height assessment, videography assessments).

- Self-Care and Domestic Life (Including ADL and IADL)
    - Ability to safely perform self-care (e.g., ADL scales, aerobic capacity tests, IADL scales, interviews, observations, fall scales).

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

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

- Re-examination

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 and a geriatric clinical specialist demonstrates evaluation by:

  - Interpreting and integrating data from examination, including results of outcome measures across the ICF domains to determine a diagnosis, prognosis, and plan of care.
  - Integrating instruments, tests, screens, and evaluations used or performed by other health care professionals.
  - Linking impairments, functional limitations, and biopsychosocial factors to the patient/clients' 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.
  - Integrates the communication, affect, cognition, language, and learning style of the patient/client into the plan of care.
  - Assessment of medication implications on the physical therapy plan of care.

- **Diagnosis**
  The physical therapist practicing as a geriatric clinical specialist demonstrates diagnosis by:

  - Interpreting data from the examination to develop a differential diagnosis.
  - Considering physiological changes and atypical presentations with aging that are specific to the diagnostic process.
  - Identifying impairments/functional limitations/disabilities that are amenable to intervention.
  - Referring patient/client to other professionals for findings that are outside the scope of the physical therapist's knowledge, experience, or expertise.

- **Prognosis**
  Prognosis is to determine the optimal level of improvement that may be attained through intervention and the amount of time required to reach that level. The prognosis also includes the 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 biopsychosocial and occupational history.
  - Considering the prognostic impact of other medical interventions (e.g., implanted devices, pumps, radiation therapy, chemotherapy).
  - Considering the prognostic impact of depression, dementia, and other psychosocial issues (e.g., grieving, recent loss) when determining prognosis.
  - Considering the prognostic effect of pharmacological interventions (e.g., prescribed medications, over the counter medications, herbal supplements).
  - Collaborating with the patient/family/caregiver(s) to determine 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 regarding end-of-life wishes, transitions, and advanced directives.

- **Intervention**

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

- Patient/Client Instruction including but not limited to:
  - Adapting instruction for the situation.
  - Facilitating motivation and self-efficacy.
  - Providing instruction about diagnosis, prognosis, and intervention strategies.
  - Providing instruction regarding primary, secondary, and tertiary prevention.
  - Providing instruction to increase patient/client understanding of individual impairments in body functions and structures, activity limitations and participation restrictions.

- Airway Clearance Techniques including but not limited to breathing strategies such as:
  - Active cycle of breathing or forced expiratory techniques
  - Assisted cough/huff techniques
  - Autogenic drainage
  - Paced breathing
  - Pursed lip breathing

- Assistive Technology including but not limited to:

  - Prescription, application, and as appropriate, fabrication or modification of:
    - Aids for locomotion
    - Orthoses
    - Prostheses
    - Seating and positing technologies
    - Other assistive technologies to improve safety, function, and independence, such as transfer technologies
  - Managing impairments in body functions and structures, activity limitations, or participation restrictions with use of assistive technology.
  - Training and using devices and equipment.

- Biophysical Agents:
  - Biophysical agents (modalities) for the integumentary system.
  - Biophysical agents (modalities) other than for the integumentary system.

- Functional Training in Self-Care and in Domestic, Education, Work, Community, Social and Civic Life including but not limited to:
  - ADL and IADL training.
  - Assessment of current and potential barriers in living and work environment, including physical, psychosocial, attitudinal, and financial.
  - Barrier accommodations or modifications.
  - Functional training programs.
  - Injury prevention or reduction.

- Integumentary Repair and Protection Techniques including but not limited to:
  - Managing activities, positions, orthotic selection, protective and supportive device recommendations and modifications that produce or relieve trauma to the skin.
  - Biophysical agents (modalities) for the integumentary system.

- Manual Therapy Techniques including but not limited to:
  - Manual lymphatic drainage.
  - Mobilization/manipulation
    - Soft tissue.
    - Spinal and peripheral joints.

- Motor Function Training including but not limited to:

    - Balance training.
    - Gait and locomotion training.
    - Posture training.
    - Vestibular rehabilitation and training.

  - Therapeutic Exercise including but not limited to:
    - Aerobic capacity/endurance conditioning or reconditioning.
    - Body mechanics training.
    - Coordination and agility training.
    - Flexibility exercises.
    - Neuromotor development training.
    - Strength, power, and endurance training.

- **Outcomes Assessment**
  - Choose appropriate, evidence-based outcome measurement tools based on the patient/client's needs and examination findings (e.g., specific impairment tools, patient satisfaction measures, clinical and functional assessment tools, and quality of life scales).
  - Assess individual and collective outcomes of patient/clients using evidence-based measures that consider patient/client culture, acuity, practice setting, diagnosis, and prognosis.

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 patient-care practice hours within each setting based on the minimum patient-care practice hours outlined within "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 (e.g., 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, as noted below, specific to sex and age. A resident should experience a minimum of 5% of time in each patient population based on the minimum patient-care practice hours outlined within "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 (e.g., 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).

Sex

- Female.
- Male.

V. Medical Conditions

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

If a residency program is unable to provide each resident with an opportunity to engage in patient care activities within most of these conditions, the program must provide additional learning opportunities (e.g., observation, didactic, journal club, research) related to patient care within these conditions.

Programs must use the ABPTRFE template when submitting documentation to ABPTRFE. Medical Condition Form templates are in the Residency/Fellowship Education HUB.

Medical Conditions Geriatrics
Cardiovascular System
Arterial insufficiency
Cardiac arrhythmia / Conduction disorders
Cardiac pacemakers and defibrillators
Coronary heart disease
Deep Vein Thrombosis
Heart failure / Valvular disease
Venous insufficiency
Pulmonary System
Chronic obstructive pulmonary disease
Chronic restrictive lung disease
Lung neoplasm
Pneumonia
Pulmonary embolism
Pulmonary hypertension / Cor pulmonale
Respiratory failure
Endocrine System
Breast neoplasm
Dehydration

Diabetes
Electrolyte imbalance
Gastric and bowel neoplasm
Prostate neoplasm
Integumentary System
Burns
Neuropathic wounds
Pressure sores
Skin Tears
Vascular and lymphatic wounds
Nervous System
Alzheimer's disease
Amyotrophic lateral sclerosis
Brain tumors
Central nervous system infections
Cerebrovascular accident
Concussion
Huntington's chorea
Multiple sclerosis
Neurocognitive disorders
Other dementia types (not Alzheimer's disease)
Parkinson's disease and Parkinson syndromes
Peripheral neuropathy
Traumatic brain injury
Vestibular disorders
Musculoskeletal System
Compression fracture
Degenerative joint / disc disease
Spinal stenosis
Kyphosis / scoliosis
Rotator cuff syndromes
Shoulder osteoarthritis
Humeral fracture
Radio-ulna fracture
Wrist osteoarthritis

Hip osteoarthritis
Hip and pelvic fractures
Knee osteoarthritis
Tibial / fibular fracture
Plantar fasciitis
Fibromyalgia
Gout / pseudogout
Myopathy
Osteoporosis and osteopenia
Polymyalgia rheumatica
Tendinopathy
Involvement Of Multiple Systems
Amputations
Bladder incontinence
Failure to thrive
Falls
Lupus
Lymphedema
Organ transplant
Renal failure
Rheumatoid arthritis
Sarcopenia / Dynapenia
Sepsis
Urinary tract infection

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