1 Who are Physical Therapists, and What Do They Do?

The Guide to Physical Therapist Practice referred to hereafter as *The Guide* was developed by the American Physical Therapy Association (APTA) "to encourage a uniform approach to physical therapist practice and to explain to the world the nature of that practice."[1] *The Guide* is divided into two parts:

- Part 1 delineates the physical therapist's scope of practice and describes patient management by physical therapists (PTs).
- Part 2 describes each of the diagnostic preferred practice patterns of patients typically treated by PTs.

DEFINITION OF PHYSICAL THERAPY

The Guide defines physical therapy as follows:

> *Physical therapy includes diagnosis and management of movement dysfunction and enhancement of physical and functional abilities; restoration, maintenance, and promotion of optimal physical function, optimal fitness and wellness, and optimal quality of life as it relates to movement and health; and prevention of the onset, symptoms, and progression of impairments, functional limitations, and disabilities that may result from diseases, disorders, conditions, or injuries.*

SCOPE OF PRACTICE

Physical therapy is defined as the care and services provided by or under the direction and supervision of a physical therapist.[2]

- Physical therapists are the only professionals who provide physical therapy.
- Physical therapist assistants (PTAs)—under the direction and supervision of the physical therapist—are the only paraprofessionals who assist in the provision of physical therapy interventions.

EDUCATION AND QUALIFICATIONS

PTs are professionally educated at the college or university level and are required to be licensed in the state (or states) in which they practice. Education programs for the preparation of physical therapists have been recognized in some manner since 1928, when the APTA first published a list of approved programs.[2]

- Graduates from 1926 to 1959 completed physical therapy curricula approved by appropriate accreditation bodies.
- Graduates from 1960 to the present have successfully completed professional physical therapist education programs accredited by the Commission on Accreditation in Physical Therapy Education (CAPTE). CAPTE also makes autonomous decisions concerning the accreditation status of continuing education programs for the physical therapists and physical therapist assistants.

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CAPTE only accredits entry-level PT and PTA education programs, not transitional Doctor of Physical Therapy (tDPT) programs, which are considered post-professional programs.

The APTA house of delegates first authorized the education of physical therapist assistants at the 1967 Annual Conference.

PRACTICE SETTINGS

Physical therapists practice in a broad range of inpatient, outpatient, and community-based settings, including those described in the next sections and listed in Table 1-1.

HOSPITAL

Hospitals may be classified in a number of ways, including by:

- Length of stay (short-term or long-term)
  Acute-care (short-term hospital): An acute-care hospital can be defined as a facility that provides hospital care to patients who generally require a stay of up to 7 days, and whose focus is on a physical or mental condition requiring immediate intervention and constant medical attention, equipment, and personnel. Following a stay in the acute-care hospital, the patient is typically discharged to home or to another health-care facility.
  Subacute: Medical care is provided to patients who require more than 7 but less than 30 days' stay in a hospital, and who have a more stable condition than those receiving acute care.
- Teaching or nonteaching.
  Teaching: A hospital that serves as a teaching site for medicine, dentistry, allied health, nursing programs, or medical residency programs.
  Nonteaching: A hospital that has no teaching responsibilities or one that serves as an elective site for health-related programs.
- Major types of services: general, or specialities such as psychiatric, tuberculosis, maternity, pediatric, and ear, nose and throat (ENT).
- Type of ownership or control: federal, state, or local government; for-profit and nonprofit.

TABLE 1-1. PRACTICE SETTINGS

SETTING	CHARACTERISTICS	PHYSICAL THERAPIST ROLE
Hospital	A hospital is an institution whose primary function is to provide inpatient diagnostic and therapeutic services for a wide variety of medical, surgical and nonsurgical conditions. In addition, most hospitals provide some outpatient services, particularly emergency care.	Refer to text.
Primary care	► Basic or entry-level health care, which includes diagnostic, therapeutic, or preventive services. ► Care is provided on an outpatient basis by primary-care physicians, including family practice physicians, internists, and pediatricians.	The physical therapist serves a supportive role for the primary care teams: provides examination, evaluation, diagnoses, prognosis, and intervention for musculoskeletal and neuromuscular dysfunctions.
Secondary care	► Services provided by medical specialists, such as cardiologists, urologists, and dermatologists, who generally do not have first contact with the patients. ► This level of care may require inpatient hospitalization or ambulatory same-day surgery.	Physical therapy involvement is minimal.
Tertiary care (tertiary health care)	► Highly specialized care that is given to patients in a hospital setting who are in danger of disability or death (organ transplants, major surgical procedures). ► Services provided often require sophisticated technologies (e.g., neurosurgeons or intensive care units). ► Specialized care usually provided because of a referral from primary or secondary medical care personnel.	Physical therapy may be consulted on an as-needed basis.
Transitional care unit	► Nonmedically based facility, which may be in group home or part of a continuum of rehabilitation center. ► Typical stay is 4 to 8 months. ► Greater focus placed on compensation versus restoration.	Physical therapy emphasis is on improving functional skills for maximum independence to prepare a patient for community reentry or for transfer to an assisted-living/skilled nursing facility.
Skilled nursing facility (SNF)	► A free-standing facility, or part of a hospital, that is licensed and approved by the state (Medicare certified), where eligible individuals receive skilled nursing care and appropriate rehabilitative and restorative services. ► Sometimes referred to as an *extended care facility*. ► Accepts patients in need of rehabilitation and medical care that is of a lesser intensity than that received in the acute care setting of a hospital. ► Provides skilled nursing, rehabilitation, and various other health services on a daily basis. ► Medicare defines *daily* as seven days a week of skilled nursing care and five days a week of skilled therapy. ► Physician orders must be rewritten every 60 days.	An SNF must be able to provide 24-hour nursing coverage, and the availability of physical, occupational, and speech therapy. Minimum data set (MDS): federal data collection system for assessing nursing home patients. ► The MDS for nursing facility residents is a comprehensive resident assessment instrument (RAI) that measures functional status, mental health status, and behavioral status to identify chronic care patient needs and formalize a care plan in response to 18 resident assessment protocols (RAPs). ► Under federal regulation, assessments are conducted at a time of admission into a nursing facility, upon return from a 72-hour hospital admission, whenever there is a significant change in status, quarterly, and annually.
Acute rehabilitation facility	► Usually based in a medical setting ► Provides early rehabilitation, social, and vocational services as soon as the patient is medically stable.	Physical therapist involved in the coordinated services of medical, social, educational, vocational, and the other rehabilitative services (OT, speech).

(Continued)

TABLE 1-1. PRACTICE SETTINGS *(Continued)*

SETTING	CHARACTERISTICS	PHYSICAL THERAPIST ROLE
	► Primary emphasis is to provide intensive physical and cognitive restorative services in the early months to disabled persons to facilitate their return to maximum functional capacity. ► Typical stay is 3 to 4 months (short term).	
Chronic care facility	► Long-term care facility that is facility or community based. ► Sometimes referred to as *extended rehabilitation*. ► Designed for patients with permanent or residual disabilities caused by a nonreversible pathologic health condition. Also used for patients who demonstrate slower than expected progress. ► Used as a placement facility—60 days or longer, but not for permanent stays.	The facility has a full range of rehabilitation services (physical, occupational, and speech therapy) available.
Comprehensive outpatient rehabilitation facility (CORF)	► CORFs must provide coordinated outpatient diagnostic, therapeutic, and restorative services, at a single fixed location, to outpatients for the rehabilitation of injured, disabled, or sick individuals. ► CORFs are surveyed every 6 years at a minimum.	Physical therapy (and occupational therapy and speech-language pathology services) may be provided in an off-site location.
Custodial care facility	► Provides medical or nonmedical services, which do not seek to cure but are necessary for patients who are unable to care for themselves. ► Provided during periods when the medical condition of the patient is not changing. ► Patient does not require the continued administration of medical care by qualified medical personnel. ► This type of care is not usually covered under managed-care plans.	Physical therapy involvement is minimal.
Hospice care	► A facility or program that is licensed, certified, or otherwise authorized by law, which provides supportive care for the terminally ill. ► Focuses on the physical, spiritual, emotional, psychological, financial, and legal needs of the dying patient and the family. ► Services provided by an interdisciplinary team of professionals and perhaps volunteers in a variety of settings, including hospitals, free-standing facilities, and at home. ► Medicare and Medicaid require that at least 80% of hospice care is provided at home. Eligibility for reimbursement includes: Medicare eligibility. Certification of terminal illness (less than or equal to 6 months of life) by physician.	Physical therapy may be consulted on an as-needed basis. Occupational therapy more commonly consulted.
Personal care	► Optional Medicaid benefit that allows a state to provide services to assist functionally impaired individuals in performing the activities of daily living (e.g., bathing, dressing, feeding, grooming).	Physical therapy may be consulted on an as-needed basis.
Ambulatory care (outpatient care)	► Includes outpatient preventative, diagnostic, and treatment services that are provided at medical offices, surgery centers, or outpatient clinics (including private practice physical therapy clinics, outpatient satellites of institutions or hospitals). ► Designed for patients who do not require overnight hospitalization. ► More cost-effective than inpatient care, and therefore favored by managed-care plans.	Physical therapy may be consulted on an as-needed basis.

HOME HEALTH CARE

Home health care involves the provision of medical or health care by a Home Health Agency (HHA), which may be governmental, voluntary, or private; nonprofit or for-profit. Home care services were introduced to reduce the need for hospitalization and its associated costs. An HHA provides part-time and intermittent skilled and nonskilled services and other therapeutic services on a visiting basis to persons of all ages in their homes. Patient eligibility includes:

- Any patient who is homebound or who has great difficulty leaving their home. A person may leave home for medical treatment or short infrequent nonmedical absences such as a religious service.
- Medicaid waiver clients. The Medicaid Waiver for the Elderly and Disabled (E&D Waiver) program is designed to provide services to seniors and the disabled whose needs would otherwise require them to live in a nursing home. The goal is for clients to retain their independence by providing services that allow them to live safely in their own homes and communities for as long as it is appropriate.
- A patient who requires skilled care from one of the following disciplines: nursing, physical therapy, occupational therapy, or speech therapy.
- Physician certification. In the case of an elderly patient, recertification by Medicare is required every 62 days. Medicare only pays for skilled home health services that are provided by a Medicare-certified agency. At the time of writing, Medicare defines *intermittent* as skilled nursing care needed or given on fewer than 7 days each week, or less than 8 hours per day over a period of 21 days (or less) with some exceptions in special circumstances.
- Patients who continue to demonstrate potential for progress.

The physical therapy focus includes:

- Environmental safety including adequate lighting, securing scatter rugs, handrails, wheelchair ramps, raised toilet seats.
- Early intervention (refer to the "School System" section).
- Addressing equipment needs:
  Equipment ordered in the hospital is reimbursable.

  Most adaptive equipment ordered in the home is not reimbursable. Exceptions include items such as wheelchairs, commodes, and hospital beds.
- Observing for any evidence of substance abuse or physical abuse:
  Substance abuse should be reported immediately to the physician.

  Physical abuse should be immediately communicated to the proper authorities (varies from state to state).

SCHOOL SYSTEM

- The major goal of physical therapy intervention in the school is to enhance the child's level of function in the school setting.

- The physical therapist serves as a consultant to teachers working with children with disabilities in the classroom. Recommendations are made for adaptive equipment to facilitate improved posture, head control, and function.
- Early Intervention Program (EIP). National program designed for infants and toddlers with disabilities and their families.
  EIP was created by Congress in 1986 under the Individuals with Disabilities Education Act (IDEA)—refer to Chapter 16. To be eligible for services, children must be under 3 years of age and have a confirmed disability or established developmental delay, as defined by the state, in one or more of the following areas of development: physical, cognitive, communication, social-emotional, and adaptive.

Therapeutic and support services include:

- Family education and counseling, home visits, and parent support groups.
- Special instruction.
- Speech pathology and audiology.
- Occupational therapy.
- Physical therapy. PT can provide direct interventions within the classroom or other inclusion settings depending on the EIP.
- Psychological services.
- Service coordination.
- Nursing services.
- Nutrition services.
- Social work services.
- Vision services.
- Assistive technology devices and services.

PRIVATE PRACTICE

Private practice settings are privately owned and free-standing independent physical therapy practices.

- Practice settings vary from physical therapy and orthopedic clinics, to rehabilitation agencies.
- Documentation is required for every visit (refer to Documentation section later). Re-examinations are required by Medicare every 30 days.

CLINICAL EDUCATION OF STUDENTS

The term *clinical education* refers to the supervised practice of professional skills in a clinical setting. The purpose of clinical education is to provide student clinicians with opportunities to:

- Observe and work with a variety of patients under professional supervision and in diverse professional settings, and to integrate knowledge and skills at progressively higher levels of performance and responsibility.

- Work in situations where they can practice interpersonal skills and develop characteristics essential to productive working relationships.
- Develop clinical reasoning skills and management skills, as well as master techniques that develop competence at the level of a beginning practitioner.

Clinical education is arranged by negotiation between the staff of the respective academic unit (Academic Coordinator of Clinical Education, or ACCE) and the director of the individual clinical setting (Center Coordinator of Clinical Education, or CCCE). In most cases, formal agreements are signed between the academic institution and the placement facility.

- Instruction and supervision of PT/PTA students are provided by *clinical instructors* during scheduled clinical education experiences.

  The clinical instructor (CI), in addition to carrying out specific roles within the department, performs the role of teacher, facilitator, coordinator, and professional role model, and evaluates the student on a regular basis. The nature of the assessment varies across academic institutions, but usually includes a student evaluation by both the clinical instructor and the student; the satisfactory completion of a specified number of hours; and a variety of assignments including case studies, essays, and verbal presentations.

  Students are expected to take an active responsibility for their own education by identifying their own learning needs, assisting in the planning and implementation of the learning experiences, being familiar with and adhering to procedures and rules of the academic institution and the affiliating center, and evaluating their own performance.

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In all clinical situations, the welfare of the patient/client is paramount. The patient/client's dignity and rights to privacy and confidentiality must be respected at all times. Students who do not comply with the rules governing ethical practice may be removed from the clinical placement.

MODELS OF DISABLEMENT

A disablement model is designed to detail the functional consequences and relationships of disease, impairment, and functional limitations. The physical therapist's understanding of the process of disablement and the factors that affect its development is crucial to achieving the goal of restoring or improving function and reducing disability in the individual. Many disablement models have been proposed over the years (Table 1-2). *The Guide to Physical Therapist Practice*[3] employs terminology from the Nagi disablement model,[4] but also describes its framework as being consistent with other disablement models (the model Person with a Disability and the Rehabilitation Process [National Center for Medical Rehabilitation Research, National Institutes of Health, 1993]).[5] In 2001 the Executive Board of the World Health Organization approved the International Classification of Functioning, Disability, and Health (ICF). The ICF emphasizes "components of health" rather than "consequences of disease" (i.e., participation rather than disability), and environmental and personal factors as important determinants of health.[6]

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Impairment—Loss or abnormality of anatomic, physiologic, or psychologic structure or function. Not all impairments are modified by physical therapy, and not all impairments cause activity limitations and participation restrictions.[1]

Primary Impairment—An impairment that can result from active pathology or disease. Primary impairment can create secondary impairments and can lead to secondary pathology.

Secondary Impairment—An impairment that originates from primary impairment and pathology.[1]

Functional Limitation—a restriction of the ability to perform, at the level of the whole person, a physical action, activity, or task in an efficient, typically expected, or competent manner.[1]

TABLE 1-2. DISABLEMENT MODEL COMPARISONS

WHO (ICIDH)	NAGI SCHEME	NATIONAL CENTER FOR MEDICAL REHABILITATION RESEARCH (NCMRR)	WHO (ICIDH)-2 (2001)	HEALTH-RELATED QUALITY OF LIFE (HRQL)
Disease The intrinsic pathology or disorder	**Pathology/Pathophysiology** Interruption or interference with normal processes and efforts of an organism to regain normal state	**Pathophysiology** Interruption with normal physiologic developmental processes or structures	**Condition**	**Pathophysiology**
Impairment Loss or abnormality of psychological, physiologic, or anatomic structure or function	**Impairment** Anatomic, physiologic, mental, or emotional abnormalities or loss	**Impairment** Loss of cognitive, emotional, physiologic, or anatomic structure or function	**Body Functions and Structure**	**Impairment**
Disability Restriction or lack of ability to perform an activity in a normal manner	**Functional Limitation** Limitation in performance at the level of the whole organism or person	**Functional Limitation** Abnormality of or restriction or lack of ability to perform an action in the manner or range consistent with the purpose of an organ or organ system	**Activities** Activity limitations can cause secondary impairments	**Functional Limitation** ► Physical function component, which includes basic activities of daily living (BADLs) and instrumental activities of daily living (IADLs) ► Psychological component, which includes the *various cognitive, perceptual, and personality traits of a person* ► Social component, which involves the interaction of the person *within a larger social context or structure*
Handicap Disadvantage or disability that limits or prevents fulfillment of a normal role (depends on age, sex, sociocultural factors for the person)	**Disability** Limitation in performance of socially defined roles and tasks within a sociocultural and physical environment	**Disability** Limitation or inability in performing tasks, activities, and roles to levels expected within physical and social contexts	**Participation** Is context dependent (environmental and personal factors). Is one aspect of health-related quality of life	**Disability**
		Societal Limitation Restriction attributed to social policy or barriers that limit fulfillment of roles. Examples include lack of accessibility and funding	**Contextual, Environmental Personal Factors**	

Data from World Health Organization: International Classification of Impairments, Disabilities, and Handicaps. Geneva, Switzerland, 1993 (ICIDH).

THE FIVE ELEMENTS OF PATIENT/CLIENT MANAGEMENT

The physical therapist integrates the five elements of patient/client management, which are:

1. Examination of the patient.
2. Evaluation of the data and identification of problems.
3. Determination of the diagnosis.
4. Determination of the prognosis and plan of care (POC).
5. Implementation of the POC (intervention).[3]

EXAMINATION

The examination is an ongoing process that begins with the patient referral or initial entry and continues throughout the course of rehabilitation. The process of examination includes gathering information from the chart, other caregivers, the patient, the patient's family, caretakers, and friends in order to identify and define the patient's problem(s).[7] The examination consists of three components of equal importance: patient history, systems review, and tests and measures.[3] These components are closely related in that they often occur concurrently. One further element, observation, occurs throughout.

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Re-examination allows the therapist to evaluate progress and modify interventions as appropriate.[3]

Patient History. The patient history (refer to Chapter 6) involves the information gathered from a review of the medical records and interviews with the patient, family members, caregiver, and other interested persons, about the patient's history and current functional and health status.[8] The patient history usually precedes the systems review (see Chapter 6) and the tests and measures components of the examination, but it may also occur concurrently. The medical record provides detailed reports from members of the health care team.

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It is estimated that 80% of the necessary information to explain the presenting patient problem can be provided by a thorough history.[9]

Observation. Much can be learned from a thorough observation. Throughout the history, systems review, and tests and measures, collective observations form the basis for diagnostic deductions. The observation includes, but is not limited to, an analysis of posture, structural alignment or deformity, scars, crepitus, color changes, swelling, muscle atrophy, and the presence of any asymmetry.

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The patient history and systems review are used to generate diagnostic hypotheses.

Systems Review. The systems review (see Chapter 6) is a brief or limited examination that provides additional information about the general health (GH) and the continuum of patient/client care throughout the lifespan.

Tests and Measures. The tests and measures portion of the examination involves the physical examination of the patient. The test and measures portion provides objective data to accurately determine the degree of specific function and dysfunction.[8] There are a number of recognized tests and measures that are commonly performed by PTs. However, not all are used every time—the physical examination may be modified based on the history and the systems review. The clinician should resist the temptation to gather excessive and extraneous data, as too much data can make clinical decision-making more difficult.

TABLE 1-3. CLINICAL INDICATORS THAT WARRANT DETERMINATION OF VITAL SIGN MEASURES

Dyspnea (shortness of breath, breathlessness)
Fatigue (weakness)
Syncope
Chest pain or discomfort
Irregular heartbeat
Cyanosis
Intermittent claudication
Pedal edema

There may be other reasons why the tests and measures must be modified. For example, the examination of an acutely injured patient differs greatly from that of a patient in less discomfort or distress, the examination will be affected by the cognitive status of a patient, and the examination of a child differs in some respects from that of an adult. The tests and measures for the various systems are described in the relevant chapters. Examples of those aspects not always included in the test and measures include basic biometric measurements and the taking of vital signs (Table 1-3; see also Chapter 11).

Anthropometrics. Anthropometrics are measurable physiologic characteristics and include height and weight.

Height. Height is the anthropometric longitudinal growth of an individual.

Weight. Weight is the anthropometric mass of an individual. A scale is used to measure weight. Body mass index (BMI) is used to calculate the relationship between healthy height and weight and obesity or being overweight or underweight (see Chapter 5).

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It is important, where possible, to allow patients to make their own choices on which pain scale to use.

Pain. The assessment of pain is very important to the overall wellness of the patient. Clinically pain can be measured using a wide variety of different scales. For example, the FACES scale, which is a series of faces assigned a value from 0 (no pain at all, showing a normal happy face) to 5 (the worst pain ever experienced by the patient), can be used. There is also a visual analog scale from 0 to a maximum of 10.

EVALUATION

Following the history, systems review, and the tests and measures, an evaluation is made based on an analysis and organization of the collected data and information.[10] An evaluation is the level of judgment necessary to make sense of the findings in order to identify a relationship between the symptoms reported and the signs of disturbed function.[11] According to BOD P11-05-20-49 published by the APTA,[12] the evaluation includes the ability to:

- Synthesize available data on a patient/client expressed in terms of the disablement model to include impairment, functional limitation, and disability participation restrictions.
- Use available evidence in interpreting the examination findings.
- Verbalize possible alternatives when interpreting the examination findings.
- Cite the evidence (patient/client history, lab diagnostics, tests and measures, and scientific literature) to support a clinical decision.

The evaluation process may also identify possible problems that require consultation with, or referral to, another provider. A number of frameworks have been applied to clinical practice over the past 2 decades for guiding clinical decision making.[13-18] Although the early frameworks were based on disablement models, the more recent models have focussed on enablement perspectives.

DIAGNOSIS

A physical therapy diagnosis, which includes a prioritization of the identified impairments, functional limitations, and disabilities, can only be made when all potential causes for the symptoms have been ruled out. In order to form a diagnosis, the clinician must be able to:

- Integrate the examination findings to classify the patient/client problem in terms of a human movement dysfunction (i.e., practice pattern).
- Identify and prioritize impairments to determine a specific dysfunction toward which the intervention will be directed.[12]

The physical therapy diagnosis is a label ascribed to a cluster of signs and symptoms. The patient can be placed in a diagnostic category as well as in one or more of the practice patterns listed in the *Guide to Physical Therapist Practice.* Examples of preferred practice patterns are given in Table 1-4. Most of the time, these patterns do not occur in isolation, as a patient often presents with a mixture of signs and symptoms that indicate one or more possible problem areas. If more than one practice pattern is applicable, the therapist indicates which practice pattern is primary.

PROGNOSIS

The prognosis is the predicted level of function that the patient will attain and an identification of the barriers that may impact the achievement of optimal improvement (age, medication(s), socioeconomic status, comorbidities, cognitive status, nutrition, social support, and environment) within a certain time frame.[10] This prediction helps guide the intensity, duration, frequency, and type of intervention, in addition to providing justifications for the intervention. Factors used in determining the prognosis include knowledge of the severity of an injury, the age and physical and health status of a patient, and the healing processes of the various tissues involved.

PLAN OF CARE

The plan of care (POC), which outlines anticipated patient management, involves the setting of goals, coordination of care, progression of care, and discharge. The POC:

- Is based on the examination, evaluation, diagnosis, and prognosis, including the predicted level of optimal improvement.
- Includes statements that identify anticipated goals and the expected outcomes.
- Describes the specific interventions to be used, and the proposed frequency and duration of the interventions that is required to reach the anticipated goals and expected outcomes.
- Includes documentation that is dated and appropriately authenticated by the physical therapist who established the plan of care.
- Includes plans for discharge of the patient/client taking into consideration achievement of anticipated goals and expected outcomes, and provides for appropriate follow-up or referral.[2]

TABLE 1-4. EXAMPLES OF PREFERRED PRACTICE PATTERNS

CATEGORY/PREFERRED PRACTICE PATTERN	IMPAIRMENT
Musculoskeletal	
Pattern 4A	Primary prevention/risk factor reduction for skeletal demineralization
Pattern 4B	Impaired posture
Pattern 4C	Impaired muscle performance
Pattern 4D	Impaired joint mobility, motor function, muscle performance, and range of motion associated with connective tissue dysfunction
Pattern 4E	Impaired joint mobility, motor function, muscle performance, and range of motion associated with localized inflammation
Pattern 4F	Impaired joint mobility, motor function, muscle performance, and range of motion, or reflex integrity secondary to spinal disorders
Pattern 4G	Impaired joint mobility, motor function, muscle performance, and range of motion associated with fracture
Pattern 4H	Impaired joint mobility, motor function, muscle performance, and range of motion associated with joint arthroplasty
Pattern 4I	Impaired joint mobility, motor function, muscle performance, and range of motion associated with bony or soft tissue surgical procedures
Pattern 4J	Impaired motor function, muscle performance, range of motion, gait, locomotion, and balance associated with amputation
Neuromuscular	
Pattern 5A	Primary prevention/risk reduction for loss of balance and falling
Pattern 5B	Impaired neuromotor development
Pattern 5C/D	Impaired motor function and sensory integrity associated with nonprogressive disorders of the central nervous system—congenital origin or acquired in infancy or childhood
Pattern 5D	Impaired motor function and sensory integrity associated with nonprogressive disorders of the central nervous system—acquired in adolescence or adulthood
Pattern 5E	Impaired motor function and sensory integrity associated with progressive disorders of the central nervous system
Pattern 5F	Impaired peripheral nerve integrity and muscle performance associated with peripheral nerve injury
Pattern 5G	Impaired motor function and sensory integrity associated with acute or chronic polyneuropathies
Pattern 5H	Impaired motor function, peripheral nerve integrity, and sensory integrity associated with nonprogressive disorders of the spinal cord
Pattern 5I	Impaired arousal, range of motion, and motor control associated with coma, near coma, and vegetative state
Cardiovascular/ Pulmonary	
Pattern 6B	Impaired aerobic capacity/endurance associated with deconditioning
Pattern 6C	Impaired ventilation, respiration/gas exchange, and aerobic capacity/endurance associated with airway clearance dysfunction
Pattern 6D	Impaired aerobic capacity endurance associated with cardiovascular pump dysfunction or failure
Pattern 6E	Impaired ventilation and respiration/gas exchange associated with ventilatory pump dysfunction or failure
Pattern 6F	Impaired ventilation and respiration/gas exchange associated with respiratory failure
Pattern 6H	Impaired circulation and anthropometric dimensions associated with lymphatic system disorders
Integumentary	
Pattern 7B	Impaired integumentary integrity associated with superficial skin involvement
Pattern 7C	Impaired integumentary integrity associated with partial-thickness skin involvement and scar formation
Pattern 7D	Impaired integumentary integrity associated with full-thickness skin involvement and scar formation

Data from *Guide to Physical Therapist Practice. Phys Ther.* 2001;81:S13–S95.

To design a POC, the clinician must:

- Write measurable functional goals (short- and long-term) that are time-referenced with expected outcomes.
- Consult patient/client and/or caregivers to develop a mutually agreed to plan of care.
- Identify patient/client goals and expectations.
- Identify indications for consultation with other professionals.
- Make referral to resources needed by the patient/client.
- Select and prioritize the essential interventions that are safe and meet the specified functional goals and outcomes in the plan of care (identify precautions and contraindications, provide evidence for patient-centered interventions that are identified and selected, define the specificity of the intervention (time, intensity, duration, and frequency), and set realistic priorities that consider relative time duration in conjunction with family, caregivers, and other health care professionals).
- Establish criteria for discharge based on patient goals and functional status.[12]

Coordination of Care. The purpose of the coordination of care[12] is to:

1. Identify who needs to collaborate in the plan of care.
2. Identify additional patient/client needs that are beyond the scope of physical therapist practice, level of experience and expertise, and warrant referral.
3. Refer and discuss coordination of care with other health care professionals.
4. Articulate a specific rational for a referral.
5. Advocate for patient/client access to services.

Progression of Care. The purpose of the progression of care[12] is to:

1. Identify outcome measures of progress relative to when to progress the patient further.
2. Measure patient/client response to intervention.
3. Monitor patient/client response to intervention.
4. Modify elements of the plan of care and goals in response to changing patient/client status, as needed.
5. Make ongoing adjustments to interventions according to outcomes including the physical and social environments, medical therapeutic interventions, and biological factors.
6. Make accurate decisions regarding intensity and frequency when adjusting interventions in the plan of care.

Discharge Plan. The purpose of the discharge plan[12] is to:

1. Re-examine the patient/client if not meeting established criteria for discharge based on the plan of care.
2. Differentiate between discharge of the patient/client, discontinuation of service, and transfer of care with re-evaluation.
3. Prepare needed resources for patient/client to ensure timely discharge, including follow-up care.

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Goals should be objective and quantifiable (measurable) and have anticipated dates.

- Short-term goals (STG) are used to indicate what progress is to be made in the near future.
- Long-term goals (LTG) are used to indicate how long it will take to restore function, or when the intervention is to be terminated.

4. Include patient/client and family/caregiver as a partner in discharge planning.
5. Discontinue care when services are no longer indicated.
6. When services are still needed, seek resources and/or consult with others to identify alternative resources that may be available.
7. Determine the need for equipment and initiate requests to obtain.

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Types of physical therapy interventions may include:
- Direct intervention (e.g., manual therapy techniques, therapeutic exercise).
- Patient/client-related instruction.
- Coordination, communication, and documentation.

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Patients—People with diagnosed impairments or functional limitations.

Clients—People who are not necessarily diagnosed with impairments or functional limitations, but seek services for prevention or promotion of health, wellness, and fitness.

INTERVENTION

The Guide[1] defines an intervention as "the purposeful and skilled interaction of the physical therapist and the patient/client and, when appropriate, with other individuals involved in the patient/client care, using various physical therapy procedures and techniques to produce changes in the condition consistent with the diagnosis and prognosis." A physical therapy intervention is most effectively addressed from a problem-oriented approach, based on the evaluation, the patient's functional needs, and mutually agreed-upon goals.[10] The most successful intervention programs are those that are custom designed from a blend of clinical experience and scientific data, with the level of improvement achieved related to goal-setting and the attainment of those goals.

The various intervention categories are listed in Table A-1 of the Appendix.

COORDINATION, COMMUNICATION, AND DOCUMENTATION

Coordination, communication, and documentation[12] may include the following:

A. Addressing required functions:
   1. Establish and maintain an ongoing collaborative process of decision-making with patients/clients, families, or caregivers prior to initiating care and throughout the provision of services.
   2. Discern the need to perform mandatory communication and reporting (e.g., incident reports, patient advocacy, and abuse reporting).
   3. Follow advance directives.
B. Admission and discharge planning.
C. Case management.
D. Collaboration and coordination with agencies, including:
   1. Home care agencies.
   2. Equipment suppliers.
   3. Schools.
   4. Transportation agencies.
   5. Payer groups.
E. Communication across settings, including:
   1. Case conferences.
   2. Documentation.
   3. Education plans.
F. Cost-effective resource utilization.

G. Data collection, analysis, and reporting of:
   1. Outcome data.
   2. Peer review findings.
   3. Record reviews.

H. Documentation across settings, following APTA's Guidelines for Physical Therapy Documentation, including:
   1. Elements of examination, evaluation, diagnosis, prognosis, and intervention.
   2. Changes in impairments, functional limitations, and disabilities.
   3. Changes in interventions.
   4. Outcomes of intervention.

I. Interdisciplinary teamwork:
   1. Patient/client family meetings.
   2. Patient care rounds.
   3. Case conferences.

J. Referrals to other professionals or resources.

DOCUMENTATION

Documentation in health care includes any entry into the patient/client record. The SOAP (Subjective, Objective, Assessment, Plan) note format has traditionally been used to document the examination and intervention process.

- Subjective: Information about the condition from patient or family member.
- Objective: Measurement a clinician obtains during the physical examination.
- Assessment: Analysis of problem including the long- and short-term goals.
- Plan: A specific intervention plan for the identified problem.

More recently, the Patient/Client Management Model has been used by those clinicians familiar with the *Guide to Physical Therapist Practice*.[7] The Patient/Client Management Model described in *The Guide* has the following components:

- History: Information gathered about the patient's history.
- Systems review: Information gathered from performing a brief examination or screening of the patient's major systems addressed by physical therapy. Also includes information gathered about the patient's communication, affect, cognition, learning style, and education needs.
- Tests and measures: Results from specific tests and measures performed by the therapist.
- Diagnosis: Includes a discussion of the relationship of the patient's functional deficits to the patient's impairments and/or disability. The relevant practice pattern(s) may also be included, as well as a discussion of other health care professionals to which the therapist has referred the patient or believes the patient should be referred.
- Prognosis: Includes the predicted level of improvement that the patient will be able to achieve and the predicted amount of time to achieve that level of improvement. The prognosis

should also include the PT's professional opinion of the patient's rehabilitation potential.
- Plan of care: Includes the expected outcomes (long-term goals), anticipated goals (short-term goals), and interventions, including an education plan for the patient or the patient's caregivers or significant others.

The purposes of documentation are as follows:

- To document what the clinician does to manage the individual patient's case. Records examination findings, patient status, intervention provided, and the patient's response to treatment. This documentation, considered a legal document, becomes a part of the patient's medical record.
- To communicate with all other members of the health care team, which helps provide consistency among the services provided. This includes communication between the physical therapist and the physical therapist assistant.
- To provide information to third-party payers, such as Medicare and other insurance companies who make decisions about reimbursement based on the quality and completeness of the physical therapy note.
- To help the physical therapist organize the thought processes involved in patient care.
- To be used for quality assurance and improvement purposes and for issues such as discharge planning.
- To serve as a source of data for quality assurance, peer and utilization review, and research.[7]

APTA Guidelines for Documentation. To help develop and improve the art and science of PT, including practice, education, and research, the APTA board of directors has approved a number of guidelines for PT documentation. It is recognized that these guidelines do not reflect all of the unique documentation requirements associated with the many specialty areas within the PT profession. Applicable for both handwritten and electronic documentation systems, these guidelines are intended as a foundation for the development of more specific documentation guidelines in clinical areas, while at the same time providing guidance for the PT profession across all practice settings.[10]

The PTA or certified occupational therapy assistant (COTA) reads the initial documentation of the examination, evaluation, diagnosis, prognosis, anticipated outcomes and goals, and intervention plan, and is expected to follow the plan of care as outlined by the PT/OT in the initial patient note.[7] After the patient has been seen by the PTA or COTA for a time (the time varies according to the policies of each facility or health care system and state law), the PTA or COTA must write a progress note documenting any changes in the patient's status that have occurred since the therapist's initial note was written.[7] Also, after discussion with the PT/OT about the diagnosis and prognosis, expected outcomes, anticipated goals, and interventions, the assistant rewrites or responds to the previously written expected outcomes and documents the revised plan of care accordingly.[7] In many facilities (according to the policies of each facility or health care system and state law), the

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Students in PT or PTA programs may document when the record is additionally authenticated by the PT or, when permissible by law, documentation by PTA students may be authenticated by a PTA.

PT/OT then cosigns the assistant's notes, indicating agreement with what is documented.[7]

Initial Examination/Evaluation. Documentation of the initial encounter is typically called the "initial examination," "initial evaluation," or "initial examination/evaluation." The examination/evaluation is typically completed by the end of the first visit, but may require several visits.

Visit/Encounter. Documentation of a visit or encounter, often called a progress note or daily note, documents sequential implementation of the plan of care established by the physical therapist, including changes in patient/client status and variations and progressions of specific interventions used. Also may include specific plans for the next visit or visits.

Re-examination. Documentation of re-examination includes data from repeated or new examination elements and is provided to evaluate progress and to modify or redirect intervention.

Discharge or Discontinuation Summary. Documentation is required following conclusion of the current episode in the physical therapy intervention sequence, to summarize progression toward goals and discharge plans.

Evaluation. Evaluation is a thought process that may not include formal documentation. However, the evaluation process may lead to documentation of impairments, functional limitations, and disabilities using formats such as:

- A problem list.
- A statement of assessment of key factors (e.g., cognitive factors, comorbidities, social support) influencing the patient/client status.

Diagnosis. Documentation of a diagnosis determined by the physical therapist may include impairment and functional limitations.

Prognosis. Documentation of the prognosis is typically included in the plan of care.

Visit/Encounter. Documentation of each visit/encounter shall include the following elements:

- Patient/client self-report (as appropriate).
- Identification of specific interventions provided, including frequency, intensity, and duration as appropriate. For example, "knee extension, three sets, ten repetitions, 10# weight," or "transfer training bed to chair with sliding board."
- Equipment provided.
- Changes in patient/client impairment, functional limitation, and disability status as they relate to the plan of care.
- Response to interventions, including adverse reactions, if any.
- Factors that modify frequency or intensity of intervention and progression goals, including patient/client adherence to patient/client-related instructions.

- Communication/consultation with providers/patient/client/family/significant other.
- Documentation to plan for ongoing provision of services for the next visit(s), suggested to include, but not be limited to, the interventions with objectives, progression parameters, and precautions if indicated.

Re-examination. Documentation of re-examination shall include the following elements:

- Documentation of selected components of examination to update impairment, function, and/or disability status.
- Interpretation of findings and, when indicated, revision of goals.
- When indicated, revision of plan of care, as directly correlated with goals as documented.

Discharge/Discontinuation Summary. Documentation of discharge or discontinuation shall include the following elements:

- Current physical/functional status.
- Degree of goals achieved and reasons for goals not being achieved.
- Discharge/discontinuation plan related to the continuing care. Examples include:
  - Home program.
  - Referrals for additional services.
  - Recommendations for follow-up physical therapy care.
  - Family and caregiver training.
  - Equipment provided.

Basic Principles of Clinical Documentation

- Never record falsely, exaggerate, guess at, or make up data.[7]
- All documents must be legible and should be written in black or blue ink, typed and/or transcribed.
- Keep the information objective and clear.
- Each episode of treatment must be documented, and each entry must be dated and signed with first and last name and professional designation (PT, PTA). Professional license number may also be included, but is optional. The patient's name and ID number should be on each page.
- To avoid the potential for falsification, empty lines should not be left between one entry and another, nor should empty lines be left within a single entry.
- Avoid vague terminology.
- Information should be stated concisely. Abbreviations can help with brevity, but only medically approved abbreviations or symbols can be used.
- Incorrect spelling, grammar, and punctuation can be misleading. Any mistake should be crossed out with a single line through the error, initialed, and dated by the clinician. Correction fluid/tape or similar products should never be used to correct text in medical records.

PATIENT/CLIENT-RELATED INSTRUCTION

Patient/client-related instruction may include instruction, education, and training of patients/clients and caregivers regarding:

1. Current condition (pathology/pathophysiology [disease, disorder, or condition], impairments, functional limitations, or disabilities).
2. Enhancement of performance.
3. Plan of care:
   Risk factors for pathology/pathophysiology (disease, disorder, or condition), impairments, functional limitations, or disabilities.
   Preferred interventions, alternative interventions, and alternative modes of delivery.
   Expected outcomes.
4. Health, wellness, and fitness programs (management of risk factors).
5. Transitions across settings.[12]

Patient/client-related management forms the cornerstone of every patient visit. During the physical therapy visits, the clinician and the patient work to alter the patient's perception of their functional capabilities. Together, the patient and clinician discuss the parts of the patient's life that he or she can and cannot control and then consider how to improve those parts that can be changed. It is imperative that the clinician spends time educating patients as to their condition, so that they can fully understand the importance of their role in the rehabilitation process, and become educated consumers. The aim of patient education is to create independence, not dependence, and to foster an atmosphere of learning in the clinic. Patient/client education in its broadest sense involves informing, educating, or training patients/ clients, families, significant others, and caregivers in order to promote and optimize physical therapy services.[10] Failure to identify the relevance of the presented material will promote disinterest and decreased compliance. Instruction should be provided across all settings for all patients/clients on promoting understanding of:

1. Current condition, impairments, functional limitations, and disabilities.
2. Anticipated goals and expected outcomes, the plan of care, specific intervention elements, and self-management strategies.
3. The elements necessary for the smooth transition to home or an alternate setting, work, and community.
4. Individualized family service plans or individualized education plans.
5. Safety awareness, and risk factor reduction and prevention.

PROCEDURAL INTERVENTIONS

Procedural interventions can be broadly classified into three main groups:

- Restorative interventions: directed toward remediating or improving the patient's status in terms of impairments, functional

limitations, and recovery of function. These strategies are particularly applicable for treating secondary impairments that contribute to functional limitations and that are likely to improve with treatment. For example, impaired lower extremity strength is associated with functional loss; strength training can improve gait.

- Compensatory interventions: directed toward promoting optimal function using residual abilities. Examples include training patients with subtle left neglect to consciously attend to the left side of space, using a cane for patients with impaired balance control that persists despite intervention, and functional training for patients with complete spinal cord transection.
- Preventative interventions: direct to toward minimizing potential impairments, functional limitations, and disabilities and maintaining health.[8,17]

CHOOSING AN INTERVENTION STRATEGY

Interventions are chosen on the basis of the data obtained, diagnosis, prognosis, anticipated goals, and expected outcomes.[8] The goal of improving functional ability must be foremost in the clinician's reasoning when determining the intervention strategy. When deciding which intervention strategy to use, the clinician must weigh:

- The likelihood that the underlying impairments will improve (e.g., through natural recovery from the injury, through neural plasticity) versus the requirements for immediate functional recovery despite the underlying impairments.
- The contributions of risk factors:
  - Functional performance factors.
  - Demographic, social lifestyle, behavioral, psychological, and environmental factors.
  - Physiologic impairments.
  - Comorbidities.
  - Anatomic impairments.

The process of identifying meaningful, achievable functional goals should be a collaborative effort between the clinician and the patient, the patient's family, or the patient's significant other.[10] To identify functional goals, Randall and McEwen[19] recommend the following steps:

1. Determine the patient's desired outcome of the intervention.
2. Develop an understanding of the patient's self-care, work, and leisure activities and the environments in which these activities occur.
3. Establish goals with the patient that relate to the desired outcomes (Table 1-5).[19]

Once the goals have been agreed upon, the clinician must write the goals so that they contain the following elements:

- Who (the patient).
- Will do what (activities).
- Under what conditions (the home or work environment).

TABLE 1-5. QUESTIONS TO DETERMINE DESIRED OUTCOMES

1. If you were to concentrate your energies on one thing for yourself, what would it be?
2. What activities do you need help with that you would rather perform yourself?
3. What are your concerns about returning to work, home, school, or leisure activities?
4. What about your current situation would you like to be different in about 6 months? What would you like to be the same?

Data from Randall KE, McEwen IR. Writing patient-centered goals. *Phys Ther.* 2000;80:1197–1203, and Winton PJ, Bailey DB. Communicating with families: examining practices and facilitating change. In: Simeonsson JP, Simeonsson RJ, eds. *Children with Special Needs: Family, Culture, and Society*. Orlando: Harcourt Brace Jovanovich; 1993.

- How well (the amount of assistance, or number of attempts required for successful completion).
- By when (target date).[19,20]

OUTCOMES

The last step[12] is ongoing and involves continuous re-examination of the patient and a determination of the efficacy of treatment.[8]

1. Summarize re-examination findings and evaluation of the patient's abilities in terms of the anticipated goals and expected outcomes set forth in the POC.
2. Make determination as to whether the goals and outcomes are reasonable given the patient's diagnosis and progress made.

   If the patient attains the desired level of competence for the stated goals, revisions in the POC are indicated.

   If the patient attains the desired level of competence for the expected outcomes, discharge is considered.

   If the patient progresses more rapidly or slowly than expected, revisions in the POC are indicated.

   If the patient fails to achieve the stated goals or outcomes, the therapist must determine why. For example, were the goals and outcomes realistic given the database? Were the interventions selected at an appropriate level to challenge the patient? Were any intervening and constraining factors identified?

DISCHARGE/DISCONTINUATION OF INTERVENTION

Discharge planning, which is initiated during the data-collection phase, is the process of ending physical therapy services that have been provided during a single episode of care, when the anticipated goals and expected outcomes have been achieved.[2]

Components of an effective discharge plan include:

- Patient, family, or caregiver education.
- Plans for appropriate follow-up care or referral to another agency.
- Instruction in a home exercise plan (HEP).
- Evaluation and modification of the home environment to assist the patient returning home.[8]

Discontinuation may occur for any of the following reasons:

- The patient/client, caregiver, or legal guardian declines to continue intervention.
- The patient/client is unable to continue to progress toward anticipated goals and expected outcomes because of medical or psychosocial complications or because financial/insurance resources have been exhausted.
- The physical therapist determines that the patient/client will no longer benefit from physical therapy.[2]

Study Pearl

Physical therapists can provide instructional and educational programs for other therapists, health care providers, staff, local, state, and federal agencies, and all patients in academic and/or clinical settings. These programs are provided to increase awareness of health issues and roles of the physical therapist.

PREVENTION AND PROMOTION OF HEALTH, WELLNESS, AND FITNESS

- Primary—Prevention of disease in a susceptible or potentially susceptible population through specific measures such as general health promotion offers.[1]
- Secondary—Efforts to decrease duration of illness, severity of disease, and sequelae through early diagnosis and prompt intervention.[1]
- Tertiary—Efforts to decrease the degree of disability and promote rehabilitation and restoration of function in patients with chronic and irreversible diseases.[1]

MEMBERS OF THE HEALTH CARE TEAM

PHYSICAL THERAPY DIRECTOR

The director of physical therapy is typically a physical therapist who has demonstrated qualifications based on education and experience in the field of physical therapy and who has accepted additional administrative responsibilities.[10] The director of a physical therapy department must:

- Establish guidelines and procedures that delineate the functions and responsibilities of all levels of physical therapy personnel in the service and the supervisory relationships inherent to the functions of the service and the organization (see Chapter 2).[10]
- Ensure that the objectives of the service are efficiently and effectively achieved within the framework of the stated purpose of the organization and in accordance with safe physical therapist practice.
- Interpret administrative policies.
- Act as a liaison between line staff and administration.
- Foster the professional growth of the staff.

STAFF PHYSICAL THERAPIST

The Commission on Accreditation in Physical Therapy Education (CAPTE) serves the public by establishing and applying standards that assure quality and continuous improvement in the entry-level preparation of physical therapists and physical therapist assistants. All states require physical therapists to obtain a license to practice.

PHYSICAL THERAPIST ASSISTANT

A physical therapist assistant (PTA) works under the supervision of a physical therapist. Care provided by a PTA may include teaching patients/clients exercise for mobility, strength, and coordination; training for activities such as walking with crutches, canes, or walkers; and the use of adjunctive interventions (see Chapter 18). A PTA may modify an intervention only in accordance with changes in patient status

and within the established plan of care developed by the physical therapist (see "Professional Standards" section in this chapter). Typically, a PTA has an associates degree from an accredited PTA program and is licensed, certified, or registered in most states.

Physical Therapy/Occupational Therapy Aide

Physical therapy aides are considered support personnel who may be involved in support services. Physical therapy aides receive on-the-job training under the on-site direction and supervision of a physical therapist or in some cases a physical therapist assistant. The duties of a physical therapist aide are limited to those methods and techniques that do not require clinical decision making or clinical problem solving by a physical therapist or a physical therapist assistant.

Physical Therapy and Physical Therapist Assistant Student

The PT or PTA student can perform duties commensurate with their level of education. The PT clinical instructor (CI) is responsible for all actions and duties of the affiliating student, and can supervise both physical therapy and physical therapist assistant students (a PTA may only supervise a PTA student—not a PT student).

Study Pearl

Patients, parents, or legal guardians are within their rights to refuse treatment by a student practitioner.

Physical Therapy Volunteer

A volunteer is usually a member of the community who has an interest in assisting physical therapists with departmental activities. Responsibilities of a volunteer include:

- Taking phone messages.
- Basic nonclinical/secretarial duties.

Volunteers may not provide or setup patient treatment, transfer patients, clean whirlpools, or maintain equipment.

Home Health Aide

Home health aides provide health-related services to the elderly, disabled, and ill in their homes. Their duties include performing housekeeping tasks, assisting with ambulation or transfers, and promoting personal hygiene. The registered nurse, physical therapist, or social worker caring for the patient may assign specific duties to, and supervise, the home health aide.

Occupational Therapist

Occupational therapists (OTs) assess function in activities of everyday living, including dressing, bathing, grooming, meal preparation, writing, and driving, which are essential for independent living. In making treatment recommendations, the OT addresses a number of factors including, but not limited to, (1) fatigue management; (2) upper

body strength, movement, and coordination; (3) adaptations to the home and work environment, including both structural changes and specialized equipment for particular activities; and (4) compensatory strategies for impairments in thinking, sensation, or vision. The minimum educational requirements for the registered occupational therapist are described in the current *Essentials and Guidelines of an Accredited Educational Program for the Occupational Therapist.*[21] All states require an OT to obtain a license to practice.

Certified Occupational Therapist Assistant

A certified occupational therapy assistant (COTA) works under the direction of an occupational therapist. COTAs perform a variety of rehabilitative activities and exercises as outlined in an established treatment plan. The minimum educational requirements for the COTA are described in the current *Essentials and Guidelines of an Accredited Educational Program for the Occupational Therapy Assistant*.[22]

Speech-Language Pathologist (Speech Therapist)

A speech-language pathologist evaluates speech, language, cognitive-communication, and swallowing skills of children and adults. Speech-language pathologists are required to possess a masters degree or equivalent. The vast majority of states also require speech language pathologists to obtain a license to practice.

Certified Orthotist

Certified orthotists (CO) design, fabricate, and fit orthoses (braces, splints, collars, corsets) prescribed by physicians for patients with disabling conditions of the limbs and spine. A CO must have successfully completed the examination by the American Orthotist and Prosthetic Association.

Study Pearl

An individual may be certified in both orthotics and prosthetics (CPO).

Certified Prosthetist

A certified prosthetist (CP) designs, fabricates, and fits prostheses for patients with partial or total absence of a limb. A CP must have successfully completed the examination by the American Orthotist and Prosthetic Association.

Respiratory Therapist

Respiratory therapists evaluate, treat, and care for patients with breathing disorders. The vast majority of respiratory therapists are employed in hospitals. Patient care activities include performing bronchial drainage techniques, measuring lung capacities, administering oxygen and aerosols, and analyzing oxygen and carbon dioxide concentrations. Education programs for respiratory therapists are offered by hospitals, colleges and universities, vocational-technical institutes, and the military. Most states require a respiratory therapist to obtain a license to practice.

Respiratory Therapy Technician Certified

A respiratory therapy technician certified (CRRT) is a skilled technician who:

- Holds an associates degree from a 2-year training program accredited by the Committee in Allied Health Education and Accreditation.
- Has passed a national examination to become registered.
- Administers respiratory therapy as prescribed and supervised by a physician, including:
  - Pulmonary function tests.
  - Treatments consisting of oxygen delivery, aerosols, and nebulizers.
  - Maintenance of all respiratory equipment.

Primary Care Physician

A primary care physician (PCP) is a practitioner, usually an internist, general practitioner, or family medicine physician, providing primary care services and managing routine health care needs. Most PCPs serve as gatekeepers for the managed-care health organizations, providing authorization for referrals to other specialty physicians or services, including physical therapy.

Physician's Assistant

A physicion's assistant (PA) is a medically trained professional who can provide many of the health care services traditionally performed by a physician, such as taking medical histories and doing physical examinations, making a diagnosis, and prescribing and administering therapies (see also "Registered Nurse,").

Physiatrist

A physiatrist is a physician specializing in physical medicine and rehabilitation, who has been certified by the American Board of Physical Medicine and Rehabilitation. The primary role of the physiatrist is to diagnose and treat patients with disabilities involving musculoskeletal, neurological, cardiovascular, or other body systems.

Chiropractor

A chiropractor (DC) is a doctor trained in the science, art, and philosophy of chiropractic. A chiropractic evaluation and treatment is directed at providing a structural analysis of the musculoskeletal and neurologic systems of the body. According to chiropractic doctrine, abnormal function of these two systems may affect function of other systems in the body. In order to practice, chiropractors are usually licensed by a state board. Patients may see a chiropractor and physical therapist at the same time.

Registered Nurse

An individual who is licensed by the state to provide nursing services after completing a course of study that results in a baccalaureate degree

Study Pearl

A nurse practitioner (NP) is a registered nurse with additional specialized graduate-level training who can perform physical exams and diagnostic tests, counsel patients, and develop treatment programs.

and who has been legally authorized or registered to practice as a registered nurse (RN) and use the RN designation after passing examination by a state board of nurse examiners or similar state authority. A registered nurse may:

- Make referrals to other services under a physician's direction.
- Supervise other levels of nursing care.
- Administer medication, but cannot change drug dosages.
- Communicate to the supervising physician any change in the patient's medical or social condition.

Rehabilitation (Vocational) Counselor

Rehabilitation counselors help people deal with the personal, physical, mental, social, and vocational effects of disabilities resulting from birth defects, illness or disease, accidents, or the stress of daily life. The role of the rehabilitation counselor includes:

- An evaluatation of the strengths and limitations of individuals.
- Providing personal and vocational counseling.
- Arranging for medical care, vocational training, and job placement.

Rehabilitation counselors interview both individuals with disabilities and their families, and confer and plan with physicians, psychologists, occupational and physical therapists, and employers to determine the capabilities and skills of the individual. Conferring with the client, they develop a rehabilitation program that often includes training to help the person develop job skills and to increase the client's capacity to live independently.

Audiologist

Audiologists evaluate and treat individuals of all ages with the symptoms of hearing loss and other auditory, balance, and related sensory and neural problems.

Athletic Trainer (ATC)

The certified athletic trainer is a professional specializing in athletic health care. In cooperation with the physician and other allied health personnel, the athletic trainer functions as an integral member of the athletic health care team in secondary schools, colleges and universities, sports medicine clinics, professional sports programs, and other athletic health care settings.

Certified athletic trainers have, at minimum, a bachelor's degree, usually in athletic training, health, physical education, or exercise science.

Social Worker

The role of the social worker is to offer a broad range of services from emotional support to referrals for community resources that can assist in enhancing adaptation to acute, chronic, and terminal conditions. Social workers may intervene by providing individual, couple, or family counseling, offering group education or support, and by working with

community groups in the development of resources to assist patients in meeting their own needs. A bachelor's degree is often the minimum requirement to qualify for employment as a social worker; however, in the health field, the master's degree is often required. All states have licensing, certification, or registration requirements for social workers.

Massage Therapist

Massage therapy is a regulated health profession with a growing number of states and provinces now requiring a license. Registered massage therapists must uphold specific standards of practice and codes of ethics in order to hold a valid license. In order to become a licensed or registered massage therapist, most states and provinces require the applicant to pass specific government board examinations, which consist of a written and a practical portion.

Acupuncturist

An acupuncturist treats symptoms by inserting very fine needles, sometimes in conjunction with an electrical stimulus, into the body's surface to, theoretically, influence the body's physiologic functioning. Typical sessions last between 30 minutes and an hour. At the end of the session, the acupuncturist may prescribe herbal therapies for the patient to use at home. Some acupuncturists work alone, while others work as part of a larger team of health care professionals.

At the time of writing, 32 states and the District of Columbia use the National Certification Commission for Acupuncture and Oriental Medicine (NCCAOM) certification as the main examination criteria for licensure, which takes 3 to 4 years to achieve. Each state may also choose to set additional eligibility criteria (usually additional academic or clinical hours). A small number of states have additional jurisprudence or practical examination requirements such as passing the CNT (clean needle technique) exam.

RISK MANAGEMENT

In general, risk management refers to the process of measuring or assessing risk and then developing strategies to manage that risk.

Measurement and Assessment

Traditional risk management focuses on risks stemming from physical or legal causes (e.g., natural disasters or fires, accidents, death, and lawsuits). Ideally, risk management involves a process of prioritization that initially identifies those risks with the greatest potential for loss (patient or employee injury, property damage) and the greatest probability of occurring, followed by the identification of those risks with lower probability of occurrence and lower loss. Types of risk include:

- Knowledge risk: occurs when deficient knowledge is applied.
- Relationship risk: occurs when collaboration ineffectiveness occurs.

- Process-engagement risk: occurs when operational ineffectiveness occurs.

The level of risk can be significantly reduced by the following:

- Scheduling regular (biannual) equipment inspections and maintenance.
- Safety training for staff in the use and care of the equipment.
- Creating and adhering to policies and procedures addressing the cleaning and maintenance of exercise equipment, whirlpool cleaning, treatment table cleaning, and spill procedures.
- Review of incident reports.
- The prompt identification of risk factors in patient care.
- Annual certification/recertification of staff in cardiopulmonary resuscitation.

STRATEGIES

In general, the strategies employed to address risk include the following:

- Transferring the risk to another party (insurance policies).
- Avoiding the risk.
- Reducing the negative effect of the risk.
- Accepting some or all of the consequences of a particular risk.

PROGRAM DEVELOPMENT

Program development is a systematic process, based on the results from a needs assessment, to plan, execute, and carry out an evaluation of a program. Programs are designed to meet the needs of a specific population or group. Program development can be broken down into four phases:

1. Needs assessment. A needs assessment can be used to determine how well a department is currently meeting the needs of the community and the types of resources and services it can provide in the future. A needs assessment can be in the form of a survey, community forum, or analysis of social indicators. Information can also be gathered by interviewing key informants. Key informants of the community are people who hold socially responsible positions (such as educators, public officials, and business representatives), or are active in community events. To complete the needs assessment process, a determination must be made as to who will conduct the study, what kind of information needs to be collected (physical, social, cultural, and economic factors of the community), what is the target audience (demographics, perceived needs, real needs), how the information will be collected, and how the information will be used.
2. Program planning. In order to make use of the information collected, the results have to be interpreted. To interpret the data, some statistical analyses are often applied to identify what the majority of the community feels are the most important needs. An important feature of the results should be a

reflection of whether the current goals of the department are meeting the needs of the community. When the data analysis is complete, it should be possible to produce a rank-ordered list of the most important changes identified by the community, which can be used to set budget priorities and to determine whether the program is viable.

3. Program implementation. At the end of the planning process, a time-frame should be set for implementation. At this stage, it is a good idea to share the plans with the community or target population.
4. Program evaluation. During this phase, a determination is made as to whether the program should be continued, modified, or discontinued.

PROFESSIONAL STANDARDS

GUIDE FOR PROFESSIONAL CONDUCT OF THE PHYSICAL THERAPIST

The Guide for Professional Conduct was issued by the Ethics and Judicial Committee of the American Physical Therapy Association in 1981 and last amended in January 2004. *The Guide*[10] is intended to serve the physical therapist in interpreting the code of ethics of the American Physical Therapy Association in matters of professional conduct. The *Code* and *The Guide* apply to all physical therapists.

INTERPRETING ETHICAL PRINCIPLES

The interpretations expressed in *The Guide* reflect the opinions, decisions, and advice of the Ethics and Judicial Committee. The interpretations are intended to assist a physical therapist in applying general ethical principles to specific situations. They should not be considered inclusive of all situations that could evolve.

Principle 1. A physical therapist shall respect the rights and dignity of all individuals and shall provide compassionate care.

A. A physical therapist shall recognize individual differences and shall respect and be responsive to those differences.
B. A physical therapist shall be guided by concern for the physical, psychological, and socioeconomic welfare of patients/clients.
C. A physical therapist shall not harass, abuse, or discriminate against others.

Principle 2. A physical therapist shall act in a trustworthy manner toward patients/clients, and in all other aspects of physical therapy practice.

2.1. Patient/Physical Therapist Relationship

A. To act in a trustworthy manner the physical therapist shall act in the patient/client's best interest. Working in the patient/client's best interest requires knowledge of the patient/client's

needs from the patient/client's perspective. Patients/clients often come to the physical therapist in a vulnerable state and will rely only on the physical therapists advice, which they perceive to be based on superior knowledge, skill, and experience. The trustworthy physical therapist acts to ameliorate the patient's/client's vulnerability, not to exploit it.

B. A physical therapist shall not exploit any aspect of the physical therapist–patient relationship.
C. A physical therapist shall not engage in any sexual relationship or activity, whether consensual or nonconsensual, with any patient while the physical therapist–patient relationship exists.
D. The physical therapist shall encourage an open and collaborative dialogue with the patient/client.
E. In the event the physical therapist or patient terminates the physical therapist–patient relationship while the patient continues to need physical therapy services, the physical therapist should take steps to transfer the care of the patient to another provider.

2.2. Truthfulness. A physical therapist shall not make statements that he or she knows or should know are false, deceptive, fraudulent, or unfair. See Section 8.2.C and D.

2.3. Confidential Information

A. Information relating to the physical therapist–patient relationship is confidential and may not be communicated to a third party not involved in that patient's care without the prior consent of the patient, subject to applicable law.
B. Information derived from peer review shall be held confidential by the review unless the physical therapist who was reviewed consents to the release of the information.
C. A physical therapist may disclose information to appropriate authorities when it is necessary to protect the welfare of an individual or the community or when required by law. Such disclosure shall be in accordance with applicable law.

2.4. Patient Autonomy and Consent

A. A physical therapist shall respect the patient/client's right to make decisions regarding the recommended plan of care, including consent, modification, or refusal.
B. A physical therapist shall communicate to the patient/client the findings of his or her examination, evaluation, diagnosis, and prognosis.
C. A physical therapist shall collaborate with the patient/client to establish the goals of treatment and the plan of care.
D. A physical therapist shall use sound professional judgment in informing the patient/client of any substantial risks of the recommended examination and intervention.
E. A physical therapist shall not restrict patients' freedom to select their provider of physical therapy.

Principle 3. A physical therapist shall comply with rules and regulations governing physical therapy and shall strive to effect changes that benefit patients/clients.

3.1. Professional Practice. A physical therapist shall comply with laws governing the qualifications, functions, and duties of a physical therapist.

3.2. Just Laws and Regulations. A physical therapist shall abdicate the adoption of rules, regulations, and policies by providers, employers, third-party payers, legislatures, and regulatory agencies to provide and improve access to necessary health care services for all individuals.

3.3. Unjust Laws and Regulations. Next, a physical therapist shall endeavor to change unjust laws, regulations, and policies that govern the practice of physical therapy. See Section 10.2.

Principle 4. A physical therapist shall exercise sound professional judgment.

4.1. Professional Responsibility

A. A physical therapist shall make professional judgments that are in the patient/client's best interests.
B. Regardless of practice setting, a physical therapist has primary responsibility for the physical therapy care of the patient and shall make independent judgments regarding that care consistent with accepted professional standards. See Section 2.4.
C. A physical therapist shall not provide physical therapy services to a patient/client while his or her ability to do so safely is impaired.
D. A physical therapist shall exercise sound professional judgment based upon his or her knowledge, skill, education, training, and experience.
E. Upon accepting a patient/client for physical therapy services, a physical therapist shall be responsible for the examination, evaluation, and diagnosis of that individual; the prognosis and intervention; re-examination and modification of the plan of care; and the maintenance of adequate records, including progress reports. A physical therapist shall establish the plan of care and shall provide and/or supervise and direct the appropriate interventions. See Section 2.4 and 6.1.
F. If the diagnostic process reveals findings that are outside the scope of the physical therapist's knowledge, experience, or expertise, the physical therapist shall so inform the patient/client and refer to an appropriate practitioner.
G. When the patient has been referred from another practitioner, the physical therapist shall communicate the findings and/or information to the referring practitioner.
H. A physical therapist shall determine when a patient/client will no longer benefit from physical therapy services. See Section 7.1.D.

4.2. Direction and Supervision

A. The supervising physical therapist has primary responsibility for the physical therapy care rendered to a patient/client.
B. A physical therapist shall not delegate to a less qualified person any activity that requires the unique skill, knowledge, and judgment of the physical therapist.

4.3. Practice Arrangements

A. Participation in a business, partnership, corporation, or other entity does not exempt physical therapists, whether employers, partners, or stockholders, either individually or collectively, from the obligation to promote, maintain, and comply with the ethical principles of the Association.

B. A physical therapist shall advise his/her employer (s) of any employer practice that causes a physical therapist to be in conflict with the ethical principles of the American Physical Therapy Association. A physical therapist shall seek to eliminate aspects of his or her employment that are in conflict with the ethical principles of the Association.

4.4. Gifts and other Considerations

A. A physical therapist shall not invite, or accept, gifts, monetary incentives, or other considerations that affect or give an appearance of affecting his or her professional judgment.

B. A physical therapist shall not offer or accept kickbacks in exchange for patient referrals. See Sections 7.1.F and G and 9.1.D.

Principle 5. A physical therapist shall achieve and maintain professional competence.

5.1. Scope of Competence. A physical therapist shall practice within the scope of his or her competence and commensurate with his or her level of education, training, and experience.

5.2. Self-assessment. A physical therapist has a lifelong professional responsibility for maintaining competence through ongoing self-assessment, education, and enhancement of knowledge and skills.

5.3. Professional Development. A physical therapist shall participate in educational activities to enhance his or her basic knowledge and skills. See Section 6.1.

Principle 6. A physical therapist shall maintain and promote high standards for physical therapy practice, education, and research.

6.1. Professional Standards. A physical therapist's practice shall be consistent with accepted professional standards. A physical therapist shall continuously engage in assessment activities to determine compliance with the standards.

6.2. Practice

A. A physical therapist shall achieve and maintain professional competence. See Section 5.

B. A physical therapist shall demonstrate his or her commitment to quality improvement by engaging in peer and utilization review and other self-assessment activities.

6.3. Professional Education

A. A physical therapist shall support high-quality education in academic and clinical settings.

B. A physical therapist participating in the educational process is responsible to the students, the academic institutions, and the clinical settings for promoting ethical conduct. A physical therapist shall model ethical behavior and provide student with information about the Code of Ethics, opportunities to discuss ethical conflicts, and procedures for reporting unresolved ethical conflicts. See Section 9.

6.4. Continuing Education

A. A physical therapist providing continuing education must be competent in the content area.
B. When a physical therapist provides continuing education, he or she shall ensure that the course content, objectives, faculty credentials, and responsibilities of the instructional staff are accurately stated in the promotional and instructional course materials.
C. A physical therapist shall evaluate the efficacy and effectiveness of information and techniques presented in continuing education programs before integrating them into his or her practice.

6.5. Research

A. A physical therapist participating in research shall abide by ethical standards governing protection of human subjects and dissemination of results.
B. A physical therapist shall support research activities that contribute knowledge for improved patient care.
C. A physical therapist shall report to appropriate authorities any acts in the conduct or presentation of research that appear unethical or illegal. See Section 9.

Principle 7. A physical therapist shall seek only such remuneration as is deserved and reasonable for physical therapy services.

7.1. Business and Employment Practices

A. A physical therapist's business/employment practices shall be consistent with the ethical principles of the Association.
B. A physical therapist shall never place his or her own financial interests above the welfare of individuals under his or her care.
C. A physical therapist shall recognize that third-party payer contracts may limit, in one form or another, the provision of physical therapy services. Third-party limitations do not absolve the physical therapist from making sound professional judgments that are in the patient's best interest. A physical therapist shall avoid underutilization of physical therapy services.
D. When a physical therapist judgment is that the patient will receive negligible benefit from physical therapy services, the physical therapist shall not provide or continue to provide such services if the primary reason for doing so is to further the financial self-interest of the physical therapist or his or her employer.
E. Fees for physical therapy services should be reasonable for the service performed, considering the setting in which it is provided, practice costs in the geographic area, judgment of other organizations, and other relevant factors.

F. A physical therapist shall not directly or indirectly request, receive, or participate in the dividing, transferring, assigning, or rebating of an unearned fee. See Sections 4.4.A and B.
G. A physical therapist shall not profit by means of credit or other valuable consideration, such as unearned commission, discount, or gratuity, in connection with the furnishing of physical therapy services. See Sections 4.4.A and B.
H. Unless laws impose restrictions to the contrary, physical therapists who provide physical therapy within a business entity may pool fees and monies received. Physical therapists may divide or apportion these fees and monies in accordance with the business agreement.
I. A physical therapist may enter into agreements with organizations to provide physical therapy services if such agreements do not violate the ethical principles of the Association or applicable laws.

7.2. Endorsement of Products or Services

A. A physical therapist should not exert influence on individuals under his or her care or their families to use products or services based on the direct or indirect financial interest of the physical therapist in such products or services. Realizing that these individuals will normally rely on the physical therapist's advice, their best interest must always be maintained, as must their right of free choice relating to the use of any product or service. Although it cannot be considered unethical for a physical therapist to have a financial interest in the production, sale, or distribution of products/services, they must act in accordance with law and make full disclosure of the interest whenever individuals under their care use such products/services.
B. A physical therapist may receive remuneration for endorsement or advertisement of products or services to the public, physical therapists, or other health care professionals provided he or she discloses any financial interest in the production, sale, or distribution of said products or services.
C. When endorsing all advertising products or services, a physical therapist shall use sound professional judgment and shall not give the appearance of Association endorsement unless the Association has formally endorsed the products or services.

7.3. Disclosure. A physical therapist shall disclose to the patient if the referring practitioner derives compensation from the provision of physical therapy.

Principle 8. A physical therapist shall provide and make available accurate and relevant information to patients/clients about their care and to the public about physical therapy services.

8.1. Accurate and Relevant Information to the Patient

A. A physical therapist shall provide the patient/client information about his or her condition and plan of care. See Section 2.4.
B. Upon the request of the patient, the physical therapist shall provide, or make available, the medical records to the patient or a patient designated third party.

C. A physical therapist shall inform patients of any known financial limitations that may affect their care.
D. A physical therapist shall inform the patient when, in his or her judgment, the patient will receive negligible benefit from further care. See Section 7.1.C

8.2. Accurate and Relevant Information to the Public

A. A physical therapist shall inform the public about the societal benefits of the profession and who is qualified to provide physical therapy services.
B. Information given to the public shall emphasize that individual problems cannot be treated without individualized examination and plans/programs of care.
C. A physical therapist may advertise his or her services to the public. See Section 2.2.
D. A physical therapist shall not use, or participate in the use of, any form of communication containing a false, plagiarized, fraudulent, deceptive, unfair, or sensational statement or claim. See Section 2.2.
E. A physical therapist who places a paid advertisement shall identify it as such unless it is apparent from the context that it is a paid advertisement.

Principle 9. A physical therapist shall protect the public and the profession from unethical, incompetent, and illegal acts.

9.1. Consumer Protection

A. A physical therapist shall provide care that is within the scope of practice as defined by the state practice act.
B. A physical therapist shall not engage in any conduct that is unethical, incompetent, or illegal.
C. A physical therapist shall report any conduct that appears to be unethical, incompetent, or illegal.
D. A physical therapist may not participate in any arrangements in which patients are exploited due to the referring sources' enhancing their personal incomes as a result of referring for, describing, or recommending physical therapy. See Sections 2.1.B, 4, and 7.

Principle 10. A physical therapist shall endeavor to address the health needs of society.

10.1. Pro Bono Services. A physical therapist shall render pro bono publico (reduced or no fee) services to patients lacking the ability to pay for services, as each physical therapist's practice permits.

10.2. Individual and Community Health

A. A physical therapist shall be aware of the patient health-related needs and act in a manner that facilitates meeting those needs.
B. A physical therapist shall endeavor to support activities that benefit the health status of the community. See Section 3.

Principle 11. A physical therapist shall respect the rights, knowledge, and skills of colleagues and other health care professionals.

11.1. Consultation. A physical therapist shall seek consultation whenever the welfare of the patient will be safeguarded or advanced by consulting those who have special skills, knowledge, or experience.

11.2. Patient/Provider Relationships. A physical therapist shall not undermine the relationship(s) between his or her patient and other health care professionals.

11.3 Disparagement. Physical therapist shall not disparage colleagues and other health care professionals. See Sections 9 and 2.4.A.

The guide for conduct of the physical therapist assistant is provided in Table A-2 of the Appendix.

STANDARDS OF PRACTICE FOR PHYSICAL THERAPY AND THE CRITERIA

PREAMBLE

The physical therapy profession's commitment to society is to promote optimal health and function in individuals by pursuing excellence in practice. The American Physical Therapy Association attests to this commitment by adopting and promoting the following Standards of Practice for Physical Therapy.[10] These standards are the profession's statement of conditions and performances that are essential for provision of high-quality professional service to society and provide a foundation for assessment of physical therapy practice.

LEGAL/ETHICAL CONSIDERATIONS

1. Legal considerations.
   a. A physical therapist complies with all the legal requirements of jurisdictions regulating the practice of physical therapy.
   b. The physical therapist assistant complies with all the legal requirements of jurisdictions regulating the work of the assistant.
2. Ethical considerations.
   a. The physical therapist practices in accordance with the Code of Ethics of the American Physical Therapy Association.
   b. The physical therapist assistant complies with the Standards of Ethical Conduct of the Physical Therapist Assistant of the American Physical Therapy Association.

ADMINISTRATION OF THE PHYSICAL THERAPY SERVICE

1. Statement of mission, purposes, and goals.
   a. The physical therapy service has a statement of mission, purposes, and goals that reflect the needs and interests of the patients and clients served, the physical therapy personnel affiliated with the service, and the community.

2. Organizational plan.
   a. The physical therapy service has a written organizational plan.
3. Policies and procedures.
   a. The physical therapy service has written policies and procedures that reflect the operation of the service and that are consistent with the Association's standards, mission, policies, positions, guidelines, and Code of Ethics.
4. Administration.
   a. A physical therapist is responsible for the direction of the physical therapy service.
5. Fiscal management.
   a. The director of the physical therapy service, in consultation with physical therapy staff and appropriate administrative personnel, participates in planning for, and allocation of, resources. Fiscal planning and management of the service is based on sound accounting principles.
6. Improvement of quality of care and performance.
   a. The physical therapy service has a written plan for continuous improvement of quality of care and performance of services.
7. Staffing.
   a. The physical therapy personnel affiliated with the physical therapy service have demonstrated competence and are sufficient to achieve the mission, purposes, and goals of the services.
   b. The physical therapy service has a written plan that provides for appropriate and ongoing staff development.
8. Physical setting.
   a. The physical setting is designed to provide a safe and accessible environment that facilitates fulfillment of the mission, purposes, and goals of the physical therapy service. The equipment is safe and sufficient to achieve the purposes and goals of the service.
9. Collaboration.
   a. The physical therapy service collaborates with all appropriate disciplines.

PATIENT/CLIENT MANAGEMENT

1. Patient/client collaboration.
   a. Within the patient/client management process, the physical therapist and patient/client establish and maintain an ongoing collaborative process of decision-making that exists throughout the provision of services.
2. Initial examination/evaluation/diagnosis/prognosis.
   a. A physical therapist performs an initial examination and evaluation to establish a diagnosis and prognosis prior to intervention.
3. Plan of care.
   a. The physical therapist establishes a plan of care and manages the needs of the patient/client based on the examination, evaluation, diagnosis, prognosis, goals, and outcomes of the planned interventions for identified impairments, functional limitations, and disabilities.

   b. The physical therapist involves the patient/client and appropriate others in the planning, implementation, and assessment of the plan of care.
   c. The physical therapist, in consultation with appropriate disciplines, plans the discharge of the patient client taking into consideration achievements of anticipated goals and expected outcomes, and provides for appropriate follow-up or referral.
4. Intervention.
   a. The physical therapist provides, or directs and supervises, the physical therapy interventions consistent with the results of the examination, evaluation, diagnosis, prognosis, and plan of care.
5. Re-examination.
   a. The physical therapist re-examines the patient/client as necessary during an episode of care to evaluate progress or change in the patient/client status to modify the plan of care accordingly or discontinues physical therapy services.
   b. The physical therapists re-examination.
      1) Identifies ongoing patient/client needs.
      2) May result in recommendations for additional services, discharge, or discontinuation of physical therapy needs.
6. Discharge/discontinuation of intervention.
   a. The physical therapist discharges the patient/client from physical therapy services when the anticipated goals or expected outcomes for the patient/client have been achieved.
   b. The physical therapist discontinues intervention when the patient/client is unable to continue to progress toward goals or when the physical therapist determines that the patient/client will no longer benefit from physical therapy.
7. Communication/coordination/documentation.
   a. The physical therapist communicates, coordinates, and documents of aspects of patient/client management including the results of the initial examination and evaluation, diagnosis, prognosis, plan of care, interventions, response to interventions, changes in patient/client status relative to the interventions, reexamination, and discharge/discontinuation of intervention and other patient/client management activities.
8. Education.
   a. The physical therapist is responsible for individual professional development. The physical therapist assistant is responsible for individual career development.
   b. The physical therapist and the physical therapist assistant, under the direction and supervision of the physical therapist, participate in the education of the students.
   c. The physical therapist educates and provides consultation to consumers and the general public regarding the purposes and benefits of physical therapy.
   d. The physical therapist educates and provides consultation to consumers and the general public regarding the roles of the physical therapist, the physical therapist assistant, and other support personnel.
9. Research.
   a. The physical therapist applies research findings to practice and encourages, participates in, and promotes activities that establish the outcomes of patient/client management provided by the physical therapist.

10. Community responsibility.
    a. The physical therapist demonstrates community responsibility by participating in community and community agency activities, educating the public, formulating public policy, or providing pro bono physical therapy services.

GLOSSARY

a. Client—an individual who is not necessarily sick or injured but who can benefit from a physical therapist's consultation, professional advice, or services. A client also is a business, a school system, or other entity that may benefit from specific recommendations from a physical therapist.
b. Diagnosis—both the process and the end result of the evaluation of information obtained from the patient examination. The physical therapist organizes the evaluation information into defined clusters, syndromes, or categories to determine the most appropriate intervention strategies for each patient.
c. Evaluation—a dynamic process in which the physical therapist makes clinical judgments based on data gathered during the examination.
d. Examination—the process of obtaining a history, forming the relevant systems reviews, and selecting and administering specific tests and measures.
e. Intervention—the purposeful and skilled interaction of the physical therapist with the patient or client. Intervention has three components: direct intervention; instruction of the patient or client and of the family; and coordination, communication, and documentation.
f. Patient—an individual who is receiving direct intervention for an impairment, functional limitations, disability, or changing physical function and health status resulting from injury, disease, or other causes; an individual receiving health care services.
g. Physical therapist patient management model—the model on which physical therapist based management of the patient throughout the episode of care, including the following elements: examination, evaluation and re-evaluation, diagnosis, prognosis, and intervention leading to the outcome.
h. Plan of care—a plan that specifies the long-term and short-term outcomes/goals, the predicted level of maximal improvement, the specific interventions to be used, the duration and frequency of the intervention required to reach the outcomes/goals, and the criteria for discharge.
i. Prognosis—the determination of the level of maximal improvement that might be attained by the patient and the amount of time needed to reach that level.
j. Treatment—one or more interventions used to ameliorate impairments, functional limitations, or disability or otherwise produce changes in the health status of the patient; the sum of all interventions provided by the physical therapist to a patient during an episode of care.

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Comprehension Questions

1. A patient comes into your outpatient clinic without a physician's prescription asking to be treated. Whether you can examine and treat this patient depends upon:
   A. Ethical principles.
   B. State licensure laws.
   C. Departmental procedures.
   D. Whether the patient has medical insurance.
2. What was developed to "encourage a uniform approach to physical therapist practice and to explain to the world the nature of that practice"?
   A. State licensure laws.
   B. The Guide to Physical Therapist Practice.
   C. The National Physical Therapy Examination.
   D. The Medicare Act of 1973.
3. True or false: Physical therapists are the only professionals who provide physical therapy.
   A. True.
   B. False.
4. What is the function of the Commission on Accreditation in Physical Therapy Education (CAPTE)?
   A. To design policies and procedures with regard to physical therapy.
   B. To make autonomous decisions concerning the accreditation status of continuing education programs for physical therapists and physical therapist assistants.
   C. To design questions for the National Physical Therapy Examination.
   D. To oversee state licensing laws.
5. A home health agency (HHA) may be:
   A. Governmental.
   B. Voluntary.
   C. Private.
   D. Nonprofit or for-profit.
   E. All of the above.
6. What is the Medicaid Waiver for the Elderly and Disabled (E&D Waiver) program?
7. What is the Early Intervention Program?
8. The purpose of clinical education is to provide student clinicians with opportunities to:
   A. Observe and work with a variety of patients under professional supervision and in diverse professional settings, and to integrate knowledge and skills at progressively higher levels of performance and responsibility.
   B. Take a break from schoolwork.
   C. Develop clinical reasoning skills and management skills, as well as to master techniques that develop competence at the level of a beginning practitioner.
   D. A and C.

9. A loss or abnormality of anatomic, physiologic, or psychologic structure or function is a description of which category of the disablement model?
   A. Impairment.
   B. Functional limitation.
   C. Disability.
   D. None of the above.

10. Which element of patient/client management includes gathering information from the chart, other caregivers, the patient, the patient's family, caretakers, and friends in order to identify and define the patient's problem(s)?
   A. The evaluation.
   B. The intervention.
   C. The examination.
   D. The test and measures.

11. What is the purpose of the re-examination?
   A. Allows the therapist to evaluate progress and modify interventions as appropriate.
   B. Provides the insurance companies with justification for payment.
   C. All of the above.
   D. None of the above.

12. Which component of the examination includes an analysis of posture, structural alignment or deformity, scars, crepitus, color changes, swelling, muscle atrophy, and the presence of any asymmetry?
   A. Palpation.
   B. Observation.
   C. Patient history.
   D. None of the above.

13. What are anthropometrics?
   A. Measurable physiological characteristics, including height and weight.
   B. Studies involving the history of man.
   C. A form of laboratory test.
   D. None of the above.

14. Which of the elements of patient/client management attempts to identify a relationship between the symptoms reported and the signs of disturbed function?
   A. Test and measures.
   B. Patient history.
   C. Examination.
   D. None of the above.

15. Which element of patient/client management determines the predicted level of function that the patient will attain, and identifies the barriers that may impact the achievement of optimal improvement (age, medications, socioeconomic status, comorbidities, cognitive status, nutrition, social support, and environment) within a certain time frame?
   A. The evaluation.
   B. The examination.

C. The prognosis.
D. The diagnosis.

16. Which of the following statements are true about the plan of care?
    A. It is based on the examination, evaluation, diagnosis, and prognosis, including the predicted level of optimal improvement.
    B. It describes the specific interventions to be used, and the proposed frequency and duration of the interventions, required to reach the anticipated goals and expected outcomes.
    C. It includes plans for discharge of the patient/client, taking into consideration achievement of anticipated goals and expected outcomes, and provides for appropriate follow-up or referral.
    D. All of the above.
17. Which of the elements of patient/client management can be defined as "the purposeful and skilled interaction of the physical therapist and the patient/client and, when appropriate, with other individuals involved in patient/client care, using various physical therapy procedures and techniques to produce changes in the condition consistent with the diagnosis and prognosis."
    A. Examination.
    B. Prognosis.
    C. Intervention.
    D. Evaluation.
18. What is the major difference between a client and a patient?
19. What are the four components of the traditional SOAP note?
20. True or false: Correction fluid/tape can be used to correct text in medical records.
    A. A. True.
    B. B. False.
21. Which of the following patient attributes would not impact the clinician's choice of an intervention?
    A. Comorbidities.
    B. Physiological impairments.
    C. Anatomic impairments.
    D. Race.
22. In a typical physical therapy department, which staff member ensures that the objectives of the service are efficiently and effectively achieved within the framework of the stated purpose of the organization?
    A. Staff physical therapist.
    B. Physical therapy director.
    C. Department secretary.
    D. None of the above.
23. True or false: A PTA may modify an intervention only in accordance with changes in patient status and within the established plan of care developed by the physical therapist.

A. True.
B. False.

24. The following are all job responsibilities of the PT volunteer, except:
    A. Taking phone messages.
    B. Cleaning the whirlpool.
    C. Performing secretarial functions.
    D. All of the above are the job responsibilities of the PT volunteer.

25. All of the following are considered categories of the operating budget, except:
    A. Salaries and wages.
    B. Travel expenses.
    C. Continuing education.
    D. Office party expenses.

26. What type of costs can be identified specifically with a particular project, instructional activity, service, or other institutional activity, or can be directly assigned to such activities relatively easily with a high degree of accuracy?
    A. Indirect.
    B. Direct.
    C. Contingency.
    D. Escalation.

27. You are the director of the physical therapy department and will be conducting a job interview for an opening. Which of the following questions would not be appropriate to ask a candidate at a job interview?
    A. What is your level of experience?
    B. Why do you want to join this company?
    C. Do you have any children?
    D. What salary range are you interested in?

28. As the physical therapy director of a facility, you have been asked to write a policy on retention and preservation of clinical records following patient discharge. Of the following, which is not an example of a policy on retention and preservation of clinical records?
    A. The records are accessible to all personnel.
    B. The records will be maintained for a period of 5 years following discharge.
    C. The records will be stored in a locked cabinet during nonworking hours.
    D. The records of a minor will be retained for a period of 3 years after the patient comes of age.

29. As the physical therapy director of a facility, you have been asked to write an action plan to identify deficiencies, implement corrective action(s) to improve performance, and monitor the corrective actions to ensure that quality of care has been enhanced. In which of the following are you likely participating?
    A. Peer review.
    B. Quality assurance.
    C. Program evaluation.
    D. Utilization review.

30. As the physical therapy director of a facility, you have been asked to write a program that assures proper use of the facility's funds and personnel. In which of the following are you likely participating?
    A. Peer review.
    B. Quality assurance.
    C. Program evaluation.
    D. Utilization review.

31. Which of the following are included in the APTA Code of Ethics?
    A. A physical therapist shall exercise sound professional judgment.
    B. A physical therapist shall achieve and maintain professional competence.
    C. A physical therapist shall respect the rights and dignity of all individuals and shall provide compassionate care.
    D. A and C.
    E. All of the above.

32. You are a physical therapist assigned a physical therapy student who is performing his first clinical internship. Which of the following would be the most appropriate goals for this physical therapy student?
    A. To be able to perform an orthopedic examination on all patients.
    B. To perform all aspects of examination and treatment using correct body mechanics.
    C. To correctly evaluate all patient problems.
    D. To perform all patient care duties assigned.

33. Which of the following duties cannot be performed legally by a physical therapist assistant?
    A. Call a physician about a patient's status.
    B. Add 3 pounds to a patient's current exercise protocol.
    C. Allow a patient to increase in frequency from 2 times/week to 3 times/week.
    D. Perform ultrasound on a patient.

34. A physical therapist decides to buy two electrical stimulation units from a sales representative. The representative offers the therapist a free dinner at a local restaurant as a token of appreciation. What is the best course of action for the physical therapist?
    A. Decline the dinner gracefully.
    B. Accept the offer gracefully.
    C. Offer to buy more units.
    D. Take the sales representative out to dinner.

35. CORF is an acronym for which of the following?
    A. Certified owner of a rehabilitation facility.
    B. Certified outpatient rehabilitation facility.
    C. Control organization for rehabilitation facilities.
    D. None of the above.

36. A patient with a diagnosis of carpal tunnel syndrome presents with a prescription for occupational therapy at an outpatient rehabilitation facility. The occupational therapist informs the physical therapist that the patient's insurance will not reimburse for occupational therapy services. What is the best course of action?
    A. Allow the OT to treat the patient and the PT to sign off on his or her work.
    B. Inform the patient that he or she will be billed for the OT services.
    C. Call the doctor's office and obtain an order for PT, then proceed to treat the patient.
    D. Tell the patient to return to his or her doctor to obtain a prescription for physical therapy.

37. As the treating physical therapist, when should you begin discharge planning for a patient admitted to a rehabilitation unit who is status post-total hip replacement?
    A. At the first team meeting.
    B. At the last team meeting.
    C. Two weeks before discharge.
    D. After the initial evaluation.

38. A physical therapist is performing a chart review and discovers that lab results reveal that the patient has malignant cancer. When evaluating the patient, the physical therapist is asked by the patient, "Did my lab results come back?" The appropriate response for the physical therapist is:
    A. To inform the patient about the results and contact the social worker to assist in consultation of the family.
    B. To inform the patient that it would be inappropriate for you to comment on the lab results before the physician has assessed the lab results and spoken to the patient.
    C. To inform the patient that he or she has a malignant cancer.
    D. To tell the patient the results are in, but that physical therapists are not allowed to comment on the results.

39. You instruct a PT assistant to teach a patient on how to ascend and descend the front steps of her home. After first exercising the patient at her home, the PT assistant calls you from the home and informs you that, because of the patient's increased size and severe dynamic balance deficits, training on the steps is unsafe at this time. Which of the following is your best course of action?
    A. You should instruct the assistant to continue the step training, but cautiously.
    B. You should instruct the assistant to recruit the family members to assist with step training.
    C. You should instruct the assistant to discontinue step training until both of you can be present.
    D. You should contact the physician and seek further instructions.

40. A physical therapist is instructing a PT student in documentation using a SOAP note. Where should the following phrase be placed in a SOAP note—*The patient reports wanting to return to playing soccer in 5 weeks*?
    A. Subjective.
    B. Objective.
    C. Assessment.
    D. Plan.

Answers

1. The answer is B.
2. The answer is B.
3. The answer is A. This statement is true.
4. The answer is B.
5. The answer is E.
6. A program designed to provide home care services to seniors and the disabled whose needs would otherwise require them to live in a nursing home.
7. A national program designed for infants and toddlers with disabilities and their families.
8. The answer is D.
9. The answer is A.
10. The answer is C.
11. The answer is A.
12. The answer is B.
13. The answer is A.
14. The answer is D.
15. The answer is C.
16. The answer is D.
17. The answer is C.
18. A patient has a diagnosed impairment or functional limitation, whereas a client is not necessarily diagnosed with impairments or functional limitations, but seek services for prevention or promotion of health, wellness, and fitness.
19. Subjective, objective, assessment, and plan.
20. The answer is B. This statement is false.
21. The answer is D.
22. The answer is B.
23. The answer is A. This statement is true.
24. The answer is B.
25. The answer is D.
26. The answer is B.
27. The answer is C.
28. The answer is A.

29. The answer is B.
30. The answer is D.
31. The answer is E.
32. The answer is B.
33. The answer is C.
34. The answer is A.
35. The answer is B.
36. The answer is C.
37. The answer is D.
38. The answer is B.
39. The answer is C.
40. The answer is A.