American Board of Physical Therapy Residency & Fellowship Education

Application Resource Manual

Examples of Evidence

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Thank you for your interest in credentialing your developing or existing residency or fellowship program. Congratulations on your commitment to excellence in physical therapy education and practice.

The American Physical Therapy Association’s (APTA) American Board of Physical Therapy Residency and Fellowship Education has compiled this Application Resource Manual to serve as a guide as you prepare your program’s application for credentialing. As a “living document,” the Application Resource Manual will be updated regularly and additional sections will be added.

There are many benefits to having residency and/or fellowship programs including improving patient/client outcomes, promoting evidence based practice in physical therapy, and establishing your clinic’s reputation of excellence in patient/client care and physical therapist education.

Going through the credentialing process also has many benefits as you take an in-depth look at your program, compare it to the credentialing requirements, identify your strengths and weakness, and further develop your program in a systematic way.

As an adjunct to the Application for Credentialing, the Application Resource Manual provides actual examples for the “Evidences” required as part of the application. These examples were taken from our credentialed programs and are not intended to be prescriptive as every program is unique and that individuality should be reflected in the application.

You will find additional copies of the application on the Residency/Fellowship webpage under “Professional Development” at www.apta.org, or by clicking here. Additionally, APTA Residency/Fellowship staff are available to answer your questions and may be reached at:

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Good luck and we look forward to receiving your application.
1.0 Organization

Evidence 1.1.1 – Provide the statement of mission and goals of the umbrella organization that most directly influences the Program.

Example 1

(From St. Catherine’s Rehabilitation Hospital & Villa Maria Nursing Center Post-professional Residency in Geriatric Physical Therapy, 2009)

Catholic Health Services (CHS) MISSION:

To provide health care and services to those in need, to minimize human suffering, to assist people to wholeness, and to nurture an awareness of their relationship with God.

CHS will strive to improve the health, independence, and spiritual life of the elderly, the poor, and the needy in the archdiocese, through innovative and proactive approaches to:
- Managing care and providing services;
- Facilitating transitions across levels of care
- Community partnerships and collaboration;
- Advocacy efforts.

Example 2

(From Hospital for Special Surgery Sports Physical Therapy Clinical Residency, 2009)

MISSION

The Mission of Hospital for Special Surgery is to provide the highest quality patient care, improve mobility, and enhances the quality of life for all and to advance the science of orthopedic surgery, rheumatology, and their related disciplines through research and education. We do this regardless of race, color, creed, sexual orientation, or ethnic origin.

VISION

The Vision of Hospital for Special Survey is to lead the world as the most innovative source of medical care, the premier research institution, and the most trusted educator in the field of orthopedics, rheumatology, and their related disciplines.

VALUES

Excellence. HSS is an institution of excellence and shall meet and exceed the expectations of all those we serve. We set and adhere to the highest standards possible for all that we do.

Integrity. HSS shall maintain the highest levels of personal and professional conduct. We shall always conduct ourselves in an ethical and honest manner.
Compassion. HSS shall provide a friendly caring environment where the patient comes first. We shall deliver compassionate care, treating patients and families with respect and dignity.

Respect. We pledge respect for the diversity of traditions and cultures within our organization and the broader community we serve. We will maintain an environment that encourages fair treatment and equal opportunity.

Teamwork. HSS will foster collaboration and cooperation among individuals and departments. We will work together as a team and treat each other with respect.

Quality. Quality in all aspects of health care delivery is of the utmost importance. We will work together to continuously improve our standards of care and our clinical outcomes.

Safety. HSS will strive to maintain safe clinical and physical environments for patients, staff, and physicians.

Innovation. We value new ideas. HSS’s clinical, research, and educational efforts will be directed toward innovation in the identification, prevention, and treatment of orthopedic and rheumatic diseases and conditions.

Education. We are committed to the professional growth and development of staff and to the education of patients and the community.

Efficiency. HSS will strive to operate efficiently and cost effectively while maintaining the highest of standards of care. We will fulfill our mission only if we successfully manage our financial and other resources.

Rehabilitation Department Value Statement:

Department leaders will engage in a participatory management style that embraces our strong belief in teamwork and excellence. The department will support and encourage the unique contribution of each employee, the goal achievement of each individual section, and the integrity and growth of the department at large.

It is the philosophy of the management team to create an environment:

- To recruit, mentor and retain the best individuals who understand and embrace the expectations of our department,
- To ensure employees gain, continuously improve upon, and share their knowledge, talent, skills and expertise, and
- To promote the recognition of these efforts on a local, national and international level.

The result of these collaborative efforts is a dynamic and synergistic, high performing Rehabilitation team; the department as a whole is greater than the sum of its parts.

Example 3

(From The Jackson Clinics Orthopedic Physical Therapy Residency Program, 2009)

Our mission is to establish a regional presence of physical therapy clinics in Northern Virginia that offer the public the highest quality and consistency of patient care. We seek to be a model practice in all respects; including clinical care, research and education.
Our Goals/Values: Quality, consistency in everything we do. Professional excellence with a personal touch.

Our organizational objectives:
- *An organization where everyone is involved in making the business better.*
- *Develop a free flow of ideas and information that improves the business.*
- *To seek and develop methods to respond and act on new ideas throughout the organization.*
- *An organization that learns and encourages learning in itself and in its staff.*
Evidence 1.1.2 – Describe the umbrella organization’s ongoing methods used to evaluate the effectiveness of the umbrella organization’s performance. Include evidence of any external agency accreditations (e.g., JCAHO, CARF, Medicare provider or provider network standards, if applicable).

Example 1

(From Hospital for Special Surgery Sports Physical Therapy Clinical Residency, 2009)

Hospital for Special Surgery is accredited by the Joint Commission on Accreditation of Healthcare Organizations. It is a member of the New York-Presbyterian Healthcare System and affiliate of Weill Cornell Medical College, and cooperates in patient care with New York-Presbyterian Hospital at New York Weill Cornell Medical Center, Memorial Sloan-Kettering Cancer Center, and The Rockefeller University. All HSS medical staff are on the faculty of Weill Cornell Medical College. HSS is a Medicare provider.

HSS Quality Indicators
- For 19 consecutive years, ranked No. 1 in the Northeast in orthopedics and rheumatology by U.S. News & World Report
- Nationally ranked as No. 2 in orthopedics and No. 3 in rheumatology by U.S. News & World Report in 2009
- Scored in top 15 percent nationwide by Hospital Quality Alliance in overall patient satisfaction and patient willingness to recommend the hospital to others
- Magnet Recognition for Excellence in Nursing Service
- No. 1 Knee-Hip Orthopedic Hospital in AARP Modern Maturity
- Recipient of first New York State Hospital Patient Safety Award
- Recognized as premier in the field of Radiology by Consumers’ Research Council of America Guide to America’s Top Radiologists
- One of two medical institutions designated by the National Institutes of Health as a Core Center for Skeletal Integrity
- Ranked one of the top 35 Pain Management Centers by Castle Connolly Medical Ltd. In Good Housekeeping
- Participant in the Institute for Healthcare Improvement’s 100,000 Lives Campaign
- Ranked in the 99th percentile of the Press Ganey inpatient survey database for likelihood of recommending our facility to others

Hospital for Special Surgery uses a wide variety of measures to evaluate the effectiveness of its performance including Press Ganey patient satisfaction surveys and Gallop surveys of employee engagement. In a hospital-wide program of Continuous Quality Improvement, each HSS department identifies important aspects of care and service for that department and measures performance. Each department is challenged to find out whom, outside HSS, is performing best in that area and to compare our performance with theirs (“benchmark”) as we strive to surpass that performance. For instance, the Service Excellence Department compares our patient satisfaction scores to other Magnet award winning hospitals and Perioperative Services compares performance on select measures to a Baldrige award winning hospital. In addition to Press Ganey patient satisfaction scores, the Rehabilitation Department tracks and benchmarks access to care, patient incidents, and the clinical pathway for total hip arthroplasty.

Hospital staff members receive a probationary performance appraisal 6 months after the start of employment followed by annual performance appraisals. Members of the Rehabilitation Department receive an additional annual mid-year performance review. The Clinical Competency Program of the
Rehabilitation Department ensures and documents initial and ongoing clinical competency of each clinician in the department.

**Example 2**

*(From St. Catherine’s Rehabilitation Hospital & Villa Maria Nursing Center Post-professional Residency in Geriatric Physical Therapy, 2009)*

St. Catherine’s Rehabilitation Hospital and Villa Maria Skilled Nursing Center’s methods of evaluating program effectiveness and effectiveness of performance include ongoing performance improvement and quality assurance projects, lead by a facility Director of PI. PI Teams include Surveillance Improvement Team (SIT), Resource Management Improvement Team (RMIT), and Provision of Care Improvement Team (PCIT). Other methods include meeting the accreditation standards of the Joint Commission and CARF. Joint Commission and CARF accreditations are conducted every 3 years. Additionally, the facility meets the requirements of Medicare, Medicaid, and the State of Florida on an annual basis.

**Example 3**

*(Adapted from The Jackson Clinics Orthopedic Physical Therapy Residency Program, 2009)*

Patient Surveys: We do two types of patient surveys. Written surveys with formal analysis of the results indicates levels of patient satisfaction in a variety of measures from front desk performance to clinical performance. We also do patient interviews and focus groups to aide in assessing our performance and devise ways to improve.

Insurers track outcome measures of our clinic vs. our competitors. They freely share this data with us so that we can track our performance. We also perform our own outcome measures. A significant (over 30%) and sustained growth of referrals indicates a growing perception in the medical community of The Jackson Clinics as the “go to” practice in the region.

Self assessment through our internal quality assurance program (chart reviews) indicates to us the consistency of our examinations, reporting, and Medicare compliance. “Secret shopping” of our own clinics is an effective measure of front desk customer services.

Finally, we recently contracted with XXXX, PY of XXXX and Associates to analyze our business operations and make recommendations for improvement.
Evidence 1.2.1 – Program Mission, Goals, and Objectives

A. Provide the Program’s mission statement, goals and objectives. Multi-site Programs must include at least one goal and corresponding objectives addressing consistency of program delivery in all clinical settings.

B. Describe how the Program’s mission statement, goals, and objectives are consistent with one another.

C. Describe how the Program’s mission, goals, and objectives are consistent with the mission of the umbrella organization.

Example 1

(Adapted from Unity Health System/Ithaca College Residency in Neurologic Physical Therapy, 2009)

1.2.1.A Program’s Mission Statement, Goals, and Objectives

The mission of the Unity Health System/Ithaca College Residency in Neurologic Physical Therapy is to mentor the professional development and advanced clinical training of neurologic physical therapists so they may exemplify the core values of physical therapy professionalism and may capably contribute to the field of neurorehabilitation through leadership and skill as practitioners, educators, and clinical scholars who understand, value, and practice guided by current evidence.

Program Goals and Objectives

1. Support the mission and core values of Unity Health System and its Department of Physical Medicine and Rehabilitation:
   a. by creating an innovative mechanism to increase the skill and education of neurologic physical therapy providers, thereby
   b. expanding the quality of care delivered to individuals across the lifespan with physical, cognitive, and social disability resulting from neurologic pathology

   Objectives:
   a. The Program will provide training in evidence-based, comprehensive skilled physical therapy services across all elements of the patient management model to young adults and adults with pathology affecting all anatomic levels of the nervous system. The Program will lead to competence in dealing with neurologically-involved populations normally seen within the practice settings of in-patient acute rehabilitation and out-patient rehabilitation, and will provide exposure to pediatric neurologic care and the practice setting of acute neurology and neurologic intensive care.
   b. The clinical faculty will provide supervision of the resident within selected clinical sites available through Unity Health System.

2. Develop and deliver a curriculum for post-professional experiential learning program in neurologic physical therapy that integrates advanced patient-centered practice and interdisciplinary training with a theoretical knowledge base in rehabilitation science.

   Objectives:
   a. The Program’s curriculum, which includes both didactic and clinical components, will address all aspects of the Neurologic Physical Therapy Description of Specialty Practice.
b. The Program will be responsive to educational opportunities that arise throughout the residency.

3. Engage physical therapists in a deliberate and systematic use of reflection in delivering patient-centered care.
   **Objective:**
   a. The Program’s faculty will provide mentoring in the areas of clinical skills, professionalism, leadership, and scholarly activities.

4. Empower physical therapists to practice ethical clinical decision-making and demonstrate virtuous behavior.
   **Objective:**
   a. The Program will engage physical therapists in discussions of ethical analysis and moral culture applicable to neurologic physical therapy practice.

5. Develop the clinical and didactic teaching skills of the resident and the residency faculty, fostering a practice environment where clinical knowledge is freely shared through dialogue and interdisciplinary education.
   **Objectives:**
   a. The Program will be structured to allow the resident to acquire teaching experience within the entry level physical therapy program at Ithaca College and within Unity Health System.
   b. The Program will provide the residency faculty with resources and opportunities to develop, practice, and refine their teaching skills.

6. Advance a commitment to service and social responsibility.
   **Objectives:**
   a. Identify service opportunities through Unity Health System or Ithaca College which would enhance the function, health, or wellness of individuals with neurologic dysfunction within the Rochester, New York community or beyond.
   b. The Program will require the resident to complete a service project.

7. Promote advancement in the field of neurologic physical therapy by engaging physical therapists in activities that promote excellence and seek to discover or appraise new evidence to guide practice decisions.
   **Objectives:**
   a. The Program will require the resident to contribute to the body of knowledge in neurorehabilitation through participation in and dissemination of knowledge gained through clinical research, administrative/consultative projects, or in the development of a patient case report.
   b. The Program will be structured to provide opportunities for interdisciplinary education.

8. Graduate physical therapists that are prepared to pursue American Board of Physical Therapy Specialties (ABPTS) certification as a neurologic clinical specialist.
   **Objective (from 2a above):**
   a. The Program’s curriculum, which includes both didactic and clinical components, will address all aspects of the Neurologic Physical Therapy Description of Specialty Practice.

**1.2.1.B How Program Mission Statement and Goals are consistent with each other**
The goals and objectives of the Unity Health System/Ithaca College Residency in Neurologic Physical Therapy offer an expanded expression of the intent of the mission statement of the program, which identifies mentoring as the fundamental component of the residency. This mentoring is focused on two key functions: to promote the professional development of neurologic physical therapists as defined by the core values of physical therapy professionalism, and to advance clinical practice in neurologic physical therapy. Both of these focus areas are intertwined.

Each of the Program goals and their respective objectives address one or more of these mission statement components in the following ways:

Mentoring services as the cornerstone of the residency program:
The process of mentoring requires both mentee and mentor to reflect upon many different aspects of patient care delivery, with special attention to the values and beliefs of their patients so that patient-centered care is enhanced. This is supported by the Program goal: Engage physical therapists in a deliberate and systematic use of reflection in delivering patient-centered care.

The process of mentoring serves to advanced clinical practice by modeling leadership and promoting skill development on the part of the mentor and the mentee. Mentoring is considered a part of the professional duty of a physical therapist.

The residency mission addresses the professional development of neurologic physical therapists:
Mentoring the professional development of a neurologic physical therapists involves the study of the characteristics of expert practice and exposure to and appreciation for the core values of physical therapy professionalism, which are referenced in the mission statement. These core values include accountability, altruism, compassion/caring, excellence, integrity, professional duty, and social responsibility. The following program goals and their respective objectives intentionally address these core values:

Empower physical therapists to practice ethical clinical decision-making and demonstrate virtuous behavior
This program goal addresses the core value of integrity and professional duty.

Advance a commitment to service and social responsibility
Social responsibility and service begin with an understanding of the health needs of individuals or communities. The advanced clinical training of neurologic physical therapists promotes an awareness of these needs and the optimal way to service them. The core values of altruism and compassion/caring are also expressed through this residency program goal.

Promote advancement in the field of neurologic physical therapy by engaging physical therapists in activities that promote excellence and discover or appraise new evidence to guide practice decisions.
To develop leadership and skill as a clinical scholar, neurologic physical therapists must feel comfortable discovering and/or appraising evidence to optimize their practice decisions. This Program goal addresses the core value of excellence as a physical therapy professional.

Develop the clinical and didactic teaching skills of the resident and the residency faculty, fostering a practice environment where clinical knowledge is freely shared through dialogue and formal interdisciplinary education.
To develop leadership and skill as an educator, opportunities to develop and refine teaching skills must be made available to the resident and residency faculty. These opportunities for teaching and the sharing of knowledge support the core value of clinical excellence.

The Program’s mission is to advance the clinical training of neurologic physical therapists:
Advancing the clinical training of neurologic physical therapists is intended to enhance patient care, which is addressed in the residency goal of:

*Support the mission and core values of Unity Health System and its Department of Physical Medicine and Rehabilitation by creating an innovative mechanism to increase the skill and education of neurologic physical therapy providers, thereby expanding the quality of care delivered to individuals across the lifespan with physical, cognitive, and social disability resulting from neurologic pathology.*

The clinical training of neurologic physical therapists combines experiential learning, professional practice, and didactic knowledge; this is reflected in the residency goal:

*Develop and deliver a curriculum for a post-professional experiential learning program in neurologic physical therapy that integrates advanced patient-centered practice and interdisciplinary training with a theoretical knowledge base in rehabilitation science.*

As stated in the program objectives, this curriculum follows the APTA’s Neurologic Physical Therapy Description of Specialty Practice.

The advanced clinical training and didactic learning offered through this Program prepares neurologic physical therapists to assume leadership roles as practitioners recognized for their clinical excellence. This is reflected in the residency goal:

*Graduate physical therapists that are prepared to pursue American Board of Physical Therapy Specialties (ABPTS) certification as a neurologic clinical specialist.*

### 1.2.1.C How Program Mission/Goals are consistent with the mission of the umbrella organization

Unity Health System’s mission statement explains its commitment to education and delivering high quality health care, and notes the interrelationship of these two factors. The mission and goals of the Program are also directed at achieving these two outcomes. As stated in the Program’s goals and supported through its objectives, the residency program offers an innovative mechanism to increase the skill and education of neurologic physical therapists within the health system. This includes those individuals serving as faculty members providing didactic and performance-based training within the program, as well as the resident enrolled in the Program. The intent of this didactic and skill-based education is directly linked to expanding the quality of care to individuals treated within the health system, with emphasis on Unity’s practice settings of in-patient acute rehabilitation and outpatient rehabilitation. The Program’s training is evidence-based and comprehensive across all elements of the patient management model. The Program’s emphasis on developing the clinical and didactic teaching skills of the resident and residency faculty provides another example of the consistency of the Program’s goals with the health system’s overall mission to make a positive difference in the lives of individuals through education and high quality health care.

Unity’s Health System’s core values of respect, quality services, empowerment, compassion, and creativity guide the work of its members. The Program’s commitment to mentoring the professional development of neurologic physical therapists provides direct support of the core values identified by the health system. The goals of the program emphasizing ethical decision-making and virtuous behavior, promoting clinical excellence, and advancing a commitment to service and responsibility are well aligned with the intent of Unity’s mission statement.

**Example 2**

(Adapted from Centers for Rehab Services WomensRehab Physical Therapy Residency Program, 2010)

### 1.2.1.A Program’s Mission Statement, Goals, and Objectives
Mission Statement: The mission of the Centers for Rehab Services WomensRehab Physical Therapy Residency Program is to advance the competent physical therapists through education, research and professional service into a board certified clinical specialist in the area of women’s health physical therapy – emphasizing the development of psychomotor skills, theoretical rationales and clinical reasoning to enhance the resident’s ability to prevent, treat, and rehabilitate injuries in this specialized population.

Goals: The goals of the program are to prepare graduates who will:
1. Practice advanced clinical decision-making skills – with emphasis on managing physically active and inactive females through the lifespan.
2. Provide superior clinical practice and manual therapy skills.
3. Be able to participate as part of multi-disciplinary team to optimize the management of women’s health diagnoses.
4. Become a resource for the community in the prevention and rehabilitation of women’s health diagnoses.
5. Contribute to the physical therapy profession and the WomensRehab program team through writing, teaching, and leadership skills.

Objectives: The objectives of the program are to:
1. Provide an advanced plan of study through a detailed and structured curriculum that is consistent with the Women’s Health Description of Specialty Practice which will include didactic coursework and academic mentoring.
2. Provide a mentored clinical experience, with emphasis on the women’s health population, under the supervision of recognized experts to include: ABPTS-certified faculty, Lymphedema-certified faculty, Urogynecology physicians, Urology physicians, OB-GYN physicians, GI/Colorectal physicians, and Physical Medicine and Rehabilitation physicians.
3. Provide a mentored experience in clinical research and academic instruction in collaboration with the University of Pittsburg.

1.2.1.B How Program Mission Statement and Goals are consistent with each other

The Program mission, goals and objectives were developed concurrently to ensure consistency. Our goals were specifically designed to reflect the Program’s dedication to advancing the resident into a board certified clinical specialist in the area of women’s health physical therapy focusing on clinical practice, education, and research in this subspecialty area of physical therapy. The mission statement and goals are consistent with a program that will prepare the resident to be a productive member of the WomensRehab program within the profession and the community.

1.2.1.C How Program Mission/Goals are consistent with the mission of the umbrella organization

The philosophy of the WomensRehab Physical Therapy Residency Program is modeled after our umbrella organization with emphasis in the sub-specialty area of women’s health patient population including lymphedema. The mission of the Program is consistent with that of Centers for Rehab Services to incorporate premiere patient care, clinical research, education, teaching, and community service.

Example 3

(Adapted from Cincinnati Children’s Hospital Medical Center Sports Medicine Biodynamics Center Orthopedic Physical Therapy Residency Program, 2010)

1.2.1.A Program’s Mission Statement, Goals, and Objectives
The mission of the program is to prepare the physical therapist interested in orthopedic PT to provide excellent, evidence-based clinical care in the orthopedic practice setting. The program emphasizes the development of leadership skills, so that graduates are equipped to service as emerging leaders in the field. The graduate will be capable of providing the highest level of clinical care, will be an educated consumer of the current evidence related to our practice, and will be expanding their personal leadership abilities, so they can influence and advance the field of orthopedic physical therapy.

Program Goals:
1. To develop a competent Orthopedic Physical Therapy Specialist.
2. To prepare the resident for successful completion of the Orthopedic Clinical Specialty Examination.
3. To develop physical therapists who contribute to the profession and to health care through specialized practice, teaching, and leadership activities.

Program Objectives:
1. To develop competent Orthopedic Physical Therapy Specialists through mentored clinical experiences with experts in Orthopedic Physical Therapy and Sports Medicine.
2. To offer the resident diverse didactic educational experiences.
3. To provide training and opportunities for the resident to expand their skills in leadership.
4. To provide diverse interactions with other health care and research professionals.
   a. Physician observation experience with orthopedic surgeons and sports medicine physicians.
   b. Orthopedic/Sports Medicine research experience

1.2.1.B How Program Mission Statement and Goals are consistent with each other

The Program goals are designed with the intent to support the mission of the program. The goals are to provide an environment where the resident will be exposed to expert clinical care through observation, didactic education and utilization of clinical skills. This is to be augmented with diverse experiences with various members of the orthopedic and sports medicine health care team. Together, these goals are designed to support the mission of developing a more evidence based, orthopedic clinician who is capable of providing superior clinical care.

1.2.1.C How Program Mission/Goals are consistent with the mission of the umbrella organization

The mission of CCHMC is grounded in the base principle of providing superior clinical care, unparalleled research discoveries and excellent community service. The CCHMC Sports Medicine and Biodynamics Center Orthopedic Physical Therapy Residency Program is designed to emulate these values. Throughout the residency, the goal is to provide specialized clinical mentorship to the resident in an attempt to provide them with the tools to be a superior, evidence-based clinician. CCHMC offers many research opportunities as well as considerable research assistance, including an extensive library and numerous faculty members available for guidance. Through these opportunities, the resident will be able to learn and appreciate the value of research and how it can positively impact our clinical decision making. Finally, the center makes regular contributions to the community through involvement in continuing education courses and in community outreach clinics for runners as well as dancers within the area. Again, this provides the resident with additional opportunities to contribute to the mission of the residency and the organization. In summary, by design, the mission of the Program is completely in line with the mission of CCHMC in an attempt to serve the institution and our community, while providing an unparalleled educational opportunity for future residents.
Example 4

(Adapted from St. Catherine’s Rehabilitation Hospital & Villa Maria Nursing Center Post-professional Residency in Geriatric Physical Therapy, 2009)

1.2.1.A Program’s Mission Statement, Goals, and Objectives

Mission Statement:

To prepare trainees for independent advanced practice in geriatric physical therapy and as a clinical specialist in an integrated environment of clinical excellence and educational effort by a team of professionals who are committed and knowledgeable in gerontology and geriatric physical therapy and who are role models in the professional biopsychosocial care of elderly patients. Graduates express their education through excellence in evidence based practice and teaching of clinical skills, and continue to expand the body of knowledge in geriatric physical therapy by participating in clinical research, and make a lasting contribution to their local and professional community.

Goals:

The goals of the residency program are to educate the physical therapist to:

1. Meet the needs of society by becoming advanced practitioners of geriatric physical therapy
2. Become critical consumers of the relevant scientific literature who, by virtue of critically assessing the literature, incorporate appropriate new techniques and knowledge into practice
3. Contribute to the body of knowledge in geriatric physical therapy by participating in clinical research
4. Become competent instructors of geriatric physical therapy practice
5. Become consultants, advocates, and ambassadors to the public and medical communities for the profession of physical therapy
6. Exhibit the highest standards of professionalism

Objectives:

Goal 1: Practice advanced geriatric physical therapy clinical and administrative skills

- Demonstrate advanced skill in the practice dimensions described in the current ABPTS description of specialty practice in geriatric physical therapy
- Demonstrate knowledge in all knowledge areas described in the current ABPTS description of specialty practice in geriatric physical therapy
- Demonstrate the ability to perform patient examination, evaluation, diagnosis, prognosis, and intervention consistent with the description of specialty practice in geriatric physical therapy
- Demonstrate application of the principals of evidence based practice in patient care on an ongoing basis
- Demonstrate knowledge of payer rules and regulations pertinent to the practice of geriatric physical therapy, including, but not limited to, prospective payment systems, healthcare delivery sites, and Medicare
- Develop a written project that reflects knowledge of administrative concerns and issues relative to geriatric physical therapy.

Goal 2: Demonstrate the skills necessary to critically review the scientific literature pertinent to geriatric physical therapy:

- Demonstrate the ability to utilize available search services to obtain relevant literature
• Discuss the applicability of current literature to current practice and incorporate new knowledge and skills into practice
• Discuss relative merits of research studies in terms of rationale, design, methods, instrumentation, statistical analysis, and conclusions
• Discuss given research articles within the context of the current body of knowledge

Goal 3: Participate in clinical research:
• Prepare a case report or similar written product suitable for publication in a peer reviewed journal or presentation at a state or national professional conference.

Goal 4: Engage in the process of education:
• Identify the critical information an intern must master to successfully practice at entry-level
• Demonstrate the ability to clearly explain and perform aspects of geriatric patient management to interns and peers
• Successfully complete a certification course in clinical instruction (e.g., APTA, FPTA)

Goal 5: Become consultants, advocates, ambassadors:
• Demonstrate the oral and written capabilities required to successfully communicate information pertinent to patient management to other members of the healthcare team involved in a given patient’s care
• Demonstrate the capability to successfully communicate information regarding the profession of physical therapy to members of other healthcare professions, patients, and the public at large

Goal 6: Exhibit the highest standards of professionalism:
• Demonstrate the utmost professional behavior in all actions

1.2.1.B How Program Mission Statement and Goals are consistent with each other

The goals were developed using the mission statement as a guide. The goals are significantly different from each other and do not conflict. Goals and objectives combine to reflect how the mission will be accomplished.

1.2.1.C How Program Mission/Goals are consistent with the mission of the umbrella organization

Post-professional Clinical Residency Program Mission Statement:

To prepare trainees for independent advanced practice in geriatric physical therapy and as a clinical specialist in an integrated environment of clinical excellence and educational effort by a team of professionals who are committed and knowledgeable in gerontology and geriatric physical therapy and who are role models in the professional biopsychosocial care of elderly patients. Graduates express their education through excellence in evidence based practice and teaching of clinical skills, and continue to expand the body of knowledge in geriatric physical therapy by participating in clinical research, and make a lasting contribution to their local and professional community.

This mission is consistent with the umbrella organization’s by providing healthcare to those in need (elderly populations are at risk socioeconomically); minimizing human suffering (clinical excellence implies good physical/functional outcomes); and through involvement in patient education/wellness/health promotion and empowerment, we “foster a component of wholeness/spirituality”.

Application Resource Manual
APTA Clinical Residency and Fellowship Program Credentialing (2011)
Post-professional Clinical Resident Program Goals/Objectives:

This residency is designed to prepare participants to become skilled autonomous geriatric clinicians by providing them with education through both didactic and clinical experiences. Participants will function as an integral member of an interdisciplinary team to assure integrated care for the patient, and will be able to provide autonomous care as a point of entry into the healthcare system for geriatric clients.

The goals of the residency program are to educate physical therapists to:

- Meet the needs of society by becoming advanced practitioners of geriatric physical therapy
- Become critical consumers of the relevant scientific literature who, by virtue of critically assessing the literature, incorporate appropriate new techniques and knowledge into practice
- Contribute to the body of knowledge in geriatric physical therapy by participating in clinical research
- Become competent instructors of geriatric physical therapy practice
- Become consultants, advocates, and ambassadors to the public and medical communities for the profession of physical therapy
- Exhibit the highest standards of professionalism

These goals are consistent with the organization’s mission and VISION statement: to provide innovative and proactive approaches to managing and providing services, facilitating transitions across levels of care, community collaboration, and advocacy efforts.

Example 5

(Adapted from Glendale Adventist Medical Center’s Orthopedic Physical Therapy Residency, 2009)

1.2.1.A Program’s Mission Statement, Goals, and Objectives

Glendale Adventist Medical Center’s Orthopedic Physical Therapy Residency Program’s mission is to:

Provide clinical training of physical therapists that accelerates their professional development in becoming a resource, educator and mentor to others in the community that they serve as a:

- Highly skilled patient-care provider
- Competent consumer and contributor to the scientific literature
- APTA Board Certified Clinical Specialist in Orthopedic Physical Therapy

GOAL #1: The Program will produced residents who exhibit the highest standards of professionalism.

Objectives:
1. Meet or exceed standards required of all physical therapists employed by Glendale Adventist Medical Center (GAMC)
2. Performs all tasks required of a physical therapy resident in a dependable and reliable manner including:
   - Directed and self-directed learning of clinical skills
   - Effective oral and written communication with patients, clinical faculty, administration, physicians, and other members of the health care team
3. Assist in the clinical supervision of a physical therapy student intern
4. Assume an active role in addressing a need in the community

GOAL #2: The program will educate residents in order to perform the highest level of health care for patient at Glendale Adventist Medical Center.

Objectives:
1. Restore or preserve the patient’s muscle strength, range of motion, mobility and neuromuscular control to the maximum extent possible during the course of their treatment.
2. Promote prevention and healing for the whole person regardless of physical condition, impairment or disability.
3. Facilitate assessment, prescription, fitting and adaptive training for prosthetic, orthotic or assistive devices.
4. Assist with minimizing pain and discomfort related to pathology affecting the neuromuscular system.
5. Maximize the patient’s ability to function independently.

GOAL #3: The program will train residents to become competent with utilizing, and contributing to, the evidence-based practice of physical therapy.

Objectives:
1. Assist in the design, literature review, proposal submission, data collection, data analysis, or publication of a controlled, clinical trial in an area of orthopedic physical therapy.

GOAL #4: The program will prepare residents to obtain ABPTS board certification as a clinical specialist in Orthopedic Physical Therapy.

Objectives:
1. Obtain *skills* in the six clinical responsibilities described in the current ABPTS Description of Specialty Practice of Orthopedic Physical Therapy.
2. Obtain *knowledge* in the seven knowledge areas described in the current ABPTS Description of Specialty Practice of Orthopedic Physical Therapy.
3. Obtain *ability* to perform the patient examination and treatment procedures described in the current ABPTS Description of Specialty Practice of Orthopedic Physical Therapy.

1.2.1.B How Program Mission Statement and Goals are consistent with each other

Professionalism, health care at a higher level, competence with evidence based practice, and attainment of national certification standard are values that illustrate how we make a difference in the lives of our patients, visitors and fellow employees.

1.2.1.C How Program Mission/Goals are consistent with the mission of the umbrella organization

The mission of the Glendale Adventist Medical Center’s Orthopedic Physical Therapy Residency Program is to accelerate professional development of residents providing high quality health care for our patients. Thus, the residency program’s mission is derived directly from the Glendale Adventist Medical Center’s mission statement – “To share God’s love with our community by promoting healing and wellness for the whole person.”
Evidence 1.2.2 – Provide the Program’s policies and procedures for the resident/fellow handbook and Program and/or umbrella organization’s policy for the items listed above.

Examples

1) Patient/Client Care Issues:

a) Confidentiality safeguards for records and personal information

(Adapted from St. Catherine’s Rehabilitation Hospital & Villa Maria Nursing Center Post-professional Residency in Geriatric Physical Therapy, 2009)

All records and personal information pertinent to residents are kept strictly confidential and are accessible only to residents and faculty/staff. Records are kept for a period of at least three years. These records are stored in locked storage maintained by the Program Coordinator at St. Catherine’s/Villa Maria. When deemed appropriate, records are destroyed by shredding.

In addition, residents must follow all St. Catherine’s/Villa Maria policies and procedures related to nondisclosure of confidential information, including employee personal records, patient records, release of information, confidentiality of information transmitted via facsimile (fax machine), and third party concurrent medical record review.

The residency program and its faculty, staff, and residents must comply with HIPAA regulations.

b) Use of human subjects and procedure for informed consent

Example 1

(Adapted from St. Catherine’s Rehabilitation Hospital & Villa Maria Nursing Center Post-professional Residency in Geriatric Physical Therapy, 2009)

Catholic Health Services of Florida has its own Federal Wide Assurance (FWA) which designates the University of Miami to serve as its Institutional Review Board (IRB) of record. Residents participating in studies involving human subjects must comply with the affiliated University’s Institutional Review Board (IRB). Residents will obtain written informed consent of persons involved in demonstration studies, case studies, clinical trials, and/or depiction in audiovisual materials. All other applicable federal, state, local, or corporate rules, regulations, policies, or procedures must also be followed. Consent forms must receive IRB approval. All forms and procedures must comply with HIPAA regulation.

Example 2

(Adapted from AllStar Therapy Geriatric Residency Program, 2010)

During each residency program, each resident must adhere to appropriate policies for the protection of human research. Such required information on gathering and tracking of information must be approved by the director of Residency in collaboration with the Administrator of the clinical site where information is being obtained. Informed consent will be obtained from all individuals or family members as necessary that are enrolled as research subjects. No investigator or staff person may enroll a human subject into a research protocol without having obtained the informed consent from the person subject or his/her legally authorized representative.
Minimizing the risks of non-compliance with protection of human rights:

- Provide proper education to each prospective participant in a research trial for the collection and use of clinical samples.
- Each resident will be responsible to give those patients/clients who may be participant in such a research program the Patient/Client Care Research Disclosure Form.
- Employee training by company as well as contracted clients.
- Provide proper education to each prospective participant in a research trial for the collection and use of clinical samples.
- Personal or clinical information on subjects used for research purposes will be eliminated or be linked through separate identifiers if needed in preparation for analysis.
- Records will be kept in a locked drawer.
- Termination of resident contract may result from non-compliance of corporate policies on the protection of human rights.

c) Procedure for informing the patient/client of any substantial risks of the recommended examination and intervention, where the resident is involved in specialized procedures

*(Adapted from AllStar Therapy Geriatric Residency Program, 2010)*

It is the mandatory policy of the corporation that each patient be educated on the risks from the examination or intervention. Improper education for patient/client on risks may result in termination of a resident. Such education should be conducted verbally to each patient/client by each resident.

d) Safety regulations and evidence of its annual review

*Example 1*

*(Adapted from St. Catherine’s Rehabilitation Hospital & Villa Maria Nursing Center Post-professional Residency in Geriatric Physical Therapy, 2009)*

Appropriate safety regulations are posted and reviewed in accordance with St. Catherine’s/Villa Maria policy and procedure including regulations outlining universal precautions, use of equipment and storage and use of any hazardous materials. Specifically, information on the following subjects is found within the facilities:

- Workplace safety
- Universal Precautions
- Bloodbourne Pathogens
- Material Safety Data Sheets
- Use, storage, and cleaning of durable medical equipment

Residents will be oriented as to their location by the Program Coordinator or designee no later than three days after arrival. Administration for St. Catherine’s & Villa Maria review these policies and procedures annually, and when necessary, residency staff will provide input. All employees (including residents) receive a general orientation upon hire, and annually thereafter, which includes all of these topics.

*Example 2*

*(Adapted from Centers for Rehab Services WomensRehab Physical Therapy Residency Program, 2010)*

Patient and Staff Safety
A. All situations which compromise or potentially compromise the safety of patients, visitors, others, or involve complaints regarding patient care must be reported online through UPMC Riskmaster. The online Initial Incident Event Reporting Form must be completed within 24 hours of occurrence.

B. All situations which compromise the safety of employees must be reported on the Employee Incident Report Form. The Employee Incident Report Form must be completed within 24 hours of occurrence. The completed Incident Report Form is to be sent as an attachment to HR. HR will reply to the email and provide an internal tracking number for recording on the hard copy. Original signed hardcopies are to be mailed to the HR at the CRS Corporate Office.

C. Incidents will be individually reviewed on a monthly basis by the Safety Committee. The number of incidents, noted trends, and corrective action plans will be summarized quarterly on the facility QI reports.

D. Departmental safety inspections must be performed on a quarterly basis. The inspection will assess the condition of the physical plant; availability of universal precaution materials; correct storage and labeling of hazardous materials; maintenance of equipment; posting of emergency procedures, exit plan, and professional licenses; availability of occupancy permit, fire inspection, and pest control report; resumes for professional staff; policy and procedures manual; and annual disaster inservice report. Corrective action to satisfy any deficiencies should be implemented by the Facility Director. The Quarterly Physical Environment Checklist will be submitted to the Safety Committee for review.

E. Annual preventative maintenance, calibration and testing of clinical equipment will be performed through a contractual arrangement with an outside vendor. Records of the annual maintenance inspection will be maintained in each facility and a copy will be forwarded to the Safety Committee for review.

F. Since routine cultures of hydrotherapy equipment have not proven to be effective or necessary, laboratory cultures will only be performed in cases of suspected cross contamination. Suspected cases of cross contamination should be reported online through UPMC Riskmaster for review and action as necessary. A summary of suspected cases of cross contamination will be reviewed quarterly by the Safety Committee.

2) Administrative and Human Resource Issues:

a) General policies and procedures for the faculty and staff of the Program

(Adapted from University of St. Augustine for Health Sciences Orthopedic Residency, 2010)

Clinical Faculty Mentors
The mentor is responsible for providing 150 hours of one-on-one mentored time to the resident also during mentored clinical examination sessions the mentor is responsible for evaluating the resident. The following sections are the mentor feedback forms:

- Mentor Evaluation of the Resident during Mentoring
  During 1:1 mentored learning experience the mentor will provide feedback using form 206.2. This form should be reviewed with the resident and submitted with the resident learning experience form to the program director.

- Mentor Monthly Evaluation of Resident
  The mentor will submit a monthly evaluation form on the performance of the resident. This form is due on the 5th of each month; send form 302 to the program director. If more than one clinician provides mentoring, each should provide an evaluation of the resident. Residents should schedule time to review the evaluation with the mentor each month. It is the responsibility of the resident to make sure the document is submitted by the appropriate date.

- Mentor Weekly Evaluation of Resident
The mentor will complete a weekly evaluation of the resident. Weekly feedback form 303 should be completed by Friday of each week, and reviewed with the resident. The evaluations are due to the program director on the last day of each month. It is the responsibility of the resident to make sure the document is submitted by the appropriate date.

- **Mentor Post Residency Evaluation**
  The mentor will complete a Post Residency evaluation of the resident within one week of the residency completion, see form 304, and submit to the program director. It is the responsibility of the resident to make sure the document is submitted by the appropriate date.

It is the responsibility of the resident to make sure the mentor has all needed documentation forms and due dates. Submission of all forms is required to ensure successful completion of the program.

Mentors will be required to participate in mentor development programs such as APTA CI credentialing course, evaluation of mentoring skills by director or co-director, review of monthly mentor newsletter, and participation in online lecture/presentation.

**Residency Staff**
The following are procedures to be completed on a monthly basis:

- **Bi-Monthly Residency Mentoring and Assistant Timesheets**: e-mail reminder, collection, filling out check requests
- **Journal Club**: sending out monthly e-mail reminder, sending announcement to faculty meeting agenda, determining article with resident, reserving room, attending journal club, collect evaluation forms from residents and the week following
- **Case Rounds**: sending out monthly e-mail reminder, collecting all case from residents to be presented, send out to all mentors, residents, reserving room, collect follow evaluation forms from residents the week following
- **Marketing**: meeting with marketing committee, developing/improving website information and brochures, coordinating/attending conferences (CSM, NSC, PPS, FPTA). Follow-up handwritten cards to inquiries
- **Inquires Residents, Resident Sites**: Daily calls to answer questions regarding all aspects of residency sites, participants, and mentors. Mail of brochures, creation of detailed information specific to certain sites/mentors/participants
- **Site Evaluations/Communication**: weekly phone calls with sites to answer questions that develop, ask for paperwork, and ensure quality is being provided
- **Monthly newsletter**: send to sites/mentors to cover big concepts to eliminate the volume of questions/phone calls
- **Mentor Observations**: APTA requires directors to observe each mentor in a mentoring session with the residents
- **Application Review**: Bi-monthly meetings to evaluate any new site, or resident applications. E-mail correspondence to follow up with any decision.
- **Residency Interview**: All residents must go through an interview process either on campus or via phone. Scheduling must be coordinated between USA, sites (if off campus), and mentors. All evaluations from interviews must then be reviewed.
- **Residency Committee Meeting**: monthly meetings to discuss program
- **Management Meeting**: monthly report to be sent in and attendance at meetings
- **Mentor Meetings**: communication on feedback from residents, as well as developments or changes in the program

b) **Nondiscriminatory policies and procedures for the recruitment, admission, retention, and dismissal of students or employees**
Example 1

(Adapted from AllStar Therapy Geriatric Residency Program, 2010)

AllStar is an Equal Employment Opportunity Employer. It is the policy of the company from recruitment through all employment decisions to provide equal opportunity without regarding to race, creed, color, religion, age, sex, national origin, disability, sexual orientation or any other protected class in accordance with applicable state and federal laws. The policy governs all aspects of employment, including selection, job assignment, compensation, discipline, termination, and access to benefits and training.

We affirm that we will make reasonable accommodations for qualified individuals with known disabilities unless doing so would result in an undue hardship.

AllStar emphasizes this policy to assure compliance with the Civil Rights Act of 1964, as amended, president Executive Order No’s 11246 and 11375, and all other applicable Federal, State, and Local laws which pertains to equal opportunity.

Example 2

(Adapted from St. Catherine’s Rehabilitation Hospital & Villa Maria Nursing Center Post-professional Residency in Geriatric Physical Therapy, 2009)

Resident Non-discrimination

It is the policy of the program to recruit, admit, and retain participants on a nondiscriminatory basis. Specifically, the program does not discriminate on the basis of race creed, color, gender, age, national or ethnic origin, marital status, sexual orientation, disability or health status.

(Adapted from Army-Baylor University Doctoral Fellowship in Orthopaedic Manual Physical Therapy, 2009)

Equal Employment Opportunity Policy

1. References:

2. I am committed to safeguarding an inclusive work environment, free of discrimination. As such, I will not tolerate actions, in any form – taken by members of this Command that degrades human dignity on the basis of race, gender, age, skin color, religious beliefs, physical or behavioral disabilities, or national origin. The prevention of this type of offensive behavior is everyone’s responsibility. I charge each individual to maintain a professional attitude, treat others with dignity and respect, and monitor his/her own behavior.

3. I fully support the concept, policies and objectives of the Equal Employment Opportunity (EEO) Program. In addition to my commitment to preventing acts of discrimination, I will not tolerate reprisal or threats of reprisal against any person involved with the EEO complaint process. Of note, the complainant does not have to be the person harassed, but simply anyone affected by the offensive conduct. I hold managers, supervisors, and employees responsible and accountable for complying with laws and regulations that govern the EEO policy.
4. The Affirmative Employment and Special Emphasis programs are designed to assist managers when making selections for training, career development programs, merit promotion actions, awards, and other types of recognition and personnel actions in accordance with sound personnel management practices. We must ensure our recruitment and selection processes support fair and equitable consideration of all qualified individuals and decisions are based solely on well-established merit principles.

5. Any employee, former employee, or applicant for employment who believes he or she was discriminated against in an employment matter has a right to file a complaint. To preserve one’s legal rights, the complainant must contact the EEO Office within 45 calendar days of occurrence, the effective date of the personnel action, or the date that the aggrieved became aware, or reasonably should have become aware, of the discriminatory event or personnel action.

6. The EEO will advise the aggrieved individual of the Alternate Dispute Resolution (ADR) option (i.e., mediation). In these cases, the complainant may choose either ADR or traditional pre-complaint counseling. If ADR and/or pre-complaint counseling fail to achieve resolution, or if the complainant so chooses, a formal complaint may be filed within 15 calendar days from the date of receipt of the Notice of Right to File a Discrimination Complaint. The complaint must contain a statement signed by the complainant or his/her attorney describing in detail the actions, practices, or issues giving rise to the complaint.

7. All Great Plains Regional Medical Command personnel will cooperate fully with and support the EEO counselor in the performance of counseling duties. The EEO counselor will be free of interference, harassment, coercion, discrimination, or reprisal in connection with the performance of counselor duties.

8. This policy memorandum will be issued to new employees during orientation training, newly appointed supervisors; and permanently posted on all official bulletin boards.

9. Point of contact for this memorandum is your servicing EEO Office.

c) Grievance Policy

(Adapted from Harris County Hospital District Orthopaedic Physical Therapy Residency Program, 2009)

<table>
<thead>
<tr>
<th>POLICY AND REGULATION MANUAL</th>
<th>Policy No: 6004</th>
</tr>
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<tbody>
<tr>
<td>Page Number: 1 of 2</td>
<td>Effective Date: 01/01/2009</td>
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<table>
<thead>
<tr>
<th>TITLE</th>
<th>RESIDENT GRIEVANCE PROCEDURE</th>
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<tr>
<td>PURPOSE:</td>
<td>The purpose of this policy is to set guidelines for addressing grievances promptly and equitably.</td>
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<tr>
<th>POLICY STATEMENT:</th>
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<tr>
<td>Residents will have the opportunity to appeal actions taken by faculty. The Orthopaedic Physical Therapy Residency Program is committed to addressing resident grievances and will ensure a fair and prompt resolution to any such grievance.</td>
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<tr>
<th>DEFINITION:</th>
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<tr>
<td>Grievance – a residency-related matter that adversely affects the resident’s standing in the program. This may include, but is not limited to the following:</td>
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<tr>
<td>1. Disciplinary actions regarding resident performance (e.g. probation, suspension, or termination);</td>
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</table>
2. Grades on practical or written exams.

GRIEVANCE PROCEDURE
A. Program Manager’s Review
   1. The Program Manager will serve as coordinator of the grievance process. A Resident seeking resolution of a grievance must submit a completed Grievance Form to the Program Manager within seven (7) calendar days after the occurrence of the decision/acts which give rise to the grievance. The Grievance Form may be obtained through the Department. The form must be accompanied by a written explanation of the grievance(s) and desired resolution(s).
   2. Once the grievance is received, the Program Manager will promptly review and respond with a written decision within 7 calendar days.
   3. The Program Manager may meet with the resident and faculty during the review process.
B. Program Director and Panel Review
   1. If the resident is dissatisfied with the decision made by the Program Manager, the decision may be appealed within seven (7) calendar days to the Program Director who will assemble a Review Panel.
   2. The Review Panel will consist of individuals from the Residency Advisory Council and other individuals that the Program Director deems necessary.
   3. The Review Panel members may be excused if they believe they are unable to render an impartial decision.
   4. The Program Director will serve as the presiding officer. In addition to the Review Panel members, the resident and the Program Manager will attend.
   5. The Review Panel’s decision will be consistent with the existing Harris County Hospital District policies, practices, rules, and regulations.
   6. After all pertinent information is presented to the Review Panel; the Program Director will render a decision in writing to the resident within seven (7) calendar days.

REFERENCES/BIBLIOGRAPHY:
- Texas Public Information Act
- Non Discrimination Policy
- Performance Appraisals Policy

OFFICE OF PRIMARY RESPONSIBILITY: The Orthopaedic Physical Therapy Residency Program Director

REVIEW/REVISION HISTORY:
<table>
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<tr>
<th>Effective Date</th>
<th>Version #</th>
<th>Review/Revision Date (IndicateReviewed or Revised)</th>
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</tr>
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<tbody>
<tr>
<td>1/05/2009</td>
<td>1.0</td>
<td></td>
<td>Carol Oddo, PT, MS, FACHE</td>
</tr>
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</table>

d) Probationary period policy

Example 1
(Adapted from University of St. Augustine for Health Sciences Orthopedic Residency, 2010)

The first 30 days of the resident will be under a probationary period. During this probationary period both the University of St. Augustine and the mentor will determine the resident’s potential for completing the requirements of the program satisfactorily. This period also provides the resident with the opportunity to ensure the program meets the needs of the resident.

Example 2
Probationary Period: Residents will be in a probationary period for 3 months. During this time they meet weekly with the Residency Program Director to discuss overall performance. During this period, they will also meet weekly with the Faculty Member leading the course to which they are assigned as a Laboratory Assistant.

Probationary Review: Probationary review is performed at the 3 months and includes a formative and summative review of the performance on the following: Practical Examinations, Written Examinations, Journal Club, Case Conference, Projects and Case Reports. Clinical performance is assessed based on review of Mentorship Performance, Clinical Outcome Measure Grids, and Monthly Productivity Reports.

e) Termination policy

Example 1

Residents will be dismissed from the program for any of the following reasons:
- Failure to abide by Florida Physical Therapy Practice Act
- Failure to abide by the American Physical Therapy Association’s Code of Ethics/Conduct
- Failure to abide by the policies of St. Catherine’s Rehabilitation Hospital & Villa Maria Nursing Center or the policies of the Residency Program
- In the event a resident does not meet the employment requirements of the residency, he/she will be dismissed from the residency program.
- Failure to achieve a score of “satisfactory” or better in each of the rotations required as a part of the residency program
- At the discretion of the Program Director (for reasons not listed above)

DUE PROCESS:

As employees of St. Catherine’s/Villa Maria, residents are subject to the same policies governing dismissal, termination, and grievance as any employee at St. Catherine’s/Villa Maria.

Example 2

Residents may be terminated for the following reasons:
1. Failure to meet the requirements for each course as defined in the Course Syllabus.
2. Academic dishonesty.
4. Clinical or classroom behavior deemed to be unsafe, unprofessional, or unethical by the Residency Program Director. Typically, such termination would occur only after the resident has been warned in writing and reviewed by the Residency Program Director and has not demonstrated sufficient improvement.
5. Formal suspension of a physical therapy license in any state as part of a disciplinary action.
6. Conviction of any criminal activity which prevents the candidate from acting as a therapist in good standing.
7. Evidence of an ethical violation that prevents the candidate from being a member in good standing with the APTA.
8. Failure to satisfactorily complete probationary period and/or remediation process.

**Example 3**

*(Adapted from University of St. Augustine for Health Sciences Orthopedic Residency, 2010)*

USA holds the right to terminate the residency agreement barring unresolved grievances and/or the resident fails to maintain and uphold the resident responsibilities at any time during the residency period. When unsatisfactory performance is identified in a resident in the clinic, it is the responsibility of the clinical mentor to note it in the weekly and monthly evaluation forms, and immediately begin instruction to remediate performance. The director of the program is available to assist the clinical faculty if needed in this process.

**Example 4**

*(Adapted from AllStar Therapy Geriatric Residency Program, 2010)*

Within AllStar Therapy all residents are subject to the same grievance, dismissal and termination policies as all employees. Termination of employment may occur if an employee does not meet the company’s standards of performance, ethical integrity, or adherence to AllStar policies and procedures. Possible cause for termination is identified in AllStar Handbook section 4.10. Additional termination for residents may include:

- Resident become ineligible to practice in State
- Failure to abide by the American Physical Therapy Association Code of Ethics/Conduct
- Failure to abide by all policies and procedures of AllStar Therapy and their related contracts
- Failure to score a “satisfactory” or better for each clinical objective within the residency program.

Additional reasons for termination may occur at the discretion of the Program Director.
Evidence 1.2.3.1.A – Provide the recruitment materials.

Example 1

(APTA Staff, 2010)

Items that will sufficiently answer this Evidence:

- Copies of recruitment/advertising materials
  - Fliers
  - Copies of advertisements placed in professional magazines/resources
- Print off of Program’s webpage

*NOTE: Please include actual copies of recruitment materials or a print off of Program’s webpage, do not simply direct reviewers to the webpage in your application.

Example 2

(Adapted from The Jackson Clinics Orthopedic Physical Therapy Residency Program, 2009)

Apply NOW for The Jackson’s Clinic’s Orthopedic Residency Program
(application deadline August 1, 2009)

Accelerate your professional development by participating in The Jackson Clinic’s Orthopedic Physical Therapy Residency Program. Join our team to work in a stimulating environment and receive an excellent salary and benefits as you gain advanced knowledge and skills in Orthopedic Physical Therapy.

Residents receive:

- 30 days (240 hours) of classroom and lab instruction covering all aspects of Orthopedic Physical Therapy
- Ongoing, one-on-one clinical supervision/mentoring while treating patients
- Training in evidence-based guidelines and advanced clinical practice
- Focused skill building on examination, treatment and clinical reasoning aspects of patient care
- Preparation for Orthopedic Clinical Specialist examination
- Medical “shadowing” experience. Spend six days in clinic and six days in surgery with orthopedic surgeons of six different specialties

Residency facts:

- Residency Program begins each January and runs for 50 weeks
- Residents are employed at The Jackson Clinics on a full time basis
- Full time employees are compensated at the current market rate and receive a full benefit package

Application Process: To obtain more information about applying to The Jackson Clinics Orthopedic Physical Therapy Residency Program, please contact:

Richard Jackson, PT, OCS via email rjackson@thejacksonclinics.com. You will be sent details of the application process and detailed information describing the program. DON’T DELAY.

APPLICATION DEADLINE IS August 1, 2009.
The Jackson Clinics is an equal opportunity employer and does not discriminate on the basis of race, creed, color, gender, age, national or ethnic origin, sexual orientation, and disability or health status.

www.thejacksonclinics.com

The following is provided to therapists who respond to our advertisement.

THE JACKSON CLINICS ORTHOPEDIC RESIDENCY PROGRAM

To apply for a residency, send a MS Word document that contains a cover letter and curriculum vitae via email to rjackson@thejacksonclinics.com, or send a hard copy to Richard Jackson, Box 1769, Middleburg, VA 20118.

Below are guidelines outlining what to include in your application document.

Cover Letter:

In your cover letter, provide responses to the following inquires:

a) Name of the facility/s, in no order of preference, for which you are applying (Mt. Vernon, Franconia, Manassas, Herndon, Fairfax, Worldgate, etc)
b) What do you wish to gain through participation in this clinical residency?
c) What areas of expertise you possess that you feel would contribute to the growth in clinical skills of the other participants in this residency?
d) What are your future plans in the area of orthopedic physical therapy?

Curriculum Vitae:

Please include the following information in this portion of the document:

1. Personal data (e.g., name, email address, mailing address, phone number)
2. Academic education (e.g., undergraduate, professional, and post professional education)
3. Clinical education (e.g., clinical residency, continuing professional education)
4. Description of clinical experiences. Please include the following information, if pertinent, for each organization in which you have performed direct patient care: Name, address and phone number of the facility, name of your clinical supervisor (if any) or supervisor, type of facility, job description, date employed (or dates of residency), description of patient load, description of any clinical supervision or mentoring, time period (in hours) involved in direct patient care. The total number of hours at a particular facility can be calculated by using the following formula: Total hours= (number of hours per week) x (number of weeks per year) x (number of full time years).
5. Other relevant information such as research, teaching and/or community services experiences.

Two Letters of Recommendation

Applications will be evaluated based on the following criteria:

a. Academic education
b. Clinical education and mentoring experiences
c. Clinical experience in orthopedic physical therapy
d. Research experience
e. Community service
The Jackson Clinics is an equal opportunity employer and does not discriminate on the basis of race, creed, color, gender, age, national or ethnic origin, sexual orientation, and disability or health status.

Minimal eligibility requirements for acceptance into the program include:

1. Licensure as a Physical Therapist by the Physical Therapy Board Virginia
2. Comply with all Jackson Clinics employment requirements

Desirable applicants include those who...

1. Completed an extended internship or externship under the direct clinical supervision of a Clinical Specialist in Orthopaedic Physical Therapy.
2. Possess superior verbal and written communication skills. Have experience in data collection, analysis, and publication.
3. Possess strong fundamentals in the principles of clinical reasoning and the application of manual examination and treatment procedures.

The application deadline is August 1 for the 2010 Residency Program.

After August 1, superior candidates will be selected for an interview and evaluation of basic clinical competencies with members of the selection committee. Notification of applicants who gain admission to the program will be made by October 15. Employment will begin January 4, 2010.

Example 2

(Adapted from St. Catherine’s Rehabilitation Hospital & Villa Maria Nursing Center Post-professional Residency in Geriatric Physical Therapy, 2009)

Do you want to specialize in GERIATRICS but don’t know how to start?

St. Catherine’s Rehabilitation Hospital and Villa Maria’s Residency in Geriatric Physical Therapy

Located in Miami, Florida

- Our residency in geriatric physical therapy is a unique opportunity for you to develop skills in a mentored environment
- The program is the first fully APTA credentialed geriatric residency in PT in the United States
- The year-long program offers therapists the ability to gain structured experiences in a variety of settings including inpatient rehab, outpatient, SNF, and LTC. Residents are mentored by expert faculty, including board certified geriatric specialists
- Residents take applicable courses on-site through our partnership with University of Miami
- There is no tuition and residents earn a salary with benefits
- Residency graduates will be prepared to sit for the GCS exam
- For an application or further information, please visit our website at www.catholichealthservices.org, and click on search and look for “Residency”. Alternatively, you may write to: Residency Program Coordinator, Physical Therapy Department, St Catherine’s Rehab Hospital, 1050 NE 125th St., North Miami, FL 33161 or call 305-891-8850 ex. 4283; or email.

Applications are accepted year round.
Evidence 1.2.3.1.B – Provide the policies and procedures related to admission and retention.

Example 1

(Adapted from St. Catherine’s Rehabilitation Hospital & Villa Maria Nursing Center Post-professional Residency in Geriatric Physical Therapy, 2009)

<table>
<thead>
<tr>
<th>SUBJECT: Residency Admission Requirements</th>
<th>FORMULATION DATE: 06/11/02</th>
<th>REVISION DATE: 03/30/07</th>
<th>APPROVED BY: Greg Hartley, PT, MSPT, GCS</th>
</tr>
</thead>
</table>

Enrollment: Selected residents must meet admission criteria set forth by the advisory committee. This includes (but may not be limited to):

- Graduation from a CAPTE (Commission for Accreditation in Physical Therapy Education) accredited physical therapy program
- Hold (in good standing) a current license to practice physical therapy in the state of Florida
- A completed application received by published deadline
- An interview (for superior candidates)

Acceptance is based on interest, ability, and aptitude for a career as a geriatric physical therapist.

Applications are evaluated based on the following criteria:

1. Academic education and background
2. Clinical education, internship and mentoring experiences
3. Clinical experience in geriatric physical therapy
4. Research experience and interest

Minimal eligibility requirements for acceptance into the program include:

1. Hold a valid Florida Physical Therapy License
2. Comply with all St. Catherine’s/Villa Maria employment requirements.

Desire applicants include those who:

1. Completed an extended internship or externship under the direct supervision of a Clinical Specialist in Geriatric Physical Therapy
2. Possess superior verbal and written communication skills
3. Have experience in data collection, analysis, and publication
4. Possess strong fundamentals in the principles of clinical reasoning and the application of examination and treatment procedures related to the practice of geriatric physical therapy

Residents are selected by the Admissions Committee and their decision is final. Decisions are based on a candidate’s desire to advance their skills in geriatric physical therapy. This evidence by review of the essays (in the application), resume, letters of recommendations, interests, and genuine desire to advance skills in geriatric clinical research, administration in geriatric facilities, and/or clinical teaching. Superior candidates will be given an interview, which is conducted by at least two members of the admission committee. Candidates are assessed in the areas of commitment, knowledge of the purpose of the program, interests (as outlined above), and personality. Good candidates will possess qualities of flexibility, team building, leadership, and a desire to learn.

Applications are accepted year round.
Applicants requesting disability accommodations must do so by filing a request (detailing necessary accommodations) in writing with the program office.

Eligible applicants will be notified within 2 weeks of their eligibility and interviews will be arranged. Final notification of applicants who gain admission to the program will be made within 60 days of receipt of the completed application.

Related forms: Application forms

Application Process:

1. Online: Go to www.catholichealthservices.org and download an application. Email: Send an email to ghartley@chsfla.com requesting an application. Type “Geriatric Residency Application” in the subject line. Mail: Write to the Program Coordinator and request an application by mail.

2. In applying for admission, the following materials must be submitted:
   a. Application with essays
   b. Two (2) letters of recommendation (see application packet)
   c. Non-refundable application processing fee of $50.00
   d. Current resume or summary of career goals, employment history and extracurricular activities

3. SC/VM reserves the right not to process any application that is incomplete

4. Shortly after the application is received (generally within three weeks), applicants who meet all admission requirements will be invited for a personal interview or contacted for a phone interview.

5. Acceptance into the program is provisional pending the candidates meeting all conditions of employment at St. Catherine’s Rehabilitation Hospital & Villa Maria Nursing Center. Applicants will be notified of their status in the program in writing within 45 days of an interview.

Details concerning submission of these materials are provided with the application materials

Residents must meet the criteria for completion of the program as defined by the advisory committee and the policies of the program. Matriculation is to be full-time unless approved by the program director. Length of the residency is a minimum of 12 months and a maximum of 15 months in the clinical setting.

Related forms: P&P for “Time allotted to complete residency”

It is the policy of the program to recruit, admit, and retain participants on a nondiscriminatory basis. Specifically, the program does not discriminate on the basis of race, creed, color, gender, age, national or ethnic origin, sexual orientation, disability or health status.
St. Catherine’s Rehabilitation Hospital & Villa Maria Nursing Center

Physical Therapy Post-Professional Clinical Residency in Geriatrics
Application Form

Applicant Name: _____________________________________________________________

Address: ____________________________________________ City: ________________________
State: ____________________________ Zip Code: __________ Phone: (____)-______-_______

States in which you hold a current P.T. license: _____________________________________________

If not licensed, date you are scheduled to take the exam: ______________________________________

Physical Therapy Program/School where you graduated: ______________________________________

Date of graduation from Physical Therapy Program/School: ___________________________________

Date you expect to be available to enter the residency program if accepted: ________________________

Please respond to the items below on separate pages, sign, date and attach the pages to this application
form. Limit responses to no more than one page per item.

1. State your purpose/goals for pursuing a clinical residency in geriatric physical therapy.
2. Identify the determining factors that led you to pursue a residency program.
3. Identify your plans upon completion of the residency program.
4. State why you have chosen to apply at St. Catherine’s/Villa Maria.
5. Specifically explain how your experiences academically and as a practicing physical therapist or
   physical therapy intern have prepared you for this residency.
6. In addition, identify any courses (continuing education courses or academic courses) you have taken
   to better prepare you for the residency program since graduating from PT school.
7. Include a current resume or curriculum vitae.
8. Residents must also submit two (2) letters of recommendation. Letters must be on letterhead,
   addressed to the Admissions Committee. They must be from professionals who know you both
   personally and professionally. At least one must be from a faculty member of the PT program from
   which you graduated. The letters may be sent by you in the application packet; however, they must
   be in sealed envelopes. Alternatively, the letters may be sent directly to the program by the writers,
   but they must be received by the published deadline.

Submit this application with attachments and a $50.00 non-refundable application fee (made payable to
Villa Maria Nursing Center) to:

   Geriatric Residency Program Coordinator
   Physical Therapy Department
   St. Catherine’s/Villa Maria
   1050 NE 125th Street
   N. Miami, FL 33161

You may submit the application via email to ghartley@chsfla.com (the application will be processed
when the application fee has been received)
Application Checklist

Application materials must be submitted directly to the Program Coordinator.

- Application Form
- Six (6) pages addressing the questions on the application form
- A current resume or CV
- Two (2) letters of recommendation
- $50.00 fee

An interview will be arranged after all of the application materials have been received. Interviews are conducted in person when feasible. Phone interviews will be considered if necessary.

It is the responsibility of the applicant to insure that all materials (including letters of recommendation) are received by the program director in a timely fashion.

Applications lacking materials will not be considered. Applicants will be notified by mail of the Program’s decision within 30 days of receipt of the entire application packet.

SEND ALL APPLICATION MATERIALS AND CORRESPONDENCE TO:

Geriatric Residency Program Coordinator
Physical Therapy Department
St. Catherine’s/Villa Maria
1050 NE 125th Street
N. Miami, FL  33161

ghartley@chsfla.com
Evidence 1.2.3.2 – Provide a copy of a blank contract or agreement or letter of appointment.

Example 1

(From St. Catherine’s Rehabilitation Hospital & Villa Maria Nursing Center Post-professional Residency in Geriatric Physical Therapy, 2009)

Letter of Agreement

I hereby accept appointment in St. Catherine’s Rehabilitation Hospital & Villa Maria Nursing Center’s Geriatric Clinical Residency for Physical Therapists. I understand that I must fulfill the following requirements to complete the program:

• Abide by the policies and procedures of St. Catherine’s Rehabilitation Hospital & Villa Maria Nursing Center
• Abide by the policies and procedures of the Clinical Residency Program housed at St. Catherine’s/Villa Maria, including timelines, remediation, and termination
• Successfully complete all didactic coursework taken as a part of the requirements for the residency program as described in the policies and procedures
• Successfully complete all clinical requirements of the residency program as described in the policies and procedures
• Adhere to the American Physical Therapy Association’s Code of Ethics
• Adhere to the current law as it relates to the practice of physical therapy in the state of Florida

In addition, I understand the following:

• That this residency program is fully credentialed by the APTA
• That I am a full-time employee (40 hours/week) eligible for full-time benefits and a salary when I am employed by St. Catherine’s/Villa Maria. Employment is granted to residents who fulfill all employment requirements of St. Catherine’s/Villa Maria (e.g., background check, drug test) and once licensure to practice physical therapy in the state of Florida is granted
• Salary is to be $XX,XXX per year (with benefits).

______________________________________________      _______________
Print full name (Resident)                 Date

______________________________________________
Resident Signature

______________________________________________
(St. Catherine’s/Villa Maria Representative)

______________________________________________
St. Catherine/Villa Maria Representative Signature                Date

Example 2

(Adapted from Glendale Adventist Medical Center’s Orthopedic Physical Therapy Residency, 2009)

AGREEMENT FOR ADVANCED RESIDENCY PROGRAM IN ORTHOPEDIC PHYSICAL THERAPY
THIS AGREEMENT, effective on _______, 20__, between GLENDALE ADVENTIST MEDICAL CENTER, a not-for-profit religious corporation having its principal place of business at 1509 Wilson Terrace, Glendale, California, 91206 (“HOSPITAL”) and ________________ (“RESIDENT”).

RECITALS

WHEREAS, HOSPITAL is licensed and accredited acute-care hospital engaged in providing professional medical services to the community;

WHEREAS, HOSPITAL desires to train and retain qualified Physical Therapists to provide professional physical therapy services;

WHEREAS, RESIDENT is duly licensed and in good standing to practice physical therapy in the State of California and was recently hired by HOSPITAL;

WHEREAS, HOSPITAL desires to provide an advanced residency training program for an eligible physical therapist (RESIDENT) seeking an educational experience (both academic and clinical) to qualify for the examination for Specialist Certification in Orthopedic Physical Therapy sponsored by the American Board of Physical Therapy Specialists in exchange for RESIDENT’s voluntary decision to remain at-will employee of HOSPITAL and to participate in said Program;

WHEREAS, RESIDENT desires to voluntarily receive such training with full knowledge and intention of being subject to the terms and conditions of this Agreement.

NOW, THEREFORE, in consideration of the above recitals, and the mutual covenants herein contained, the Parties hereto agree as follows:

AGREEMENT

1. **Recitals.** The foregoing Recitals are hereby incorporated by this reference as though fully set forth at length herein.

2. **Term of Agreement.** The Agreement will be effective from ________, 20__, and shall continue in effect until the parties perform their respective obligation as stated in Paragraph 3. This Agreement supersedes all formed agreement relating in any way to orthopedic physical therapy residency training, whether written or oral, between the parties.

3. **Special Education Program.** HOSPITAL agrees to enroll RESIDENT in the Orthopedic Physical Therapy Residency Program (“Program”) to be conducted on HOSPITAL’s premises during the Program term commencing on __________, 20__, and ending on or about __________, 20__.

4. **Enrollment and Terms of Enrollment.** RESIDENT accepts and agrees to enroll, participate, complete and fulfill all academic course requirements of the above Program during the Program term as specified in Paragraph 3.

5. **Obligations of Resident.**

   RESIDENT SHALL

   A. Meet the following eligibility criteria for participation in the Program:
      1. Hold a valid California Physical Therapy License;
      2. Have at least six months clinical experience in physical therapy direct patient care as a physical therapy student intern or as a physical therapist;
      3. Have excellent communication skills;
      4. Be physically able to appropriately perform manual examination and treatment procedures;
      5. Have the psychological, social and physical stability required for participation in and successful completion of the Program;
6. Have been selected by the Program’s admission committee based on the eligibility criteria set forth in Subparagraphs 2A.1 through 2A.5 of this Paragraph I and a review of certain other factors, including, but not limited to, RESIDENT’s background, education, and experience, including relevant teaching and research experience, references, and clinical skills;

7. Satisfy the pre-employment health screening and immunization requirements and, specifically, demonstrate the RESIDENT is free of active tuberculosis as shown by PPD skin testing or chest x-ray, is immune from hepatitis B or has declined in writing to be immunized against hepatitis B, and either is immune from or has been immunized against (i) rubella, (ii) rubeola, (iii) mumps, and (iv) varicella chicken pox.

8. Submit to HOSPITAL an application for employment;

9. Report for work no later than the date of the hospital orientation in December of the year prior to the January Program start date.

B. Participate in the Program as follows:
   1. 250 hours of classroom/lab training;
   2. 150 hours of clinical training
   3. 850 clinical practice hours;
   4. 250 hours of resident direct learning activities, including 40 hours of community service experience by providing 10 sessions of physical therapy services at the LA Free Clinic;
   5. Participation in a research related project;
   6. Completion of body regions log and feedback forms essential for the Program’s ongoing review;
   7. The curriculum for the Program will be determined by the HOSPITAL in accordance with the guidelines developed by the Orthopaedic Specialty Council of the American Board of Physical Therapy Specialties as published in “Description of Specialty Practice in Orthopaedic Physical Therapy.” Resident agrees to perform at a satisfactory level as determined by the HOSPITAL.

C. Conform to all applicable laws, rules and regulations, policies, procedures, rules of conduct and professional codes of ethics as are applicable to HOSPITAL. RESIDENT acknowledges that the above laws, rules and regulations, policies, procedures, rules of conduct and professional codes of ethics may be amended from time to time, and RESIDENT hereby agrees to be bound by and adhere to any such amendments.

D. RESIDENT agrees to participate in effective, safe, and compassionate patient care, commensurate with RESIDENT’s level of advancement and responsibility.

6. Obligations of HOSPITAL.

HOSPITAL SHALL

A. Develop the curriculum for the Program in accordance with the guidelines developed by the Orthopaedic Specialty Council of the American Board of Physical Therapy Specialties as published in “Description of Specialty Practice in Orthopaedic Physical Therapy.”

B. Supervise RESIDENT’s classroom and clinical training at the clinical facilities and provide instructors for the Program.

C. Provide educational supplies, materials, and equipment used for instruction during the Program.

D. Provide RESIDENT with orientation information about the Program.

E. Prior to permitting RESIDENT access to the clinical facilities determine that RESIDENT meets all appropriate and necessary State and/or Federal requirements for licensure with the Physical Therapy Board of California.

F. Maintain the clinical facilities so that they at all times shall conform to the requirements of the California Department of Health Services and all applicable accrediting agencies.
G. Permit designated personnel at the clinical facilities to participate in the Program to enhance RESIDENT’s education so long as such participation does not interfere with the personnel’s regular service commitments.

H. Retain ultimate professional and administrative accountability for all patient care.

I. Have the right to exclude RESIDENT from participation in the Program if HOSPITAL determines that RESIDENT is not performing satisfactorily, or fails to continue to meet the eligibility standards set forth in Paragraphs 2.A.1 – 2.A.5 above, or is not complying with HOSPITAL’s policies, procedures, rules and regulation.

J. Have the right to withhold certificate of completion upon completion of the Program if the RESIDENT fails to perform at a satisfactory level during assessment of the RESIDENT’s performance on any of the following seven criteria: 1) Glendale Adventist Medical Center’s Criteria-Based Performance Evaluation; 2) 100% of the procedures listed on the Orthopaedic Physical Therapy Procedures Performance Assessment Tool; 3) Demonstrate satisfactory performance Clinical Performance Evaluation, which is receiving a total of 240 percentage points on three consecutive clinical evaluations using the Orthopaedic Physical Therapy Clinical Skills Performance Evaluation Tool; 4) 70% of the items on the Written Exams given throughout the program; 5) participation in the design, literature review, proposal submission, data collection, data analysis, or publication of a controlled, clinical trial in an area of orthopaedic physical therapy; 6) participation in up to 40 hours of community service; 7) completion of the body region’s patient logs and feedback forms required for the program’s ongoing review.

K. Have the right to offer a remediation period for a RESIDENT who is unable to complete the program within the initial 50-week timeframe. The remediation period consists of up to, but no longer than, 16 additional weeks. At the end of the remediation period, the RESIDENT would be expected to complete the criteria as outlined in Paragraph J to pass the Program. If at the end of the remediation period, the RESIDENT is unable to perform at a satisfactory level then the RESIDENT fails the residency and the certificate of completion is held indefinitely and the residency officially ends for that RESIDENT.

7. Compensation.
   A. Wages: Unsupervised clinical services under the Program, which will total 1000 hours, will be paid on a bi-weekly basis in accordance with the following rate schedule: Orthopedic Physical Therapy Resident with Hourly Pay @ $/hour (prior to benefits). It is agreed that the time spent in classroom instruction and while receiving classroom/lab instruction (250 hours), resident directed learning activities (250 hours) including community service (40 hours) will be unpaid.
   B. Benefits: Per HOSPITAL’s comprehensive benefits package (see policies section 8650 for specifics on health plan, paid leave, retirement, etc.)

8. No Guarantee of Employment. RESIDENT understands and agrees that this Agreement does not in any way guarantee that RESIDENT will be employed by HOSPITAL for any specified length of time whatsoever. Further, RESIDENT understands and agrees that the employment relationship is completely voluntary and may be terminated by either party. Finally RESIDENT recognizes that no representative of the hospital, other than its President, has the authority to enter into an express or implied contract of employment other than as set forth in the hospital’s Handbook and other written hospital policies; and, even that contract must be in writing.

9. Partial Invalidity. If any provision in this agreement is held by a Court of competent jurisdiction to be invalid, void, or unenforceable, there shall be deemed to be made such minor changes (and only minor changes) in such term, provision, covenant or condition as are necessary to make it valid and enforceable and any remaining provisions will, nevertheless, continue in full force and effect without being impaired or invalidated in any way.
10. **Headings.** The headings Paragraphs of this Agreement have been included for convenience of reference only and shall not be modify, define, limit or expand the express provisions of this Agreement.

11. **California Law.** This Agreement shall be construed and interpreted under and according to the laws of the State of California. RESIDENT understands and agrees that any action necessary to enforce the provisions of this Agreement must be brought in the courts of the County of Los Angeles, State of California. Further, RESIDENT specifically and voluntarily agrees to such jurisdiction and venue.

12. **Right to Enforce Agreement and Legal Fees.** RESIDENT and the HOSPITAL recognize that the services to be rendered under this Agreement are special, unique and of extraordinary character, and that in the event of the breach by RESIDENT of the terms and conditions of this Agreement to be performed by him/her, then the HOSPITAL shall be entitled if it so elects, to institute and prosecute proceedings in any court of competent jurisdiction, either in law or in equity, to obtain damages for any breach of this Agreement, or to enforce the specific performance thereof by RESIDENT. RESIDENT agrees to pay all of the HOSPITAL’s legal fees and costs in the event it becomes necessary for HOSPITAL to legally enforce the terms of the Agreement.

13. **Good Faith.** The Parties further agree that they have entered into this Agreement in good faith and acknowledge their respective ethical and legal obligations to fulfill this Agreement.

14. **Entire Agreement.** This Agreement supersedes any and all agreements, either oral or written; between the parties hereto with respect to the advanced residency program in orthopedic physical therapy and contains all the covenants and agreements between the Parties. Each Party to this Agreement acknowledges that no representations, inducements, promises, or agreements, oral or otherwise, have been made by any Party, or anyone acting on behalf of any Party, which are not embodied herein, and that no other agreement, statement, or promise not contained in this Agreement shall be valid or binding. Any modification of this Agreement will be effective only if it is in writing signed by the Parties to be charged.

IN WITNESS WHEREOF, by their signature below, the Parties hereto represent and warrant that they have read and clearly understand this Agreement, have the authority to execute this Agreement, and do hereby consent to the foregoing and bind the Party on whose behalf their execution is made.

**ORTHOEDIC PHYSICAL THERAPY RESIDENT**

By: __________________________ Date: _____________________

Print Name: ______________________________________________

**GLENDALE ADVENTIST MEDICAL CENTER**

By: __________________________ Date: _____________________

Print Name: ___________________ Title: _____________________
Evidence 1.2.3.3 – Utilize Form 1.2.3.3 to provide the name, physical therapy license number and state, and status (active or inactive) for all currently enrolled residents or fellows. (Form provided in Part 4 of application)

Example

(Form provided in Part 4 of application: Forms)

**Form 1.2.3.3**

*Name of Clinical Residency/Fellowship Program:*

_________The Best Orthopedic Residency in the U.S._________

**Residents/Fellows Currently Enrolled in Program**

List all currently enrolled residents or fellows.

<table>
<thead>
<tr>
<th>RESIDENT/FELLOW NAME</th>
<th>LICENSE # (with state)</th>
<th>START DATE (MONTH/YEAR)</th>
<th>STATUS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sally Resident</td>
<td>VA 230558</td>
<td>09/2009</td>
<td>X Active Full Time □ Active Part-Time □ Inactive</td>
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<tr>
<td>Good Fellow</td>
<td>VA 230556</td>
<td>09/2009</td>
<td>□ Active Full Time □ Active Part-Time □ Inactive</td>
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<td>□ Active Full Time □ Active Part-Time □ Inactive</td>
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</tbody>
</table>
2.0 Resources

Evidence 2.1.1 – Using Form 2.1.1, summarize the patient/client population seen by each resident or fellow over the past year. Please include a separate form for each resident/fellow currently enrolled. (Include only those patients/clients who were part of the resident’s/fellow’s education, i.e. do not include total clinic patient demographics.) New programs provide data to date. Categorize the patient/client population in a manner that clearly captures the intent of the DSP/DASP or practice analysis upon which the Program is based (categorize by diagnosis, impairment, body region, and/or practice location, as needed). This chart should also provide a summary of the approximate number of clients seen each year in each category and the percentage of the total patient/client population represented in this category. (Form provided in Part 4 of application)

The Orthopaedic and Sports DSP’s outline the diagnostic categories within the document. Please utilize these diagnoses in your program’s application if you are a Sports residency/fellowship or an Orthopaedic residency/Manual Therapy Fellowship program.

<table>
<thead>
<tr>
<th>SPORTS RESIDENCY/FELLOWSHIP DIAGNOSTIC GROUP OR CATEGORY</th>
<th>NUMBER OF PATIENTS/CLIENTS TREATED BY RESIDENT OR FELLOW AS PART OF THE PROGRAM</th>
<th>% OF TOTAL PATIENTS/CLIENTS TREATED BY RESIDENT OR FELLOW</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lumbar Spine</td>
<td></td>
<td></td>
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<tr>
<td>Thoracic Spine</td>
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<td></td>
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<tr>
<td>Cervical Spine</td>
<td></td>
<td></td>
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<tr>
<td>Hip/Pelvic Region</td>
<td></td>
<td></td>
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<tr>
<td>Knee/Lower Leg Region</td>
<td></td>
<td></td>
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<tr>
<td>Ankle</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Foot</td>
<td></td>
<td></td>
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<tr>
<td>Shoulder</td>
<td></td>
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<tr>
<td>Elbow</td>
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<tr>
<td>Wrist</td>
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<tr>
<td>Hand/Thumb</td>
<td></td>
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<tr>
<td>TMJ</td>
<td></td>
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</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

% of total clients that are sports physical therapy cases *(should be at least 40%)* =
<table>
<thead>
<tr>
<th>ORTHOPAEDIC RESIDENCY/MANUAL THERAPY FELLOWSHIP DIAGNOSTIC GROUP OR CATEGORY</th>
<th>NUMBER OF PATIENTS/CLIENTS TREATED BY RESIDENT OR FELLOW AS PART OF THE PROGRAM</th>
<th>% OF TOTAL PATIENTS/CLIENTS TREATED BY RESIDENT OR FELLOW</th>
<th>THE BELOW % INDICATED ARE PER THE DSP GUIDELINES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cranial/Mandibular</td>
<td></td>
<td>5%</td>
<td></td>
</tr>
<tr>
<td>Cervical Spine</td>
<td></td>
<td>15%</td>
<td></td>
</tr>
<tr>
<td>Thoracic Spine/Ribs</td>
<td></td>
<td>5%</td>
<td></td>
</tr>
<tr>
<td>Lumbar Spine</td>
<td></td>
<td>20%</td>
<td></td>
</tr>
<tr>
<td>Pelvic Girdle/Sacroiliac/Coccyx/Abdomen</td>
<td></td>
<td>5%</td>
<td></td>
</tr>
<tr>
<td>Shoulder/Shoulder Girdle</td>
<td></td>
<td>15%</td>
<td></td>
</tr>
<tr>
<td>Arm/Elbow</td>
<td></td>
<td>5%</td>
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<tr>
<td>Wrist/Hand</td>
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<td>5%</td>
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<tr>
<td>Hip</td>
<td></td>
<td>5%</td>
<td></td>
</tr>
<tr>
<td>Thigh/Knee</td>
<td></td>
<td>10%</td>
<td></td>
</tr>
<tr>
<td>Leg/Ankle/Foot</td>
<td></td>
<td>10%</td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td><strong>100%</strong></td>
<td></td>
</tr>
</tbody>
</table>

The Program Services Council of the ABPTRFE worked with the APTA Sections and ABPTS Specialty Councils to develop a guideline for diagnostic categories for other specialty areas. The following recommendations are not intended to be prescriptive in nature as each program will have their own unique set of diagnoses for their specialty, but rather used as a guide to assist you in completing Form 2.1.1 in the application. Please refer to the program examples provided below these guidelines for additional suggestions on completing Form 2.1.1.

**Sample Diagnostic Categories for Geriatrics**

**Musculoskeletal Disorders**

Fractures  
Total joint replacements  
Osteoarthritis  
Osteoporosis  
Spine Disorders  
Other - sprains, strains etc

**Cardiopulmonary**

Diabetes (peripheral neuropathy)  
Acute infections (UTI, Pneumonia)  
Peripheral Arterial circulation compromise  
Amputations  
Lymphedema
Peripheral Vascular and wounds
COPD
Other

Neurologic/Neuromuscular Disorders

Stroke
Parkinson’s Disease
Other

Other

Frailty
General Deconditioning/Gait and mobility dysfunction
Falls
Oncology
Autoimmune Disease
Other

Sample Diagnostic Categories for Clinical Electrophysiology

Clinical Electrophysiologic Physical Therapy
Diagnostic Categories
Based on: Guide to Physical Therapist Practice

A. Musculoskeletal
1. Compression, entrapment, or focal neuropathy
2. Radiculopathy
   a. Cervical
   b. Lumbosacral
3. Plexopathy (brachial and lumbosacral)
   a. Idiopathic
   b. Traumatic
   c. Infiltration
4. Traumatic mononeuropathy
   a. Carpal Tunnel Syndrome or median neuropathy at or about the wrist
   b. Cubital tunnel Syndrome or ulnar neuropathy at the elbow
   c. Guyons canal or ulnar neuropathy at the wrist
   d. Radial Tunnel Syndrome or radial neuropathy of the forearm
   e. Tarsal Tunnel or tibial neuropathy at the ankle
   f. Fibular (peroneal) nerve at the knee

B. Neuromuscular
1. Polyneuropathy
   a. Acquired
      i. Diabetes
      ii. Uremic
      iii. Autoimmune
         1. Inflammatory demyelinating
            a. Acute
b. Chronic
   2. Neuralgic amyotrophy
   3. Multifocal motor neuropathy

iv. Infection
   1. HIV
   2. Hanson’s disease
   3. Lyme disease

v. Toxic
   1. Alcohol
   2. Drug-induced

vi. Neoplastic

vii. Motor neuron disease

b. Hereditary
   i. HMSN I-VII
   ii. Compression neuropathy

2. Cranial neuropathy
3. Mononeuropathy multiplex
4. Myopathy
   a. Acquired
      i. Myositis
         1. Polymyositis
      ii. Myotonic
      iii. Endocrine
      iv. Metabolic
      v. Drug-induced
         1. Statin
         2. Steroid
         3. Alcohol
   b. Hereditary
      i. Muscular dystrophy
      ii. Congenital

5. Neuromuscular junction
   a. Autoimmune
      i. Myasthenia gravis
   b. Myasthenic syndrome
      i. Small cell lung carcinoma
      ii. Hereditary
   c. Toxin
      i. Botulism

C. Cardiopulmonaryvascular
   1. Polyneuropathy
      a. Peripheral Vascular Disease
      b. Peripheral Artery Disease
   2. Critical illness polyneuropathy

D. Integumentary
   1. Dermatomyositis
   2. Nutritional deficiencies
   3. Disturbance in skin sensation or “paresthesia”
Sample Diagnostic Categories for Neurology

Spinal Cord injury
CVA
Vestibular and Balance Disorders
Traumatic Brain Injury
Post-Polio Syndrome
Peripheral Neuropathy
Multiple Sclerosis
Parkinson’s disease
Oncology (brain tumor)
Cerebral Palsy and other developmental disorders
Amputation
Other Progressive disorders (ALS, chronic inflammatory peripheral neuropathy)
Other Non-Progressive Disorders (transverse myelitis, seizure)

Sample Diagnostic Categories for Pediatrics

Neuromuscular Disorders
Cardio-pulmonary Impairments (cystic fibrosis, etc)
Oncology
Bone marrow/cord blood recipients
Spina bifida/SCI (Non-progressive or congenital disorders of spinal cord)
Musculoskeletal disorders
Prematurity/high risk infants
General deconditioning
Genetic syndromes (Downs, metabolic)
Gross/Global developmental delay
Progressive disorders of CNS
Brain injury (acquired or congenital)

Sample Diagnostic Categories for Women’s Health

Gynecological Oncology
Lymphedema/Breast Cancer
Musculoskeletal disorders assoc/w breast or gynecological issues
Urinary Incontinence
Musculoskeletal (pregnancy related)
Osteoporosis
Pelvic Pain
Colorectal Disorders
Female Athlete
High-risk Pregnancy
Pediatric voiding/defecatory disorders
**Example 1**

(Adapted from Duke University Health System Physical Therapist Women’s Health Residency, 2009)

<table>
<thead>
<tr>
<th>Diagnostic Group/Category or Impairment or Diagnostic Category*</th>
<th>Number of Patients/Clients Seen by Resident/Fellow** per Year as Part of the Education Program (Not visits)</th>
<th>Percentage of Total Number of Patients/Clients Per Year (Not Visits)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breast/GYN Cancer Lymphedema</td>
<td>307</td>
<td>34%</td>
</tr>
<tr>
<td>Urinary Incontinence</td>
<td>145</td>
<td>16%</td>
</tr>
<tr>
<td>Musculoskeletal Dysfunction assoc/Pregnancy</td>
<td>99</td>
<td>11%</td>
</tr>
<tr>
<td>Musculoskeletal dysfunc assoc/w breast/gyn cancer</td>
<td>127</td>
<td>14%</td>
</tr>
<tr>
<td>Osteoporosis</td>
<td>27</td>
<td>3%</td>
</tr>
<tr>
<td>Pelvic Pain</td>
<td>118</td>
<td>13%</td>
</tr>
<tr>
<td>Fecal Incontinence</td>
<td>54</td>
<td>6%</td>
</tr>
<tr>
<td>Female Athlete</td>
<td>9</td>
<td>1%</td>
</tr>
<tr>
<td>High Risk Pregnancy</td>
<td>18</td>
<td>2%</td>
</tr>
<tr>
<td>Total</td>
<td>904</td>
<td>100%</td>
</tr>
</tbody>
</table>

**Example 2**

(Adapted from Duke University Health System Cardiovascular and Pulmonary Physical Therapist Residency, 2009)

<table>
<thead>
<tr>
<th>Diagnostic Group/Category or Impairment or Diagnostic Category*</th>
<th>Number of Patients/Clients Seen by Resident/Fellow** per Year as Part of the Education Program (Not visits)</th>
<th>Percentage of Total Number of Patients/Clients Per Year (Not Visits)</th>
</tr>
</thead>
<tbody>
<tr>
<td>COPD</td>
<td>38</td>
<td>10%</td>
</tr>
<tr>
<td>Cystic Fibrosis</td>
<td>25</td>
<td>7%</td>
</tr>
<tr>
<td>Asthma</td>
<td>10</td>
<td>3%</td>
</tr>
<tr>
<td>Heart Failure</td>
<td>64</td>
<td>17%</td>
</tr>
<tr>
<td>Pulmonary Hypertension</td>
<td>23</td>
<td>6%</td>
</tr>
<tr>
<td>Lung and Cardiac Transplants</td>
<td>93</td>
<td>25%</td>
</tr>
<tr>
<td>Restrictive Lung Diseases</td>
<td>58</td>
<td>16%</td>
</tr>
<tr>
<td>CABG and Valve Surgery</td>
<td>8</td>
<td>2%</td>
</tr>
<tr>
<td>Aortic Surgery</td>
<td>3</td>
<td>0.5%</td>
</tr>
<tr>
<td>Pneumonectomy/Lobectomy</td>
<td>2</td>
<td>0.5%</td>
</tr>
<tr>
<td>Heart-Mechanical Assist Devices</td>
<td>14</td>
<td>4%</td>
</tr>
<tr>
<td>PCI</td>
<td>5</td>
<td>1%</td>
</tr>
<tr>
<td>CAD</td>
<td>13</td>
<td>3%</td>
</tr>
<tr>
<td>MI</td>
<td>10</td>
<td>3%</td>
</tr>
<tr>
<td>Arrhythmia</td>
<td>6</td>
<td>2%</td>
</tr>
<tr>
<td>Total</td>
<td>372</td>
<td>100%</td>
</tr>
</tbody>
</table>

**Example 3**

(Adapted from Gundersen Lutheran Sports Physical Therapy Residency, 2009)
<table>
<thead>
<tr>
<th>Diagnostic Group/Category or Impairment or Diagnostic Category*</th>
<th>Number of Patients/Clients Seen by Resident/Fellow** per Year as Part of the Education Program (Not visits)</th>
<th>Percentage of Total Number of Patients/Clients Per Year (Not Visits)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lumbar Spine</td>
<td>12</td>
<td>7%</td>
</tr>
<tr>
<td>Thoracic Spine</td>
<td>2</td>
<td>1%</td>
</tr>
<tr>
<td>Cervical Spine</td>
<td>10</td>
<td>6%</td>
</tr>
<tr>
<td>Hip/Pelvic Region</td>
<td>6</td>
<td>4%</td>
</tr>
<tr>
<td>Knee/Lower Leg Region</td>
<td>65</td>
<td>38%</td>
</tr>
<tr>
<td>Ankle</td>
<td>40</td>
<td>24%</td>
</tr>
<tr>
<td>Foot</td>
<td>7</td>
<td>4%</td>
</tr>
<tr>
<td>Shoulder</td>
<td>19</td>
<td>11%</td>
</tr>
<tr>
<td>Elbow</td>
<td>5</td>
<td>3%</td>
</tr>
<tr>
<td>Wrist</td>
<td>2</td>
<td>1%</td>
</tr>
<tr>
<td>Hand/Thumb</td>
<td>2</td>
<td>1%</td>
</tr>
<tr>
<td>TMJ</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>166</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>

**% of total clients that are sports physical therapy cases** 80%

**Example 4**

*(Adapted from MossRehab Neurologic Physical Therapy Residency Program, 2009)*

<table>
<thead>
<tr>
<th>Diagnostic Group/Category or Impairment or Diagnostic Category*</th>
<th>Number of Patients/Clients Seen by Resident/Fellow** per Year as Part of the Education Program (Not visits)</th>
<th>Percentage of Total Number of Patients/Clients Per Year (Not Visits)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cerebral Vascular Accident*</td>
<td>39</td>
<td>45.35%</td>
</tr>
<tr>
<td>Traumatic Brain Injury*</td>
<td>17</td>
<td>19.77%</td>
</tr>
<tr>
<td>Vestibular*</td>
<td>11</td>
<td>12.79%</td>
</tr>
<tr>
<td>Spinal Cord Injury*</td>
<td>5</td>
<td>5.82%</td>
</tr>
<tr>
<td>Seizure Disorder</td>
<td>1</td>
<td>1.17%</td>
</tr>
<tr>
<td>Multiple Sclerosis*</td>
<td>2</td>
<td>2.33%</td>
</tr>
<tr>
<td>Encephalopathy</td>
<td>3</td>
<td>3.49%</td>
</tr>
<tr>
<td>Brain Tumor*</td>
<td>3</td>
<td>3.49%</td>
</tr>
<tr>
<td>Cervical myelopathy</td>
<td>2</td>
<td>2.33%</td>
</tr>
<tr>
<td>Neurofibromatosis</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Parkinson’s Disease*</td>
<td>1</td>
<td>1.17%</td>
</tr>
<tr>
<td>Guillain-Barré (GB)*</td>
<td>2</td>
<td>2.33%</td>
</tr>
<tr>
<td>Progressive multifocal leukoencephalopathy (PML) due to HIV</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Cerebral Palsy*</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>(specialty observation)</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Amyotrophic Lateral Sclerosis (ALS)* (specialty observation)</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>86</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>
*Please see 2.1.1.A for details on how Program is assuring adequate resident learning experiences in categories with low patient diagnostic categories.

**Example 5**

(Adapted from *The Jewish Home for the Elderly Clinical Residency in Geriatrics, 2009*)

<table>
<thead>
<tr>
<th>Diagnostic Group/Category or Impairment or Diagnostic Category*</th>
<th>Number of Patients/ Clients Seen by Resident/ Fellow** per Year as Part of the Education Program (Not visits)</th>
<th>Percentage of Total Number of Patients/ Clients Per Year (Not Visits)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hip pathology – THR, hip fx</td>
<td>43</td>
<td>16.5%</td>
</tr>
<tr>
<td>Knee pathology – TKR, OA, other</td>
<td>33</td>
<td>12.6%</td>
</tr>
<tr>
<td>Other LE pathology – pelvic fx, other</td>
<td>9</td>
<td>3.5%</td>
</tr>
<tr>
<td>UE pathology – Shoulder, elbow fxs</td>
<td>8</td>
<td>3.1%</td>
</tr>
<tr>
<td>Cardiac – med/surg</td>
<td>21</td>
<td>8.2%</td>
</tr>
<tr>
<td>Peripheral vascular</td>
<td>5</td>
<td>1.9%</td>
</tr>
<tr>
<td>Pulmonary – pneumonia, COPD, etc</td>
<td>23</td>
<td>8.8%</td>
</tr>
<tr>
<td>CVA</td>
<td>8</td>
<td>3.1%</td>
</tr>
<tr>
<td>Parkinsonism</td>
<td>5</td>
<td>1.9%</td>
</tr>
<tr>
<td>Other neurologic – vestibular, spinal pathology</td>
<td>18</td>
<td>6.9%</td>
</tr>
<tr>
<td>Integumentary</td>
<td>6</td>
<td>2.3%</td>
</tr>
<tr>
<td>Oncology</td>
<td>8</td>
<td>3.1%</td>
</tr>
<tr>
<td>Cognitive Impairment – dementia, encephalopathy</td>
<td>26</td>
<td>10%</td>
</tr>
<tr>
<td>Medical – UTI, urosepsis, GI, etc</td>
<td>21</td>
<td>8.2%</td>
</tr>
<tr>
<td>Amputees</td>
<td>3</td>
<td>1.1%</td>
</tr>
<tr>
<td>Misc – falls, balance impairment</td>
<td>23</td>
<td>8.8%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>260</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>

**Example 6**

(Adapted from *The Children’s Hospital of Philadelphia Pediatric Residency Program, 2009*)

<table>
<thead>
<tr>
<th>Diagnostic Group/Category or Impairment or Diagnostic Category*</th>
<th>Number of Patients/ Clients Seen by Resident/ Fellow** per Year as Part of the Education Program (Not visits)</th>
<th>Percentage of Total Number of Patients/ Clients Per Year (Not Visits)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neuromuscular: Acquired Brain Injury (cerebral palsy, stroke, brain tumor, encephalitis, infant botulism, multiple sclerosis)</td>
<td>57</td>
<td>18.5%</td>
</tr>
<tr>
<td>Neuromuscular: Traumatic Brain Injury</td>
<td>8</td>
<td>2.6%</td>
</tr>
<tr>
<td>Neuromuscular: Developmental Delay (Down Syndrome, gross motor delay, other syndromes)</td>
<td>20</td>
<td>6.5%</td>
</tr>
<tr>
<td>Neuromuscular: Muscle disease (muscular dystrophy, spinal muscle atrophy, myopathies)</td>
<td>18</td>
<td>5.8%</td>
</tr>
<tr>
<td>Neuromuscular:</td>
<td>17</td>
<td>5.5%</td>
</tr>
<tr>
<td>Diagnostic Group/Category or Impairment or Diagnostic Category*</td>
<td>Number of Patients/Clients Seen by Resident/Fellow** per Year as Part of the Education Program</td>
<td>Percentage of Total Number of Patients/Clients Per Year (Not Visits)</td>
</tr>
<tr>
<td>---------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------</td>
<td>------------------------------------------------------------------</td>
</tr>
<tr>
<td>Spinal impairment (spinal cord injury, transverse myelitis, Guillain Barre Syndrome, demyelinating diseases, spina bifida, spinal cord tumor)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Neuromuscular:</strong> Other (seizure disorder, hypotonia, hypertonia, peripheral nerve injuries, solid organ tumors)</td>
<td>8</td>
<td>2.6%</td>
</tr>
<tr>
<td><strong>Musculoskeletal:</strong> Bony Impairment (fractures, bony tumors, osteopenia, osteogenesis imperfecta, limb length discrepancy, surgical procedure for malalignment)</td>
<td>41</td>
<td>13.4%</td>
</tr>
<tr>
<td><strong>Musculoskeletal:</strong> Postural impairment (scoliosis, limb length discrepancy, torticollis)</td>
<td>14</td>
<td>4.6%</td>
</tr>
<tr>
<td><strong>Musculoskeletal:</strong> Joint impairment and dysfunction (connective tissue disorders, joint replacements, sprains/strains/instability, orthopedic injuries, surgical rehab)</td>
<td>19</td>
<td>6.2%</td>
</tr>
<tr>
<td><strong>Musculoskeletal:</strong> Chronic pain</td>
<td>15</td>
<td>4.9%</td>
</tr>
<tr>
<td><strong>Musculoskeletal:</strong> Sports injuries</td>
<td>4</td>
<td>1.3%</td>
</tr>
<tr>
<td><strong>Musculoskeletal:</strong> Blood disorders (leukemia, hemophilia, sickle cell disease, anemia, DVT)</td>
<td>17</td>
<td>5.5%</td>
</tr>
<tr>
<td><strong>Musculoskeletal:</strong> Other (obesity, deconditioning, idiopathic toe walking, diabetes)</td>
<td>13</td>
<td>4.2%</td>
</tr>
<tr>
<td><strong>Cardiopulmonary:</strong> Cardiac (congenital heart defects, cardiomyopathy, heart transplant)</td>
<td>16</td>
<td>5.2%</td>
</tr>
<tr>
<td><strong>Cardiopulmonary:</strong> Pulmonary (asthma, cystic fibrosis, lung transplant, bronchopulmonary dysplasia, vent-dependency, respiratory distress syndrome, deconditioning)</td>
<td>29</td>
<td>9.4%</td>
</tr>
<tr>
<td><strong>Integumentary:</strong> Burns</td>
<td>1</td>
<td>0.3%</td>
</tr>
<tr>
<td><strong>Integumentary:</strong> Wounds and pressure ulcers</td>
<td>2</td>
<td>0.6%</td>
</tr>
<tr>
<td><strong>Integumentary:</strong> Other (crush injuries, IV infiltrates, cellulitis)</td>
<td>1</td>
<td>0.3%</td>
</tr>
<tr>
<td><strong>Other:</strong> Organ transplant, kidney disease</td>
<td>7</td>
<td>2.2%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>307</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>

**Example 7**

*(From Child Development and Rehabilitation Center Pediatric Physical Therapy Residency Program, 2009)*
<table>
<thead>
<tr>
<th>Diagnostic Group/Category or Impairment or Diagnostic Category*</th>
<th>Number of Patients/Clients Seen by Resident/Fellow** per Year as Part of the Education Program (Not visits)</th>
<th>Percentage of Total Number of Patients/ Clients Per Year (Not Visits)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient Orthopedic (ages 3 yrs-20 yrs)</td>
<td>20</td>
<td>5%</td>
</tr>
<tr>
<td>Inpatient Oncology (ages birth-20 yrs)</td>
<td>21</td>
<td>6%</td>
</tr>
<tr>
<td>Inpatient Neurology (ages birth-20 yrs)</td>
<td>3</td>
<td>1%</td>
</tr>
<tr>
<td>Inpatient Medical/Surgical (ages birth-20 yrs)</td>
<td>4</td>
<td>1%</td>
</tr>
<tr>
<td>Generic Syndromes</td>
<td>35</td>
<td>9%</td>
</tr>
<tr>
<td>Torticollis</td>
<td>2</td>
<td>1%</td>
</tr>
<tr>
<td>Neuro</td>
<td>55</td>
<td>14%</td>
</tr>
<tr>
<td>Gross Motor Delay</td>
<td>76</td>
<td>20%</td>
</tr>
<tr>
<td>Orthopedics</td>
<td>7</td>
<td>2%</td>
</tr>
<tr>
<td>Spina Bifida (birth-44 yrs)</td>
<td>56</td>
<td>15%</td>
</tr>
<tr>
<td>Prematurity (birth-3 yrs)</td>
<td>* (see Evidence 2.1.1.A)</td>
<td>*(see Evidence 2.1.1.A)</td>
</tr>
<tr>
<td>Hemophilia (birth-76 yrs)</td>
<td>84</td>
<td>22%</td>
</tr>
<tr>
<td>Chronic Pain</td>
<td>12</td>
<td>3%</td>
</tr>
<tr>
<td>Overweight/Obesity</td>
<td>3</td>
<td>1%</td>
</tr>
<tr>
<td>Total</td>
<td>378</td>
<td>100%</td>
</tr>
</tbody>
</table>

**Example 8**

(From Army-Baylor University Doctoral Fellowship in Orthopaedic Manual Physical Therapy, 2009)
Evidence 2.1.1.A – In cases where there is limited access to certain patient categories, please indicate how the Program assures that the resident/fellow has adequate learning experiences in these areas, including clinical exposure.

**Example 1**

*(Adapted from Gundersen Lutheran Sports Physical Therapy Residency, 2009)*

For the diagnostic categories with low patient volumes (<10 patients) an attempt has been made to provide learning experiences for the residents in both didactic and clinical formats. These categories would include cervical spine, elbow, wrist/hand, and TMJ clients.

Didactic lecture sessions do cover each of these areas through our “Clinical Rounds” portion of the curriculum with laboratory experience also included in these learning experiences. Classroom teaching experiences have specifically included preparation by the residents to present both lecture and lab sessions on elbow, wrist, and hand evaluation and treatment. TMJ topics are likewise covered in didactic classroom sessions with additional exposure provided via interaction in Medical Staff noon conference lectures.

It should be noted that additional exposure to client categories for cervical spine, elbow, wrist/hand also occur during 1:1 clinical mentoring with program faculty which is not reflected in program numbers for this year.

**Example 2**

*(Adapted from The Ohio State University Medical Center Neurologic Physical Therapy Residency Program, 2009)*

<table>
<thead>
<tr>
<th>Diagnostic Category</th>
<th>Planned Educational Experiences</th>
</tr>
</thead>
</table>
| Balance and Vestibular Disorders             | - Participates in (4) 1 hour didactic sessions covering pathology, assessment, treatment, and current relevant research with regard to vestibular disorders.  
- Planned mentoring (April/May 2010) with a vestibular specialist (PT) for a total of approximately 20 hours.  
- Participates in 3 hours of classroom and laboratory experiences covering advanced peripheral and central vestibular case studies in the PT 730 course. |
| Congenital and Acquired Conditions of Childhood | - Continued mentoring from XXXX, PT at The Nisonger Center. Includes physical therapy intervention for children up to age 6 with a variety of developmental/congenital impairments.  
- Spends 40 hours in this specialty clinic performing evaluations and interventions.  
- Also participates in (8) 1 hour didactic sessions covering pathology, assessment, treatment, and current relevant research with regard to spinal muscular atrophy, cerebral palsy, and muscular dystrophy.  
- Planned mentoring (March 2010) with XXXX, PT in the muscular dystrophy specialty clinic performing evaluations and interventions for a total of 8-10 hours. |
Progressive Disorders of the Central Nervous System

- Participates in (8) 1 hour didactic sessions covering pathology, assessment, treatment, and current relevant research with regard to Parkinson’s Disease, Huntington’s Disease, and Multiple Sclerosis.
- Planned mentoring (March 2010) with XXXX, PT in the ALS specialty clinic performing evaluations and interventions for a total of 8-10 hours.
- Planned mentoring (March 2010) with Dr. XXXX, PT, NCS in the Parkinson’s Disease/Huntington’s Disease specialty clinic performing evaluations and interventions for a total of 20-40 hours.

Acute or Chronic Peripheral Neuropathies

- Participates in (4) 1 hour didactic sessions covering pathology, assessment, treatment, and current relevant research with regard to Guillan-Barre.
- Planned 4-8 hour observation (February 2010) with physical medicine and rehabilitation physician(s) performing EMGs.

Example 3

(Adapted from MossRehab Neurologic Physical Therapy Residency Program, 2009)

For limited resident exposure to diagnostic categories, specific didactic learning experiences are provided to address these diagnoses through guest speakers and Topics in Physical Therapy: Neurology take-home study course (available through the APTA). Specialty observation is also arranged at the MDA/ALS Center of Hope (addressing diagnosis of ALS) and The Children’s Hospital of Philadelphia (addressing pediatric neurologic diagnoses).

Example 4

(Adapted from The Jewish Home for the Elderly Clinical Residency in Geriatrics, 2009)

Peripheral vascular/amputees – Residents participated in the prosthetic evaluation and fitting of transtibial amputees. This included initial measurement with the prosthetist, observing the fabrication and alignment of the prosthesis and the prosthettist’s office. The resident was the primary therapist, networking closely with the prosthetist for further modifications as shrinkage of the residual limb occurred. The resident also instructed the patient and nursing staff in donning/doffing and mobility activities.

CVA’s and Parkinsonism – The resident also participated in simulated mobility activities for neurologically compromised patients.

UE pathology – Exposure is enhanced through the case conferences and journal club that the geriatric resident participates with the orthopedic residents.

Example 5

(From Army-Baylor University Doctoral Fellowship in Orthopaedic Manual Physical Therapy, 2009)

Areas with lower numbers, such as elbow/wrist/hand and TMJ, are indicative of low referrals of these conditions as the chief or primary compliant. However, these areas are routinely screened during every upper quarter and cervical spine patient encounter. Impairments noted in these regions are treated
routinely; therefore, exposure to evaluation and treatment of these areas is significantly under-appreciated in this chart. Furthermore, fellows seeing patients presenting or referred with primary complaints of elbow/wrist/hand and TMJ are highly encouraged and allotted time to invite other fellows to participate in the care of these patients.

**Example 6**

*(From Child Development and Rehabilitation Center Pediatric Physical Therapy Residency Program, 2009)*

1. **Inpatient Neurology and Inpatient Medical/Surgical:** It is felt that the resident received adequate exposure to these populations via the direct clinical experience and 1:1 mentoring discussions in this setting. Additionally, the resident attends General Pediatrics Grad Rounds Presentations at our hospital to provide a didactic supplement to the inpatient clinical experiences. General Pediatrics Grand Rounds are focused on the medical management of infants, children, and adolescents with a variety of medical conditions and are based on current research. Discussions with the rehab department staff following the Grand Rounds allows for reflection on the implications for pediatric physical therapists. If, in the future it is not felt that the resident can gain the experience necessary in these areas at our facility, the resident is able to spend time at another local children’s hospital acute care and inpatient rehabilitation units.

2. **Torticollis:** Resident was provided with 1:1 didactic and clinical mentoring sessions specific to the evaluation and management of children with torticollis. This diagnosis is often present as a co-morbidity, but patients are categorized into only one diagnosis category for the purposes of this analysis.

3. **Prematurity:** Many of the patients seen in our clinics have multiple diagnoses. Our residents evaluate and treat many patients who have prematurity as a part of their medical history in most of our outpatient clinics and acute care setting. These patients are more appropriately accounted for by one of the other categories provided in the form which serves as a more primary diagnosis and reason for physical therapy. Prematurity and its implications are factored into the examination, evaluation, prognosis and interventions clinically on a consistent basis. The resident also receives didactic instruction about the implications of prematurity with a variety of medical conditions through interdisciplinary seminars.

4. **Overweight/Obesity:** This is a relatively new area of concentration in our clinic population, and it is very new to the residency program. Residents are provided with 1:1 didactic instruction and will be provided with increased opportunity for participation in this clinic in the future.

**Example 7**

*(Adapted from Glendale Adventist Medical Center’s Orthopedic Physical Therapy Residency, 2009)*

Residents will have adequate clinical exposure to all patient body regions. If limited access occurs, the program director will triage specific patients to the Resident. In addition, Wrist/Hand and Cranio/Mandibular tend to be limited access categories. This year, the program director scheduled additional mentor time for our resident with therapists who specialize in TMJD and Hand Therapy.
Evidence 2.2.1.A – Provide the program director or coordinator’s job description.

Example 1

(Adapted from St. Catherine’s Rehabilitation Hospital & Villa Maria Nursing Center Post-professional Residency in Geriatric Physical Therapy, 2009)

| SUBJECT: Program Director Qualifications/Duties | FORMULATION DATE: 06/30/02 REVISION DATE: 03/30/07 APPROVED BY: Greg Hartley, PT, MSPT, GCS |
|--------------------------------------------------|-------------------------------------------------|--------------------------------------------------|

A. The director of the clinical residency program is either certified by the American Board of Physical Therapy Specialties (ABPTS) in Geriatrics or has developed a professional portfolio supporting their qualifications.
B. The director is responsible for the fiscal management of the program.
C. The director is responsible for the overall clinical management of the program.
D. The director is responsible for the oversight of the faculty evaluation process.
E. The director is responsible for coordinating all internal and external activities related to the program, i.e., activities that may include use of outside resources, etc.
F. The program director is available for consultation with each resident, faculty member, and staff as needed.
G. The program director will arrange advisory committee meetings at the appropriate times.
H. The program director is responsible for maintaining adequate support staff and services.
I. The program director will assure that the physical facilities of St. Catherine’s/Villa Maria provide adequate space, equipment, and supplies to support resident, faculty, and staff needs.
J. The program director is responsible for maintaining access to educational resources for both residents and faculty.
K. The director assures equipment and materials needed are provided or made available.
L. The director monitors outcomes of the program.
M. The director manages any grievances or disciplinary actions required. He/she also manages any special requests/needs of the residents; e.g., part-time status, substitution of course-work, special assistance required, a change in instructional methods.
N. The director will conduct, on an annual basis, a survey to collect information regarding the performance of graduates. This information will be used for future program evaluation and modification.
O. The director is responsible for the maintenance and distribution of all program policies and procedures.

The program director reports to the Advisory Committee of the Residency Program.

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| SUBJECT: Residency Coordinators Qualifications/Duties | FORMULATION DATE: 01/06/06 REVISION DATE: 06/04/08 APPROVED BY: Greg Hartley, PT, MSPT, GCS |
|------------------------------------------------------|-------------------------------------------------|--------------------------------------------------|

The administrative duties of the residency are the responsibility of the program coordinator(s). Job duties may be divided among faculty. For example, one faculty member may be responsible for recruitment/marketing/admissions, another for the curriculum/schedule/speakers, and another for resident assessment/advising/remediation, etc. As a whole, the coordinators share the following responsibilities:
A. The coordinators of the clinical residency program are either certified by the American Board of Physical Therapy Specialties (ABPTS) in Geriatrics or have developed a professional portfolio supporting their qualifications.
B. The coordinators are responsible for the orientation of new residents.
C. The coordinators are responsible for the coordination of program inquiries and applications.
D. The program coordinators are responsible for scheduling prospective resident interviews with the admission committee.
E. The coordinators are responsible for the maintenance of residency program materials, including resident records, assignments, and applications.
F. The coordinators are responsible for coordinating all internal and external activities related to the program; i.e., activities that may include use of outside resources, etc.
G. The coordinators are available for consultation with each resident, faculty member, and staff as needed.
H. The coordinators will arrange advisory committee meetings at the appropriate times.
I. The coordinators are responsible for maintaining resident clinical and academic schedules as outlined by the program guidelines.
J. The coordinators will assure the resident is completing all required mentoring hours as outlined in the program.
K. The coordinators are responsible for maintaining matriculation records for each resident.
L. The coordinators are responsible for arranging faculty development activities.
M. The coordinators are responsible for the maintenance of all records for credentialing purposes.
N. The coordinators are responsible for coordinating all graduate follow-up surveys and program evaluations as per program guidelines.
O. The coordinators are responsible for the maintenance and acquisition of advertising relationships, including assisting the director with marketing/recruitment/etc. as needed.
P. The coordinators are responsible for assisting with mentoring of the resident.
Q. The residency coordinators directly report to the Program Director

**Example 2**

*(From Army-Baylor University Doctoral Fellowship in Orthopaedic Manual Physical Therapy, 2009)*

The director’s position is a full-time (1.0) FTE. Responsibilities are:

1) To provide overall management of the students, faculty, research, curriculum, clinical schedules, clinical mentorship, and financial/administrative/educational resources for the fellowship;

2) To provide the highest standard for postprofessional clinical training for physical therapists including advanced clinical skills in OMPT, academics, research, and an awareness of how all of these are related to the practice of evidence-based medicine;

3) To develop and revise, as needed, the curriculum to achieve the program’s goals and objectives through an annual strategic planning conference attended by key faculty where revisions and changes are discussed and approved; ensures revisions are implemented within 30 days of the approved changes;

4) To promote the clinical residency/fellowship model for postprofessional physical therapy education;
5) To teach advanced examination and intervention concepts and clinical decision making processes through didactic instruction and one-on-one clinical mentorship;

6) To prepare, submit, and oversee the operating budget;

7) To assess student, faculty, and program outcomes and present analysis at the annual strategic planning conference attended where revisions and changes are discussed and approved;

8) To promote clinical research to establish the proper role of physical therapy intervention within the larger context of best-practice, evidence-based medicine and patient-oriented healthcare.

**Example 3**

*(Adapted from Kaiser Permanente Los Angeles Movement Science Fellowship, 2009)*

**Job Title:** Physical Therapy Training Coordinator  
**Reports To:** Director, Physical Medicine & Rehabilitation

**Position Purpose**
Directs, plans, organizes and supervises the ongoing development, evaluation and operation of the physical therapy residency and fellowship program.

**Essential Duties & Responsibilities**
- Develops, implements, evaluates, and monitors cost effective, quality programs for training of the graduate physical therapists.
- Develops and insures compliance to the program’s philosophy, goals, and objectives. 5%
- Develops and presents budget proposals to the Department Director/Administrator. Jointly monitors the fiscal activity of the program with the Department Director/Administrator. 10%
- Collaborates with the regional physical therapy Directors/Administrators and other appropriate personnel in the establishment and implementation of regional standards in musculoskeletal care. 10%
- Develops and implements formal and informal affiliations/agreements with universities for the purpose of creating educational resources, programs, and clinical affiliations for the residents in the program. 5%
- Establishes and coordinates orthopedic fellowships/residencies at requesting locations throughout the Kaiser Southern California region. 10%
- Develops and implements systems, processes and standards for establishing, evaluating and reviewing the performance level of the program’s personnel. 10%
- Supervises the data collection and statistical analysis in the areas of resident/fellow performance and quality/level of patient care. 10%
- On an ongoing basis, directs and evaluates the performance of professional personnel, instructional personnel and residents/fellows. 20%
- Communicates with licensing and accrediting bodies regarding licensure of new faculty members and residents. 5%
- Performs annual fellowship and residency program analysis/evaluation including; participant satisfaction, review of program performance relative to established goals, feedback from clinic administrators where programs currently exists, feedback from instructors. Resolution of problems that are identified. 15%
- Must be able to work in Labor/Management Partnership environment.
Job Specifications

- Bachelor’s degree in health education, education, instructional design, management or physical therapy. Masters degree preferred in a relevant field such as Physical Therapy, education.
- Graduate of a Curriculum in Physical Therapy approved by APTA; licensed as a Physical Therapist issued by the Board of Medical Examiners, State of California.
- Five or more years (usually) relevant physical therapy experience including experience as a clinical practitioner, supervisor/manager and clinical instructor.
- Ability to demonstrate knowledge of and utilize the principles, practices and techniques of instructional design, clinical education/training program development and evaluation and orthopaedic physical therapy.
- Ability to demonstrate knowledge of and utilize the principles, practices and techniques of instructional design, clinical education/training program development and evaluation and orthopaedic physical therapy.
- Ability to demonstrate and utilize knowledge of clinical research proposal development and implementation.
Evidence 2.2.1.B – Provide the program director or coordinator’s abbreviated resume.

Example

(Adapted by APTA Residency/Fellowship Staff, 2004.)

Sample Curriculum Vitae

The following information could be included in a curriculum vita:

- Work Address
- Home Address
- Education (comprehensive)
- Professional Experience (include time span, name of facility, and position title)
- Board Certification(s)
- Licensure (to include state and number)
- Professional Associations/Memberships
- Consulting Experience (if applicable)
- Research Publications
- Publications (other)
- Abstract Presentations
- Invited Speaker Presentations
- Teaching Experience
- Awards
Evidence 2.2.2 – Utilize Form 2.2.2 for each faculty member that meets the description (full-time or part-time) in the “Interpretive Guideline” above. Provide names, credentials, title, primary place of employment, including the site where the faculty provides instruction/mentoring, areas of responsibility, recent professional development activities and percentage of FTE dedicated to the Program, based on 40 hours. If single faculty member, briefly describe the Program’s contingency plan should the faculty member not be able to function in this role.

Example

(Form provided in Part 4 of application: Forms)

Form 2.2.2/2.2.3

Name of Clinical Residency/Fellowship Program:

Program Faculty

Complete this form for all faculty active in the Program within the last 18 months.

<table>
<thead>
<tr>
<th>NAME (with credentials)</th>
<th>ABPTS CERTIFICATION/RECERTIFICATION (Designate year certified/Year of latest recertification)</th>
<th>TITLE</th>
<th>% FTE (based on 40 hrs)</th>
<th>□ Cardiopulmonary</th>
<th>□ Clinical Electrocardiography</th>
<th>□ Geriatric</th>
<th>□ Neurologic</th>
<th>□ Orthopaedic</th>
<th>□ Pediatric</th>
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<th>□ Women’s Health</th>
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<th>Recert.</th>
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<tr>
<td>RECENT PROFESSIONAL DEVELOPMENT ACTIVITIES (i.e., continuing education, publications, research, etc.)</td>
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</table>
### Example 1

*(Adapted from St. Catherine’s Rehabilitation Hospital & Villa Maria Nursing Center Post-professional Residency in Geriatric Physical Therapy, 2009)*

<table>
<thead>
<tr>
<th>NAME (with credentials)</th>
<th>XXXX, PT, GCS</th>
<th>ABPTS CERTIFICATION/RECERTIFICATION (Designate year certified/Year of latest recertification)</th>
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<tr>
<td></td>
<td></td>
<td>% FTE (based on 40 hrs) 10%</td>
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<tr>
<td>TITLE</td>
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<tr>
<td>Program Director – Geriatric Residency; Director of Rehabilitation Services and Assistant Hospital Administrator</td>
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<td>PLACE OF EMPLOYMENT</td>
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<td>St. Catherine’s Rehabilitation Hospital &amp; Villa Maria Nursing Center</td>
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<tr>
<td>AREAS OF RESPONSIBILITY IN PROGRAM</td>
<td>Program Director, Mentor Training, Instructor for didactic content to include healthcare delivery sites, musculoskeletal, Medicare regulation, advocacy, functional assessment, balance and falls, case management, and consulting. Oversight of administrative and research projects.</td>
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<tr>
<td>RECENT PROFESSIONAL DEVELOPMENT ACTIVITIES (i.e., continuing education, publications, research, etc.)</td>
<td>See Resume/CV above (Evidence 2.2.1.B)</td>
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<table>
<thead>
<tr>
<th>NAME (with credentials)</th>
<th>XXXX, PT, GCS</th>
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<td>TITLE</td>
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<td>Senior PT, Residency Faculty, Residency Program Advisor</td>
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<tr>
<td>AREAS OF RESPONSIBILITY IN PROGRAM</td>
<td>See residency coordinator’s job description. Serves as advisor to residents, ensuring progress through program is appropriate, responsible for oversight of resident’s assessment and progression. Also teaches didactic content related to geriatric neurology. Serves as a primary mentor.</td>
<td></td>
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<tr>
<td>RECENT PROFESSIONAL DEVELOPMENT ACTIVITIES (i.e., continuing education, publications, research, etc.)</td>
<td>Certified Clinical Instructor, attended course in “Mentoring in Post-Professional Residency Programs” in 2007; APTA annual Conference 2005, NDT Course 2008, Parkinson’s ATTP Certification 2006, CSM 2009, attended Residency/Fellowship Sub-Committee Reviewer Training 2009. Member of Section on Geriatrics Advanced Clinical Practice Committee.</td>
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**Example 2**

*(From Army-Baylor University Doctoral Fellowship in Orthopaedic Manual Physical Therapy, 2009)*

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<td>Associate Professor, Baylor University</td>
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<td>2001</td>
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<td>Brook Army Medical Center</td>
<td>Deputy Program Director, Clinical Mentor, Course Director</td>
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<td>Fort Sam Houston, Texas</td>
<td>Fort Sam Houston, Texas</td>
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</table>

**RECENT PROFESSIONAL DEVELOPMENT ACTIVITIES** (i.e., continuing education, publications, research, etc.)

**Peer Reviewed Publications:**


**Scientific and Professional Presentations:**


2. Evidence-based diagnosis and screening in Physical Therapy Practice; APTA Annual Conference; San Antonio, TX, 2008.


**Professional Activities:**

**APTA:** Developing curriculum for the American Physical Therapy Association Advanced Clinical Practice Series on Evaluation and Treatment of the Cervical Spine and Shoulder, Diagnostic Imaging, and Differential Diagnosis for Physical Therapists, 2002-Present.

**Orthopaedic Section:** Editorial Board Member and Reviewer for the Journal of Orthopaedic and Sports Physical Therapy, 2000-Present.
Evidence 2.2.3 – Identify all ABPTS-certified/FAAOMPT faculty. Include the area(s) of specialty and the year of certification and/or recertification.

The same form used for Evidence 2.2.2 can be completed, or submission of a two-page resume for each faculty member that is inclusive of those areas clearly delineated in the “Interpretative Guideline” for 2.2.2.

Example 1

(Adapted from St. Catherine’s Rehabilitation Hospital & Villa Maria Nursing Center Post-professional Residency in Geriatric Physical Therapy, 2009)

<table>
<thead>
<tr>
<th>Name of Faculty Member</th>
<th>Area of Specialization</th>
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Evidence 2.2.4 – Provide a summary of professional development opportunities and resources that allow faculty to maintain and improve their effectiveness as clinicians and educators.

Example 1

(Composite collected from credentialed programs by APTA Residency/Fellowship staff, 2010)

Faculty chose from a variety of development opportunities based on their annual self-assessment and the annual program assessment. These opportunities include:

1. Internal faculty development meeting are held at least twice a year. A guest speaker is chosen based on faculty requests and speaker availability.
2. Journal Club meets monthly to discuss a recent journal article that meets faculty development goals in a selected content area.
3. Funding for continuing education or conference annually.
4. Funding for an on-line instructional course annually.
5. Invitation to all presentations for the residents/fellows.
6. Invitation to all presentations made by the residents/fellows.
7. Mentoring experiences are available with other members of the health care team.
8. Faculty attendance at the CSM pre-conference course, “Mentoring the Clinician Towards Advanced Practice”.

Example 2

(Adapted from Glendale Adventist Medical Center’s Orthopedic Physical Therapy Residency, 2009)

All of the clinical faculty are Glendale Adventist Medical Center employees. All Glendale Adventist Medical Center full-time employees are eligible for $ per year for continuing professional education and five paid educational days per year. In addition, Glendale Adventist Medical Center sponsors a continuing education course every other year that is available free to all Therapy & Wellness Center physical therapist employees. In the past four years the invited speakers who presented courses for Glendale Adventist Medical Center have included Robert Landel and Carolee Winstein. In addition, all clinical faculty are invited to attend any of the Kaiser Permanente classroom and lab instruction provided for the residents. In addition, all clinical faculty have either completed a residency in orthopedic physical therapy or have attained OCS status. Thus, they are all eligible to apply for and, if accepted, participate in any of the three fellowships offered by Kaiser Permanente in Southern California – the Orthopedic Manual Therapy Fellowship, Movement Science Fellowship, and the Hand Therapy Fellowship.

Example 3

(From Army-Baylor University Doctoral Fellowship in Orthopaedic Manual Physical Therapy, 2009)

Faculty development is an ongoing and continuously evolving process consisting of the following:

1. Each clinical faculty member receives at least one funded continuing education opportunity per year. Other faculty are funded by the AMEDD Center and School to attend professional meetings and continuing education courses. Faculty typically attend the AAOMPT Annual Conference and the APTA Combined Section Meeting in addition to various short courses. Continuing education opportunities include, but are not limited to:
a. Civilian Continuing Education Courses: Such courses should be directly related to specific teaching responsibilities. Faculty may also take courses at their own expense, in which case they are given time off. Multiple opportunities are available in San Antonio and often funding is available for more than one course when travel and per diem are not involved.

b. Military Continuing Education Courses: A variety of continuing education courses are offered through the military services in San Antonio, free of cost. Some of these courses are professional in nature and some are specific to officer development. Faculty are given time and encouraged to attend and/or teach in these courses.

c. Local Education/Development Opportunities: Locally sponsored courses are available through the fellowship program and the Alumni Distinguished Lecture Series at no cost to faculty.

d. Research: Research opportunities are available through individual effort at BAMC, in coordination with the fellowship program, or with the U.S. Army-Baylor University Doctoral Program in Physical Therapy. Additional research opportunities are available locally with the Center for Intrepid Movement Science Lab.

e. Teaching Continuing Education Courses: This activity is supported as an excellent development opportunity. Many faculty are involved and given time to teach continuing education courses at the national level, for professional organizations, and for other universities.

f. APTA Home Study Courses: These courses are frequently purchased by the program and integrated into the curriculum. Faculty are given the opportunity to complete these courses.

2. Individual review/counseling from the program director on student feedback forms for didactic classes and clinical mentorship. This occurs 3-4 times per 18-month program cycle.

3. At each faculty strategic planning conference/retreat, faculty development initiatives are discussed. Past suggestions included having all faculty complete the Advanced Faculty Development Course offered by the AMEDD Center and School and initiating a Peer Coaching Program. The Peer Coaching Program consists of peer observation and feedback of faculty in various teaching environments to develop individual teaching skills. The program director sits in during mentorship with another faculty 1-2 times per year to give feedback to the faculty and compare observations on the fellow-in-training.

4. The program faculty teach in a number of continuing education courses for military and civilian physical therapists. Faculty have the opportunity to observe other faculty in a variety of settings. This format is especially helpful for junior faculty who are able to observe senior faculty with over 20 year’s experience.

5. All faculty are actively involved in a number of research projects. Specific time is available for data collection and research committee meetings to plan for and conduct research.

6. All faculty are invited to attend weekly inservices in the physical therapy clinic and periodic presentations of literature reviews by the fellows.
**Example 4**

*(Adapted from St. Catherine’s Rehabilitation Hospital & Villa Maria Nursing Center Post-professional Residency in Geriatric Physical Therapy, 2009)*

**Faculty Resources:**

Adequate time and resources are made available to clinical faculty as related to continuing professional development. Examples include:

- Inservices and seminars
- Continuing education courses
- Journal club
- Clinical rounds
- Professional association activities (ATPA/FPTA)

**Procedure:**

Faculty wishing to participate in on-site educational opportunities need to bring to the attention of their supervisor their desire to attend the educational session so adequate time may be allowed. If a fee is charged or if the session is off-site and will require time away from the clinic, requests must be submitted to the Director of Rehabilitation Services using a “Check Request Form” and any time off coordinated with their supervisor. Time off for continuing education is approved by the Director of Rehabilitation and does not count as vacation or sick time. Continuing Education courses must support the mission and/or vision of the organization and pertain to the clients served.

**Example 5**

*(From Hospital for Special Surgery Sports Physical Therapy Clinical Residency, 2009)*

The faculty has multiple opportunities and resources to support their continuing professional development.

1. 5 paid days off work annually for participation in continuing professional education
2. Annual stipend for continuing education
3. Tuition reimbursement program (in accordance with HSS Human Resources Policy and Procedure manual, policy no. 3.16)
4. Bimonthly in-services in the Sports Rehabilitation & Performance Center specific to the specialty of Sports Physical Therapy (including journal article review)
5. Monthly educational in-services presented by the Rehabilitation Department on a broad range of topics related to rehabilitation
7. PT faculty regularly attend physician office hours
8. Weekly Sports Fellows (MD’s) Conference (broad range of topics related to the practice of Sports Medicine)
9. Attendance at Annual “West Point Fellows Day” (Sports Medicine Fellows from all regional AOSSM programs present current research projects)
11. Opportunity to attend regularly scheduled conferences/grand rounds for multiple HSS services, including Orthopedic Grand Rounds, Rheumatology Grand Rounds, and the Visiting Professor Lecture Series.

12. Access to the HSS medical library, support staff and electronic resources; the extensive resources of Cornell Weill Medical library; and the HSS Sports Physical Therapy library of reference books, e-journals, and videos/DVDs.

13. Membership in the Sports Physical Therapy Section either as APTA members or partners with SPTS that allow ongoing access to Journal of Orthopedic and Sports Physical Therapy, SPTS Sports Section (web-based newsletter) and coursework at reduced costs sponsored by the SPTS.

14. Physician faculty attend Annual professional meetings (AAOS, AOSSM, AANA, ACSM)

Example 6

*(From Kaiser Permanente Los Angeles Movement Science Fellowship, 2009)*

All of the clinical faculty are Kaiser Permanente employees. All Kaiser Permanente full-time employees are eligible for $ per year for continuing professional education and five paid educational days per year. In addition, Kaiser Permanente Southern California sponsors at least two continuing courses per year that are available for fifty dollars to all physical therapists employees. In the past three years the invited speakers who presented courses for Kaiser Residency and Fellowship clinical faculty have included David Butler, Nicole Christensen, Paul Hodges, Lorimer Moseley, and Shirley Sahrmann. In addition, all clinical faculty are invited to attend any of the classroom and lab instruction provided for the fellows. Lastly, all clinical faculty have either completed a fellowship in orthopaedic manual physical therapy or movement science.
Evidence 2.3.1.1.A – Utilize Form 2.3.1.1.A to list clinics utilized for residency/fellow education.

*Example*

(Form provided in part 4 of application: Forms)

_Name of Clinical Residency/Fellowship Program:_

Clinical Facilities Utilized in Program

List all clinical sites utilized in the education of Program residents or fellows.

<table>
<thead>
<tr>
<th>NAME OF CLINICAL FACILITY</th>
<th>CONTACT PERSON</th>
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</table>
Evidence 2.3.1.1.B – Provide affiliation agreements with clinical facilities.

Example 1

(The following is a sample of an Affiliation Agreement, provided by the American Physical Therapy Association, which identifies elements typically found in such a contract. If such a contract is not currently in use, it is recommended that legal counsel be sought in its drafting.)

AFFILIATION AGREEMENT

THIS AFFILIATION AGREEMENT (this “Agreement”) is made as of [date] (the “Effective Date”) by and between the [insert name of corporation or other entity that owns/operates the clinical residency program] (the “Residency”), a [corporation/not-for-profit corporation/partnership] organized under the laws of [insert state of incorporation/organization] having its principle place of business at [insert address], and [insert name of corporation or other entity that owns/operates the clinical facility] (the “Center”), a [corporation/not-for-profit corporation/partnership] organized under the laws of [insert state of incorporation/organization] having its principle place of business at [insert address].

WHEREAS, the Residency operates a post-professional clinical residency program in physical therapy (the “Program”) for residents who have met the clinical residency application criteria;

WHEREAS, the Program involves the residents’ managing patients under the supervision of physical therapists on the Center’s staff;

WHEREAS, the Center operates a clinical facility (the “Facility”) known as [insert name of facility] and located in [insert city and state] that offers physical therapy services to patients on an in-patient and/or out-patient basis;

WHEREAS, the Residency and the Center are interested in entering into an arrangement under which students in the Program would manage patients at the Facility under the supervision of physical therapists on the Center’s staff, subject to the terms and conditions set forth in this Agreement;

NOW, THEREFORE, in consideration of their respective agreements, the representations and warranties contained herein, and other good and valuable consideration, the parties agree as follows:

1. Joint Responsibilities
   1.1 Neither the Residency nor the Center will show any discrimination on the grounds of sex, race, creed, or color in the admission of qualified residents to any affiliated program, nor in the provision of instruction for such residents.
   1.2 The number of residents, their program of education with the Center, and the scheduling of their education at the Center will be determined by mutual agreement between the Center and its affiliate(s).
   1.3 A copy of the printed rules and regulations, and a calendar for both the Residency and its affiliate(s)’ activities should be made available to both participants.
   1.4 The dismissal of a resident for academic or disciplinary reasons will be the responsibility of the Center, but the affiliate(s) maintain the right to remove a resident from the clinical education portion of the program, if a resident’s behavior should violate existing rules and regulations of the affiliate in such matters as procedure, policies, patient contact, and in such other respects that the affiliate may require to prevent interference with its proper operation. Both the clinic and the affiliate should determine joint when and if a student, who has been removed from the clinical phase of the program, should be permitted to return to the clinical phase.

2. Responsibilities of Residency
   2.1 The clinic shall have control over all phases of the administration of the program, curriculum content, evaluation, faculty appointments, admission requirements, promotion, and graduation,
and such other matters as are internal to the clinic. The clinic will maintain the necessary records
of the residents.

2.2 The philosophy of the program will be determined by the clinic.

2.3 The clinic will assign students to an affiliate for their clinical education in accordance with the
clinic’s calendar and the agreement reached on the capacity of the affiliate to accommodate
residents for the necessary experience.

2.4 Where appropriate, and if required by accreditation or other considerations, clinical personnel will
be given clinic appointments. The rights and responsibilities of the appointees will be those that
are established by the clinic.

2.5 The clinic will provide a staff/faculty member who will serve as liaison with the clinical
instructors.

2.6 The clinic will provide certain benefits and accord privileges to the clinical faculty, appropriate to
their role in the Program. Reimbursement of expenses for clinical faculty will be based upon
established clinic policies.

2.7 The clinic warrants that it carries professional and general liability insurance, with single limits of
at least $1,000,000 per occurrence, to protect itself and its participating residents and faculty
members, from the consequences of bodily injury arising out of negligence, malpractice, error, or
mistake in the rendering or failure to render of any professional service by said residents or faculty
members, with respect to this educational clinical experience program at the affiliate(s).

2.8 The clinic credentials will provide verification of each resident’s credentials.

3. Responsibilities of Clinical Center

3.1 The affiliate(s) shall provide emergency health services and routine medical and dental care on a
space available basis for the students during assignment.

3.2 The affiliate(s) shall provide clinical instruction and supervision of the residents by qualified
personnel, who meet the standards of recognized professionals accrediting agencies or state
agencies and the stated objectives of the educational program.

3.3 The affiliate(s) shall provide emergency health services and routine medical and dental care on a
space-available basis for residents during assignment.

3.4 The affiliate(s) shall permit residents and faculty to have use of cafeteria and parking facilities, if
available, at the same rate of charges as for employees.

3.5 The affiliate(s) will provide time for clinical instructors to attend clinical supervisors’ meetings
and conferences called by the clinic as part of the educational program.

3.6 The affiliate(s) will provide cooperation when asked, in formal evaluation of the resident and will
maintain the records and reports required by the clinic for conducting the educational program.

3.7 The affiliate(s) warrant that it/they carry professional and general liability insurance with limits of
at least $1,000,000 per occurrence to cover itself and its personnel (including those who may also
have clinical appointments at the clinic) from the consequences of negligence, malpractice, error,
or mistake in the rendering or failure to render of any professional service, which includes the
Program covered by this agreement.

Officials signing the agreement for the participating institutions:

________________________  _________________________
Director, Clinic          Director, Affiliate

________________________  _________________________
Date                     Date

Application Resource Manual
APTA Clinical Residency and Fellowship Program Credentialing (2011)
Example 2

(From Kaiser Permanente Los Angeles Movement Science Fellowship, 2009)

There are no inter-facility legal agreements as all facilities are Kaiser Permanente facilities and all fellows in our program and clinical faculty of our program are employees of the Kaiser Permanente facility where the clinical supervision and clinical practice hours occur.

Example 3

(Adapted from Glendale Adventist Medical Center’s Orthopedic Physical Therapy Residency, 2009)

AGREEMENT BETWEEN GLENDALE ADVENTIST MEDICAL CENTER AND KAISER PERMANENTE

This is an agreement between Glendale Adventist Medical Center and Kaiser Permanente regarding their mutual participation in Glendale Adventist Medical Center Orthopedic Physical Therapy Residency program. Kaiser Permanente will provide the didactic training of the Glendale Adventist Medical Center residents at no cost for 2009, in return for the residents’ participation at Los Angeles Free clinic. Glendale Adventist Medical Center Orthopedic Physical Therapy Program and its resident will be responsible for providing all liability coverage for its resident and their service, while participation at the Los Angeles Free Clinic. In 2009, the Community Benefits Program within Kaiser Permanente Southern California will cover the cost of thirty days (288 hours) of classroom and lab instruction in the principles and procedures of Orthopedic physical therapy as described in the current American Board of Physical Therapy Specialties’ Description of Specialty Practice in Orthopaedic Physical Therapy. This instruction meets the curriculum requirements for credentialing by the APTA’s American Board of Physical Therapy Residency and Fellowship Education. This financial agreement for subsequent years is dependent upon securing funding from the Community Benefits Program during its annual review of programs. The financial arrangement that is in place for 2009 will be requested for 2010 – and in subsequent years.

Example 4

(Adapted from The Ohio State University Medical Center Neurologic Physical Therapy Residency Program, 2009)

RESIDENCY EDUCATION AGREEMENT
Between
OSU Division of Physical Therapy
AND
Rehabilitation Services
Ohio State University Medical Center

Faculty of the Division will assist with the development of Residents by:

- Mentoring teaching abilities in entry-level neurologic labs
- Attending Residency presentations and provide formal written feedback for Resident assessment (1 per year per resident)
- Providing faculty-led journal clubs (monthly)
- Assist with Resident advising for appropriate didactic coursework (at least one course) within SAMP
- Access to journals and textbooks within the Division
• Grade all or a portion of the Case Study (faculty responsibility will mostly be if interpretation of literature is appropriate and accurate)
• Offering supportive funding for the APTA’s Combined Sections Meeting

OSU Rehabilitation will provide the Division with:
• A minimum of 6 contact hours fall, winter, spring, and summer quarters (max of 24) from Residents teaching entry-level neurologic and neuroscience labs
  o Autumn quarter: PT 764.02 (neurorehabilitation labs) for 10 week
  o Winter quarter: PT 765.02 (neurorehabilitation labs) for 6 weeks
  o Summer quarter: PT 630 (neuroscience) for 4 weeks

Advantages for the Division:
• Formal contact with residency program may assist with recruitment into post-professional educational programs
• Qualified instructors for labs
• Qualified instructors for advanced DPT course
• Bridge clinical and academic departments
• Assist with the application of scientific knowledge
• Add to body of physical therapy literature through publication of case studies

Advantages for OSU Rehabilitation:
• Fulfill practice areas for residents in:
  o Education
  o Anatomy
  o Critical Inquiry
  o Content areas (follows content of neurologic labs that the resident will teaching)
  o Biomechanics (e.g., spatiotemporal and kinematic gait and functional task analysis)
• OSU PT Faculty as part of the Residency Program Faculty

_______________________________   ______________________________________
Director, Rehabilitation Services   Director, OSU Division of Physical Therapy
Evidence 2.3.1.2 – Describe the process for obtaining malpractice and health insurance coverage for all residents or fellows.

Example 1

(Adapted from University of St. Augustine for Health Sciences Orthopaedic Physical Therapy Fellowship, 2007)

Health Insurance Coverage: The full-time fellow will receive an allowance of $ a month for private health insurance.

Example 2

(Adapted from St. Catherine’s Rehabilitation Hospital & Villa Maria Nursing Center Post-professional Residency in Geriatric Physical Therapy, 2009)

Residents will receive malpractice coverage provided by the institution (St. Catherine’s/Villa Maria) at no charge. Health, dental, life, and disability insurance are offered at standard employee rates. See employee handbook.

Procedure: Malpractice insurance is provided automatically upon hire (and licensure). During employee orientation, residents will be given an opportunity to select the health/dental coverage plan in which they wish to enroll. Residents may elect not to participate at that time as well.

Example 3

(Adapted from Glendale Adventist Medical Center’s Orthopedic Physical Therapy Residency, 2009)

All residents are employed as full-time (minimum of 36-hours per week) Glendale Adventist Medical Center employees and, as such, are eligible to receive the comprehensive benefits package (see policies section 8650 for specifics on health plan, paid leave, retirement, etc). In addition, all residents, as employees of Glendale Adventist Medical Center, are covered under the Adventist Health malpractice insurance plan.

Example 4

(From Hospital for Special Surgery Sports Physical Therapy Clinical Residency, 2009)

The Sports Physical Therapy Resident as a full-time employee of the Hospital for Special Surgery has malpractice insurance coverage through the hospital’s group liability insurance policy. As an individual who provides medical care outside of the hospital premises (athletic venues) the sports physical therapy resident is required to carry professional malpractice insurance ($1 million/$3 million aggregate) as a supplement to the hospital’s group liability insurance.

Health insurance benefits are provided to the Sports Physical Therapy Resident by the hospital (various plans with different levels of employee contributions are available).

Example 5

(From Kaiser Permanente Los Angeles Movement Science Fellowship, 2009)
All fellows are employed as part-time (20-hours/week average) Kaiser Permanente employees and thus, are eligible to receive the benefit package that includes health, hospital, and disability insurance. In addition, all fellows are covered under the Kaiser’s malpractice insurance plan that it has for all of their physical therapy providers.
Evidence 2.3.1.3 – Describe the availability of, and accessibility to educational advising and counseling.

Example 1

(From Hospital for Special Surgery Sports Physical Therapy Clinical Residency, 2009)

During the orientation period of the program, the sports resident meets with the program director and the section manager to review hospital, department and section policies and procedures, clinical responsibilities, section rehabilitation philosophy, and equipment utilized in the Sports Rehabilitation & Performance Center. An initial hire Orientation competency is completed and again reviewed 6 weeks following the start of employment.

The resident will also be orientated to the department’s Information Technology system, “Climacs” by the Assistant Director of Rehabilitation. The Climacs system manages scheduling, patient retrieval information and intra-department communication.

The program director meets with the sports resident at the onset of the academic year to review the goals, objectives and requirements of the residency program. The grievance procedure as it pertains directly to the residency program is also reviewed.

The Sports Resident will also meet with a member of the Sports Rehab staff for instruction on the computer system for access to hospital based educational material (HSS web site), intranet (to include online library resources) and the Sports Rehabilitation and Performance Center library (textbooks, video’s/DVD’s, e-journal library)

Educational advising and counseling is provided to the Sports Resident on an on-going basis by the Residency Director and members of the Sports Rehabilitation & Performance center faculty throughout the duration of the residency program. Formal meetings are scheduled monthly (or more frequently if needed) to provide advice/consultation on scheduling, assignments, in-service topics, continuing education and special interests. The faculty are fully aware of and readily accept this responsibility so as to provide a complete and educational experience in sports physical therapy.

Example 2

(From Army-Baylor University Doctoral Fellowship in Orthopaedic Manual Physical Therapy, 2009)

The educational advisor and primary counselor for each fellow is the program director who is available on site at least ten hours per day, and by phone/email/pager after hours. All clinical and academic faculty are available in person, by phone, and email and are encouraged to advise and counsel each fellow as needed. Staff from the BAMC Department of Ministry and Pastoral Care as well as the BAMC Department of Behavioral Medicine are also available as needed for individual counseling. Additionally, a robust ombudsman program is available through BAMC.

Example 3

(From St. Catherine’s Rehabilitation Hospital & Villa Maria Nursing Center Post-professional Residency in Geriatric Physical Therapy, 2009)

Resident Access to Educational Advisement Policy and Procedure
Residents receive educational advisement including information regarding salary, tuition reimbursement, current enrollment policies, matriculation, withdrawal, and dismissal policies and procedures. This information is shared during orientation and may be obtained through the Program Director or Coordinators at any time. All residency faculty are available for advisement by appointment.

**Example 4**

*(From Kaiser Permanente Los Angeles Movement Science Fellowship, 2009)*

Educational advising is available from the clinical faculty and department administrator at the facility where the resident is employed. In addition, the program coordinator is available to assist, when requested, to provide educational advising and employment/career counseling. Counselors in the medical center’s personnel office are available to assist the resident with regard to any available financial assistance.
Evidence 2.4.1 – Financial Resources

A. Describe the Program’s current sources of funding.

B. Describe the Program’s plan to assure funding throughout the period of credentialing.

Example 1

(From The Jackson Clinics Orthopedic Physical Therapy Residency Program, 2009)

2.4.1.A Program’s current sources of funding.

The administrative and operational costs associated with the residency, such as the salaries of the residents and clinical faculty are funded by The Jackson Clinics, LLC.

2.4.1.B Program’s plan to assure funding throughout the period of credentialing.

The Jackson Clinics, LLC is very stable financially and the Residency is funded through specific line items on our profit and loss statement. The residents help to ensure adequate capital for the program by working a minimum of 33 hours per week during the resident year (50 weeks). If there are any corporate cash flow difficulties the company has a substantial line of credit to see it through these times.

Example 2

(Adapted from St. Catherine’s Rehabilitation Hospital & Villa Maria Nursing Center Post-professional Residency in Geriatric Physical Therapy, 2009)

2.4.1.A Program’s current sources of funding.

The program is funded by Villa Maria Nursing and Rehabilitation Center, Inc. However, the residency program is a budget neutral item. Resident’s receive a lower than usual salary which offsets costs associated with administering, marketing, and running the program. The program has remained budget neutral throughout its existence.

2.4.1.B Program’s plan to assure funding throughout the period of credentialing.

The Program Director is responsible for presenting an annual budget to the Director of Rehabilitation for input and feedback. The Director of Rehabilitation Services at St. Catherine’s/Villa Maria will advise the program director as needed. The residency program budget will become a part of the overall budget for St. Catherine’s/Villa Maria upon his/her approval.

The program is budgeted to be self-sufficient. In the event the program incurs a loss, the umbrella organization is prepared to support the program until adequate changes can be completed to make the program self-sufficient once again.

Example 3

(From Kaiser Permanente Los Angeles Movement Science Fellowship, 2009)
2.4.1.A Program’s current sources of funding.

The curriculum development and clinical supervision costs provided by the clinical faculty are funded by the Community Benefits Workforce budget within the Southern California Permanente Medical Group. This has amounted to .72 FTE in 2009.

The administrative costs associated with fellows, such as the salaries of the fellows, are funded by each of the three facilities that employ the fellows.

The registration fees paid by the fellows fund other miscellaneous expenses, such as APTA credentialing annual fees, graduation dinner costs, graduation certificates, and equipment expenses.

2.4.1.B Program’s plan to assure funding throughout the period of credentialing.

The financial condition of the program is dependent upon receiving funding from Kaiser Permanente Southern California Region Community Benefits program. All programs funded by the Community Benefits program are required to submit a standardized funding request form to the Grants Compliance Officer of the Southern California Region Community Benefit program review committee that assesses each program’s 1) Number of students, 2) Demographic characteristics of participants, 3) Total number of trainee FTE’s, 4) Total number of students assigned to each Medical Center the previous year, 5) Description of any special events, major milestones reached and/or distinguished awards received in the previous year, and 6) Description of community projects/activities the students participated in the previous year including the community needs addressed by these activities, direct impact of these programs on the community’s need and significant achievements made by these programs in the community.
Evidence 2.5.1 – Describe the available support staff and services.

Example 1

(From The Jackson Clinics Orthopedic Physical Therapy Residency Program, 2009)

Each clinical site employing residents has a full-time support staff and services available to meet the needs of the residents and the Program.

Available support staff and services:
- Office Manager
- Clinic Director
- Physical Therapists
- Physical Therapist Assistants

The full and part time receptionists are responsible for scheduling orthopedic evaluations for each resident and for scheduling return patients for 30-minute appointments. There are full and part time physical therapy assistants whose services are available to the residents when needed. There are full time Clinic Directors who are responsible for coordinating the clerical and clinical support staff to facilitate the clinical objectives of the residents. There is also ongoing communication with the administrators, Clinic Director, the residency program coordinator, the clinical faculty, and the residents to ensure the achievement of the goals of the residency.

Example 2

(Adapted from St. Catherine’s Rehabilitation Hospital & Villa Maria Nursing Center Post-professional Residency in Geriatric Physical Therapy, 2009)

As residents are employees of St. Catherine’s Rehabilitation Hospital & Villa Maria Nursing Center, the residents have available to them all the support services and staff as any employee. It is the responsibility of the management team at St. Catherine’s/Villa Maria to insure that adequate support services and staff are in place. This is done on an ongoing basis by management personnel. Currently support staff include:

- Physical Therapists Assistants: as defined by state law (2 full time, and 2 PRN)
- Rehab Aides: assist all rehab staff (PT, OT, SLP) in treatment as indicated (as defined by law), transport patients to/from rooms. (8 full time)
- Clerks: secretarial services, billing, scheduling, insurance verification, payroll, etc. (2 full-time)

Example 3

(From Army-Baylor University Doctoral Fellowship in Orthopaedic Manual Physical Therapy, 2009)

The Brooke Army Medical Center Physical Therapy Service, where the program resides, has a full-time support staff and services that adequately meet the needs of the fellows and the clinical faculty. Available on-site support staff and services include two full-time receptionists, an information management specialist, a department chief, 17 physical therapists, 2 physical therapist assistants and 9 military physical therapy specialists.

The full-time receptionists are responsible for preparing patient files and scheduling one-hour new evaluation appointments for each fellow and 30-minute follow-up appointments. Full-time military physical therapy specialists are available to assist the fellows as needed. The Department of Orthopaedic
and Rehabilitation Chair, and the chief of the Physical Therapy Service fully support the fellowship program. Ongoing communication between the department/service chief and the program director enhances the achievement of the program goals.

**Example 4**

*(From Hospital for Special Surgery Sports Physical Therapy Clinical Residency, 2009)*

The Sports Rehabilitation & Performance Center support staff includes three full time rehabilitation technicians, one of whom is a Northeastern University work-study student. The center also employs an office manager and five managed care liaisons. Teamwork is highly valued, and as such the support staff and professional staff work together to assure that patients receive optimal care and consumer service.

The rehabilitation technicians provide the treating physical therapists, including the sports physical therapy resident with assistance as needed in the treatment area. The office manager and managed care liaisons schedule patient appointments and assist in managing physician prescription retrieval and insurance concerns for the treating clinicians including the sports physical therapy resident.

The program director and Sports Rehabilitation & Performance Center manager (also faculty members) work closely with the Director of Outpatient Rehabilitation, the Assistant Director of Rehabilitation and the Vice President (HSS)/Director of Rehabilitation to assure that the support required by sports physical therapy resident to achieve program goals is available.

The Hospital for Special Surgery medical librarian is available to assist and educate the sports PT resident and other staff in locating journals and textbooks.

**Example 5**

*(From Kaiser Permanente Los Angeles Movement Science Fellowship, 2009)*

The three clinical sites employing fellows has a full-time support staff and services available to meet the needs of the fellows and the clinical fellowship program faculty.

Available support staff and services:

Receptionists
Senior Physical Therapists
Department Administrator
Assistant Department Administrator
Physical Therapy Assistants

The full and part-time receptionists are responsible for scheduling 4 evaluations a day for each fellow and for scheduling return patients for 30-minute appointments. There are a full and part-time physical therapy aides and assistants whose services are available to the fellows when needed. There are full time senior outpatient physical therapists that are responsible for coordinating the clerical and clinical support staff to facilitate the clinical objectives of the fellows. There is also ongoing communication with the Department Administrators, the senior outpatient physical therapists, the fellowship program coordinator, the clinical faculty, and the fellows to enhance to achievement of the goals of the fellowship.
Evidence 2.6.1 – Describe the educational resources, including methods of access, available to faculty and residents or fellows.

Example 1

(From Kaiser Permanente Los Angeles Movement Science Fellowship, 2009)

Each clinical facility has an on-site medical library that is available to the fellows and clinical faculty. In addition, each clinical facility has Internet access to most medical journals through Kaiser Permanente’s employee website. The medical center’s librarian can obtain publications that are not available on site. In addition, fellows are provided extensive syllabi and electronic media to complement the classroom and lab instruction.

Example 2

(From St. Catherine’s Rehabilitation Hospital & Villa Maria Nursing Center Post-professional Residency in Geriatric Physical Therapy, 2009)

Residents and faculty have access to the University of Miami, Miller School of Medicine, Calder Library (Health Sciences). Calder Library provides books, journals, audio-visual media, and Internet access to its users. Inter-library loans are also available. Residents and faculty alike will find a wealth of peer-reviewed journals on geriatrics. In addition to U of M online resources, residents have access to books and journals belonging to faculty and St. Catherine’s/Villa Maria. Free use of a personal computer with unlimited Internet access is available on-site at St. Catherine’s/Villa Maria. The residency program also asks its residents to provide a list of resources they might find useful as our library continues to grow. Residents are also eligible to attend continuing education courses (paid by St. Catherine’s/Villa Maria) as deemed appropriate. Residents also receive paid APTA and Section on Geriatrics dues which provides access to journals, “Open Door”, “Hooked on Evidence”, etc.

Example 3

(From Army-Baylor University Doctoral Fellowship in Orthopaedic Manual Physical Therapy, 2009)

The physical therapy fellows and faculty have access to the appropriate educational resources that support the curriculum. The fellowship program is located within the physical therapy department, Brooke Army Medical Center (BAMC), Fort Sam Houston, Texas. A medical library within BAMC is available for use by the fellows. Additional library facilities available to the fellow are the Army Medical Department Center and School at Fort Sam Houston and on-line at Baylor University. The fellowship program library is also well-maintained with a comprehensive collection of videotapes, current publications and books to which the fellows and clinical faculty have open access. These resources serve as core references supporting the fellowship curriculum and are updated as necessary to support changes in the curriculum. Recommended text references are available in the program library.

Each fellow has a designated area which includes a desk, treatment table, and desktop computer for evaluation and intervention with patients. The computers are networked throughout the hospital. They allow immediate access to radiology and laboratory reports and electronic ordering of radiographs, bone scans, and selected medications. The computers have various databases and clinical compact discs (CDs) such as ADAM (anatomical software), an MRI instructional course, Journal of Bone and Joint Surgery, American Journal of Sports Medicine, Physical Therapy journals, direct MEDLINE, and internet access for both research and educational purposes.
The mission of the medical library at BAMC is to support the medical informational and educational needs of all personnel assigned to BAMC. The librarian is Beverly Rakowitz who can be reached at (210) 916-1119. To check out books or request articles from other libraries (interlibrary loan), one must register as a library user, which allows access to library services at any time. The library is staffed from 0730 to 1630 hours, Monday through Friday, but accessible to users during evenings, weekends, Federal holidays and training holidays. Access to the library after hours is authorized for all credentialed providers including the physical therapy fellows and clinical faculty.

Services provided by the Medical Library staff included:
1. Interlibrary Loans – journal articles or books are borrowed from other libraries for fellow use. Requests can be placed in person, faxed, phoned in, or emailed to the staff.
2. Photocopy machines – there are 3 in the library.
3. Computers – there are 10 public computers for use in the library (6 networked and 4 stand-alone).
4. Scanners – there are two picture scanners and one text scanner for public use.
5. Microfilm/fiche reader – the library has a microfilm or microfiche machine that will make paper copies of the film or fiche.
6. Photocopy service – journals before 1980 are in storage. On request, the library staff will retrieve and photocopy the article for fellow use.
7. Computer Programs – OVID MEDLINE, CINAHL, HealthStar, Health Reference Center, MD Consult, STAT Ref, Up To Date, are some of the programs available to assist in locating needed information. There are a number of Full-Text journals in OVID and in the Clinical CD’s computer group. Access is also available through remote dial-in access. The librarian will search additional databases on request. DIALOG Knight-Ridder is available with over 400 bibliography databases. The OCLC service has the EPIC database which covers many of the same databases as DIALOG, plus others.
8. Journals – Over 600 journals are available in the library. These are available for use in the library or for photocopies.
9. Internet – There are computers available for connecting to the Internet. Use of the Internet will be for mission or educational needs only.
Evidence 2.6.2 – Describe the facilities that house the Program.

Example 1

*(From The Jackson Clinics Orthopedic Physical Therapy Residency Program, 2009)*

Each Jackson Clinics facility complies with the Virginia State Labor Laws, the State Occupational, Safety and Health Administration, the Americans with Disabilities Act, and the Health Insurance Portability and Accountability Act.

We have negotiated a one year contract with the Sheraton Reston Hotel. The classroom and lab facility at the Sheraton Reston has adequate space for both lecture presentations and laboratory demonstration and practice. For example, there are enough tables and space for residents to work in pairs during practice periods.

All of our clinical facilities provide the residents, clinical faculty, patients, and supportive staff with a safe, comfortable, accessible, and hazard-free environment. The facilities provide adequate space, privacy and security for the clinical faculty to prepare instructional materials, advise residents, and store records and materials.

Example 2

*(From Army-Baylor University Doctoral Fellowship in Orthopaedic Manual Physical Therapy, 2009)*

The program is located within the main physical therapy clinic at BAMC on Fort Sam Houston, Texas. The facility opened in March of 1996. It is one of San Antonio’s Level I trauma centers. The clinic is located on the third floor, and consists of over 8,269 square feet of state-of-the-art rehabilitation equipment and space. The physical therapy service is divided into four sections:

1. An outpatient neuromusculoskeletal evaluation and treatment section
2. An outpatient section at the Center for the Intrepid for polytrauma and amputee rehabilitation
3. An inpatient clinic for orthopaedic and general ward patients
4. A troop medical clinic soon to be housed in a separate facility and services our active duty training soldiers.

The program is integrated into all functions of the service. A separate academic classroom and individual evaluation/care areas are dedicated for the fellows. Each fellow has a designated work area in the clinic for evaluation/care that includes a desk, treatment table, and desktop computer. The computers are networked throughout the hospital. They allow immediate access to radiology and laboratory reports and electronic ordering of radiographs, bone scans, and selected medications. The computers have various databases and clinical compact discs (CDs) such as ADAM (anatomical software), an MRI instructional course, direct MEDLINE, Ovid full-text journals, and internet access for both research and educational purposes. All clinic computers were upgraded (hardware and software) within the past year to allow fellows to bring laptops home and have access to all automation services as if sitting at their desks, along with wireless access at home and in the hospital. The classroom has state-of-the-art audiovisual equipment including a camcorder, TV/VCR/DVD, computer, printer, scanner, slide projector, digital camera, and digital projection capabilities.

A physical therapy clinic library is maintained in the department. The clinic library has copies of the additional recommended references. The BAMC medical library as well as Stimson Library at the Army Medical Department (AMEDD) Center and School, Fort Sam Houston, Texas, are available for journal articles and additional references. The BAMC medical library is described in Evidence 2.6.1. The
Stimson Library at the AMEDD Center and School holds 39,800 books, over 20,000 bound periodical volumes, and subscriptions to 607 journals and other serials. The AMEDD Center and School also houses the anatomy lab. Fellows are provided with one cadaver for dissection. Additionally, prosections of all regions of the body are available. Fellows also have full access to the Physical Therapy Research center (PTRC) at the AMEDD Center and School. The PTRC is a state-of-the-art research facility developed for the U.S. Army-Baylor University Doctoral Program in Physical Therapy. Fellows also have full access to the Movement Science Lab at the Center for the Intrepid.

The BAMC physical therapy clinic has exceptional infrastructure and equipment in terms of open areas for supervised exercise, physical modalities (ultrasound, iontophoresis, electrical stimulation, hot/cold packs, traction), manual therapy tables, strength and endurance training equipment (treadmills, stair steppers, elliptical trainers, Gravitron®, Alliance strength training equipment), a Biodex® isokinetic dynamometer, and access to an Olympic-sized therapeutic swimming pool at the Center for the Intrepid. The hospital has an in-house medical equipment maintenance and repair department that performs schedule maintenance and required repairs on the equipment for the physical therapy service. The clinic is fully integrated into the rehabilitation mission of the hospital. Multidisciplinary clinics in sports medicine and amputee-specific care are held in our clinic. The fellows are part of the clinical staff. They are fully integrated into all clinic functions and attend weekly staff meetings.

Example 3

(From St. Catherine’s Rehabilitation Hospital & Villa Maria Nursing Center Post-professional Residency in Geriatric Physical Therapy, 2009)

Activities take place at St. Catherine’s Rehabilitation Hospital and Villa Maria Nursing Center (both housed on one campus). Within this facility, levels of care provided include outpatient rehabilitation, an inpatient rehabilitation hospital, an extended care facility (ECF)/skilled nursing facility (SNF), and a long-term care (LTC) facility. All areas have designated rehabilitation gyms. St. Catherine’s is a 60 bed rehab hospital and outpatient center. Villa Maria is a 212 bed ECF/SNF which is dually certified for LTC.

Other facilities available for use are:

St. Catherine’s West Rehabilitation Hospital (inpatient/outpatient rehabilitation)
Villa Maria West Skilled Nursing Facility (SNF)
St. Anthony’s Rehabilitation Hospital (inpatient/outpatient rehabilitation)
St. John’s Nursing Center (SNF)
St. Anne’s Nursing Center (SNF/outpatient rehabilitation)
Catholic Home Health Services of Miami-Dade and Broward
St. Anne’s Residence (assisted living facility)
St. Joseph Residence (assisted living facility)
Catholic Housing Management (elderly housing)
Catholic Hospice (inpatient hospice care)

Didactic content is taught on-site at St. Catherine’s Rehabilitation Hospital. Classes are generally held in a conference room where Internet access is available. There is adequate space for teaching, presentations, etc.

Example 4

(From Kaiser Permanente Los Angeles Movement Science Fellowship, 2009)
The Kaiser Permanente Los Angeles Movement Science Fellowship is housed within outpatient physical therapy departments of the Kaiser Permanente Harbor City, Los Angeles and West Los Angeles medical centers. Each of these Kaiser Permanente Medical Centers is currently certified by The Joint Commission of Accreditation of Hospital Organization (JCAHO). Each Kaiser Permanente facility also complies with California State Labor Laws and the State Occupational, Safety and Health Administration (Cal OSHA). The classroom and lab facilities at Kaiser Permanente Los Angeles have adequate space for both lecture presentations and laboratory demonstration and practice. For example, all treatment tables are electric hi-lo tables and there are enough tables and space for fellows to work in pairs during practice periods.

The facilities provide the fellows, patients, program faculty and staff with a safe comfortable accessible and hazard free environment.

The facilities provide adequate space, privacy and security for the program faculty to prepare instructional materials, advise fellows, and store records and materials.

**Example 5**

*(Adapted from Glendale Adventist Medical Center’s Orthopedic Physical Therapy Residency, 2009)*

Glendale Adventist Medical Center’s Orthopedic Physical Therapy Resident is housed within an outpatient physical therapy department located at the Therapy & Wellness Center that is part of Glendale Adventist Medical Center. The Joint Commission on Accreditation of Hospital Organizations (TJC) currently certifies Glendale Adventist Medical Center. Each facility also complies with California State Labor Laws and the State Occupational, Safety and Health Administration (Cal OSHA).

As Glendale Adventist Medical Center’s Orthopedic Physical Therapy Residency is partnering with Kaiser Permanente for the didactic training, our resident travels to the classroom facilities located within the physical therapy clinic facilities of the Kaiser West Los Angeles Medical Center. The classroom and lab facilities of the Kaiser Permanente West Los Angeles have adequate space for both lecture presentations and laboratory demonstration and practice. For example, all treatment tables are electric high-low tables and there are enough tables and space for residents to work in pairs during practice periods.

Both facilities provide the residents, patients, program faculty and staff with a safe, comfortable, accessible and hazard free environment. As well, both facilities provide adequate space, privacy and security for the program faculty to prepare instructional materials, advise residents and store records and materials.
Evidence 2.7.1 – List the equipment and materials available to meet the goals of the Program. The multi-site Program must provide a list of equipment available to the resident/fellow at each clinical site.

Example 1

(Developed by APTA Residency/Fellowship staff, 2004.)

Equipment and materials available for a Neurologic Physical Therapy Residency might include, but is not limited to:

1. Mat tables
2. Hi-Low plinths
3. Parallel bars
4. Trial AFOs/KAFOs
5. Variety of upper extremity assistive devices
6. Floor mats
7. Tilt table
8. Treadmill
9. Overhead body weight support system
10. Functional Electrical Stimulation unit
11. Surface EMG Biofeedback unit
12. Computerized balance equipment
13. Variety of or access to wheelchairs and seating/positioning systems
14. Swiss balls
15. Varied terrain/surfaces for balance and gait/mobility retaining
16. Exercise equipment for strength and endurance (e.g., upper extremity bike, lower extremity bike, wheelchair accessible “Nautilus-type” strengthening equipment)
17. Other therapeutic modalities as needed by patient population

Example 2

(From St. Catherine’s Rehabilitation Hospital & Villa Maria Nursing Center Post-professional Residency in Geriatric Physical Therapy, 2009)

1. The residency program is part of the physical therapy service of St. Catherine’s Rehab Hospital and Villa Maria Nursing Center. Residents have their own desks, working space, and office supplies in the “main gym”. A personal computer is available in a neighboring office with unlimited Internet access. When residents are working in an area other than the “main gym”, there is adequate desk/working space provided. For presentation purposes, residents have available to computer projection and screens, slide projectors, overhead projectors, TV/VCR/DVD’s, faxes, printers, and copiers (all easily obtained or housed within the clerical area of the “main gym”). Presentations and inservices are generally held in the “main gym”, however, if additional space is needed, Villa Maria has a large auditorium that can be set up in classroom or conference seating depending on the number of attendees.
2. The Main Gym is where most patients from St. Catherine’s Rehab Hospital are treated. The area is equipped with 6 double mats (plinths), 2 electric parallel bars, stationary bike, standing frames (2), tilt table, treadmill, partial body-weight supported gait trainer, knee extension machine, hydrocollators, refrigerator/freezer, portable whirlpool, hydrospray equipment, superficial and deep heating modalities, electrical stimulators, ultrasound, biofeedback, cuff and dumbbell weights, stairs, ramps, curbs, and ADL apartment (including kitchen, washer/dryer, bathroom,
and bedroom), a UBE, Swiss balls, positioning and seating devices, and various adaptive devices and orthotics.

3. Attached to the main gym is an aquatic center with heated indoor pool, changing rooms, showers, bathroom, etc.

4. Adjacent to the main gym are 2 private treatment rooms with electric hi-low mat tables, one capable of mechanical traction.

5. The 2nd floor gym is where most of the patients from ECF and LTC are treated. In this area, there is desk space (3 cubicles), 3 double mats (plinths), electric parallel bars, a standing frame, full body ergometer, stairs, curb, tilt table, cuff weights, hydrocollator, refrigerator/freezer, superficial and deep heating modalities, electrical stimulators, restorators, Swiss balls, positioning and seating devices, and numerous adaptive devices and orthotics.

6. All gyms have areas that can be curtained off for privacy. All gyms have ample waiting space, accessible restrooms, emergency equipment, and water.

Example 3

(From Kaiser Permanente Los Angeles Movement Science Fellowship, 2009)

The Kaiser Permanente Physical Harbor City, Los Angeles and West Los Angeles Medical Centers facilities, have equipment such as hi-lo treatment tables, extensive exercise equipment, and physical agent devices.

Kaiser Permanente has an in-house medical equipment maintenance and repair department that performs the periodic scheduled maintenance and/or repairs on the equipment in the physical therapy clinics.

The classroom for the fellows is located within the physical therapy clinic facilities of the Kaiser Los Angeles Medical Center. These classroom facilities have adequate space, equipment (e.g., electric hi-lo treatment tables), educational materials (e.g., anatomical models, mobilization straps and wedges), and audio-visual equipment (screen, whiteboard, VCR, monitor, overhead projector, slide projector, LCD projector and laptop) to serve the needs of the clinical faculty, guest lecturers and fellows.

Example 4

(From Army-Baylor University Doctoral Fellowship in Orthopaedic Manual Physical Therapy, 2009)

The program has the equipment and materials necessary to meet the goals and objectives of the program. The physical plant, described in detail above in section 2.6.2, is fully available to fellows and faculty because they are fully credentialed and privileged members of the BAMC physical therapy staff. Further, the fellowship classroom is available for the exclusive use of fellows. In addition to the equipment listed in section 2.6.2, the following equipment has been acquired since the last credentialing period: two SonoSite® diagnostic ultrasound imaging units for abdominal/low back muscle biofeedback training and research purposes; a stand-alone digital video editing and DVD production system.

Example 5

(Adapted from Glendale Adventist Medical Center’s Orthopedic Physical Therapy Residency, 2009)

The Therapy & Wellness Center is a state-of-the-art 20,000 square foot facility, which is comprised of 10 private treatment rooms, a large treatment gym, a class exercise room and a sports room. In addition to this it contains: 30 high-low treatment tables, a Biodex testing system, and extensive exercise equipment
consisting of a Smith machine, several weighted cable systems, Swiss balls, balance training tools, free weights, cardio equipment, and physical agent devices.

The Therapy & Wellness Center has an in-house clinical engineering and biomedical equipment maintenance and repair department that performs the periodic scheduled maintenance and/or repairs on the equipment in the physical therapy clinic.

As Glendale Adventist Medical Center’s Orthopedic Physical Therapy Residency is partnering with Kaiser Permanente for the didactic training, our resident travels to the classroom facilities located within the physical therapy clinic facilities of the Kaiser West Los Angeles Medical Center. These classroom facilities have adequate space, equipment (e.g., electric high-low treatment tables), educational materials (e.g., anatomical models, mobilization straps and wedges), and audio-visual equipment (screen, whiteboard, VCR, monitor, overhead projector, slide projector, LCD projector and laptop) to serve the needs of the clinical faculty, guest lecturers and residents.
3.0 Curriculum

Evidence 3.1.1 – Identify the year and version of the DSP/DASP or practice analysis used to develop the curriculum. If the curriculum is not in an ABPTS specialty area, provide a copy of the practice analysis or a detailed description of the expanded component of a DSP that was used to plan the Program.

The American Board of Physical Therapy Specialists (ABPTS) provides Descriptions of Specialty Practice (DSP) in the following areas:

- Cardiovascular and Pulmonary
- Clinical Electrophysiology
- Geriatric
- Neurologic
- Orthopaedic
- Pediatric
- Sports
- Women’s Health

These documents are available for purchase from the APTA online store.

Orthopaedic manual therapy fellowships must follow the most recent version of the American Academy of Orthopaedic Manual Therapist (AAOMPT) Orthopaedic Manual Physical Therapy Description of Advanced Specialist Practice (DASP) which is available for download at their website www.aampt.org.

If the curriculum is not in an area where ABPTS specialist certification exists, a reliable and valid practice analysis must be provided with the credentialing application for residency program or a detailed practice description for a fellowship program.

Example 1

(From Kaiser Permanente Los Angeles Movement Science Fellowship, 2009)

The curriculum of this fellowship is based upon the Description of Specialty Practice in Orthopaedic Physical Therapy published by the American Board of Physical Therapy Specialists/Orthopaedic Specialty Council in 2002. Specifically, the Movement Science knowledge area of this practice description forms the framework of the clinical education provided in this fellowship. The components of the Movement Science knowledge area of the DSP in Orthopaedic Physical Therapy are listed below:

Movement Science Knowledge Area Expected of Orthopaedic Clinical Specialists

a) Kinesiology/Clinical Biomechanics
b) Principles of Motor Learning/Control
c) Principles of Locomotion
d) Principles of Ergonomics
Evidence 3.1.2.A – Utilize Form 3.1.2.A to provide the major content areas in the Program’s curriculum and their relationship to the DSP/DASP/practice analysis.

**Example 1**

*(Form provided in part 4 of the application: Forms)*

**Form 3.1.2.A**

**Curriculum Overview**

Provide the major content areas in the curriculum and their related areas of the DSP/DASP. Also include didactic, clinical experiences, and number of mentoring hours provided in the following table:

<table>
<thead>
<tr>
<th>CONTENT AREA</th>
<th>RELATED AREA IN DSP/DASP</th>
<th>LOCATION IN CURRICULUM (e.g., semester, week)</th>
<th>DIDACTIC EXPERIENCES</th>
<th>CLINICAL EXPERIENCES</th>
<th>MENTORING HOURS PROVIDED</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cervical, Thoracic, Lumbar Spine</td>
<td>-All practice dimensions -Critical Inquiry -All Knowledge Areas -Procedures</td>
<td>Module I (weeks 1-13)</td>
<td>Classroom Instruction &amp; discussion Lab demonstration Lab practice with instructor and peer feedback Clinical supervision and practice</td>
<td>32 hours/week patient care; 16 of those hours will be shared clinic time with clinical mentor/program director Specialty Clinic Observation</td>
<td>3 hours/week unopposed mentor time (at least 2 hours with resident as primary provider)</td>
</tr>
</tbody>
</table>

*Example 2*

*(Adapted from Cincinnati Children’s Hospital Medical Center Sports Medicine Biodynamics Center Orthopedic Physical Therapy Residency Program, 2010)*
<table>
<thead>
<tr>
<th>Professional Behavior</th>
<th>Module I (weeks 1-13)</th>
<th>Classroom instruction Independent study New Employee Orientation Materials (See Module I schedule included in the Evidence 3.1.2.C)</th>
<th>Observation experiences and feedback from: -Clinical Mentor -Residency Faculty -Orthopedic MDs -Clinic Staff PTs</th>
<th>Professional behavior is an included component within the 3 hours/wk unopposed mentoring time, particularly within feedback from the mentor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Independent study</td>
<td></td>
<td>(See Module I schedule included in Evidence 3.1.2.C)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinical Reasoning</td>
<td>Module I (weeks 1-13)</td>
<td>Classroom instruction and discussion Independent Study Evidence-Based Decision Making Training and resources within CCHMC (See Module 1 schedule included in Evidence 3.1.2.C)</td>
<td>Practice and progression of clinical reasoning skills within the 32 hours/week of patient care</td>
<td>Utilization and advancement of clinical reasoning is fundamental to the 3 hours/wk unopposed mentoring time.</td>
</tr>
<tr>
<td>Evaluation, Diagnosis, Prognosis -Evidence-Based Orthopedic PT Theory and Practice -Critical Inquiry</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hip/Knee</td>
<td>Module 2 (weeks 14-26)</td>
<td>Classroom instruction and discussion Lab demonstration Lab practice with instructor and peer feedback Clinical supervision and practice Independent study (See Module 2 schedule included in Evidence 3.1.2.C)</td>
<td>32 hours/week patient care; 16 of those hours will be shared clinic time with clinical mentor/program director Specialty Clinic Observation</td>
<td>3 hours/wk unopposed mentor time (at least 2 hours with resident as primary provider)</td>
</tr>
<tr>
<td>All Practice Dimensions -Critical Inquiry -All Knowledge Areas -Procedures</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Leadership Skill Development (starts in Module 2)</td>
<td>Added emphasis in Module 2 (weeks 14-26) but ongoing through the program</td>
<td>Classroom Discussion and Observation Independent Study Self Assessment</td>
<td>Leadership skill development woven into clinical time as well as within other activities, such as integration project</td>
<td>Observation experiences and feedback from: -Clinical Mentor -Residency Faculty -Orthopedic MDs -Clinic Staff PTs</td>
</tr>
<tr>
<td>Hip/Knee</td>
<td>Module 3 (weeks 27-39)</td>
<td>Classroom instruction and discussion Lab demonstration Lab practice with instructor and peer feedback Clinical supervision and practice Independent study (See Module 3 schedule included in Evidence 3.1.2.C)</td>
<td>32 hours/week patient care; 16 of those hours will be shared clinic time with clinical mentor/program director Specialty Clinic Observation</td>
<td>3 hours/wk unopposed mentor time (at least 2 hours with resident as primary provider)</td>
</tr>
<tr>
<td>All Practice Dimensions -Critical Inquiry -All Knowledge Areas -Procedures</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ankle/Foot/TMJ</td>
<td>Module 4 (weeks 40-52)</td>
<td>Classroom instruction and discussion Lab demonstration Lab practice with instructor and peer feedback Clinical supervision and practice Independent study</td>
<td>32 hours/week patient care; 16 of those hours will be shared clinic time with clinical mentor/program director Specialty Clinic Observation</td>
<td>3 hours/wk unopposed mentor time (at least 2 hours with resident as primary provider)</td>
</tr>
<tr>
<td>All Practice Dimensions -Critical Inquiry -All Knowledge Areas -Procedures</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Application Resource Manual
APTA Clinical Residency and Fellowship Program Credentialing (2011)
Example 3

(Adapted from University of St. Augustine for Health Sciences Orthopedic Residency, 2010)

<table>
<thead>
<tr>
<th>CONTENT AREA</th>
<th>RELATED AREA IN DSP/DASP</th>
<th>LOCATION IN CURRICULUM (e.g., semester, week)</th>
<th>DIDACTIC EXPERIENCES</th>
<th>CLINICAL EXPERIENCES</th>
<th>MENTORING HOURS PROVIDED</th>
</tr>
</thead>
<tbody>
<tr>
<td>Elbow</td>
<td></td>
<td>Term 1; Week 4 Term 3; Week 10</td>
<td>• Independent Study</td>
<td>• Clinical Practice</td>
<td>Yes included in</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Online Coursework</td>
<td>and Supervision</td>
<td>mentoring</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Case Presentation</td>
<td>• Clinical Mentoring</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Lectures/Presentations at Conferences</td>
<td>• Health Care</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Journal Club</td>
<td>Observations</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>• Case Rounds</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>• Seminar Instruction</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

A. Practice Dimensions Expected of Orthopaedic Clinical Specialists
C. Knowledge Areas Expected of Orthopaedic Clinical Specialists
D. Procedures Expected of Orthopaedic Specialists

*This is an example of only one course for use here in the Resource Manual and not the Program’s entire curriculum.*
Evidence 3.1.2.B – Utilize Form 3.1.2.B to provide an example of a typical weekly schedule for the resident or fellow.

**Example 1**

(Form provided in part 4 of application: Forms)

**Form 3.1.2.B**

*Name of Clinical Residency/Fellowship Program:*

<table>
<thead>
<tr>
<th>Sample Weekly Schedule</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>SUNDAY</strong></td>
</tr>
<tr>
<td>7:00 AM</td>
</tr>
<tr>
<td>1:00 PM</td>
</tr>
<tr>
<td>7:00 PM</td>
</tr>
</tbody>
</table>

**Example 2**

*(From St. Catherine’s Rehabilitation Hospital & Villa Maria Nursing Center Post-professional Residency in Geriatric Physical Therapy, 2009)*

**Typical Weekly Schedule**

<table>
<thead>
<tr>
<th><strong>Sun</strong></th>
<th><strong>Mon</strong></th>
<th><strong>Tue</strong></th>
<th><strong>Wed</strong></th>
<th><strong>Thu</strong></th>
<th><strong>Fri</strong></th>
<th><strong>Sat</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>8:00-4:30 Patient Care</td>
<td>8:00-4:30 Patient Care</td>
<td>8:00-4:30 Patient Care</td>
<td>8:00-4:30 Patient Care</td>
<td>Learning experience 1½ hrs. plus self-study time in am Projects time pm (4 hrs)</td>
<td>OFF</td>
<td>OFF</td>
</tr>
</tbody>
</table>
### Example 3

*(Adapted from Army-Baylor University Doctoral Fellowship in Orthopaedic Manual Physical Therapy, 2009)*

**Sample Weekly Schedule**

<table>
<thead>
<tr>
<th></th>
<th>SUN</th>
<th>MONDAY</th>
<th>TUESDAY</th>
<th>WEDNESDAY</th>
<th>THURSDAY</th>
<th>FRIDAY</th>
<th>SAT</th>
</tr>
</thead>
<tbody>
<tr>
<td>7:00 AM</td>
<td></td>
<td>OMPT Skills Practice PHT 6191-6194 7am – 8:30am</td>
<td>OMPT Skills Practice PHT 6191-6194 7am – 8am</td>
<td>OMPT Skills Practice PHT 6191-6194 7am – 8:30am</td>
<td>OMPT Skills Practice PHT 6191-6194 7am – 8am</td>
<td>OMPT Skills Practice PHT 6191-6194 7am – 8:30am</td>
<td></td>
</tr>
<tr>
<td>8:00 AM</td>
<td></td>
<td>Patient care PHT 6391-6394 8:30am – 12pm</td>
<td>Tutorial 8am – 12pm</td>
<td>Patient care PHT 6391-6394 8:30am – 12pm</td>
<td>OMPT Hip: Eval and Tx, Course PHT 5382 8am – 12pm</td>
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</tr>
<tr>
<td>9:00 AM</td>
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<tr>
<td>10:00 AM</td>
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<tr>
<td>11:00 AM</td>
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<td>NOON</td>
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<tr>
<td>1:00 PM</td>
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</tr>
<tr>
<td>2:00 PM</td>
<td></td>
<td>Differential Diagnosis Course PHT 5241 1:00pm – 5pm</td>
<td></td>
<td>Research Design, Course PHT 5230 1pm – 5pm</td>
<td></td>
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<tr>
<td>3:00 PM</td>
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<tr>
<td>4:00 PM</td>
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</tr>
</tbody>
</table>

### Example 4

*(Adapted from United States Military-Baylor University Post-professional Physical Therapy-Sports Medicine Doctoral Program, 2009)*

**Sample Weekly Schedule**

<table>
<thead>
<tr>
<th></th>
<th>Monday</th>
<th>Tuesday</th>
<th>Wednesday</th>
<th>Thursday</th>
<th>Friday</th>
</tr>
</thead>
<tbody>
<tr>
<td>0630-0900</td>
<td>Patient Care</td>
<td>Patient Care</td>
<td>Patient Care</td>
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<tr>
<td>0900-1100</td>
<td>Academic Activities</td>
<td>ISRT</td>
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<tr>
<td>1100-1300</td>
<td>PT/Lunch</td>
<td>PT/Lunch</td>
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<tr>
<td>1300-1530</td>
<td>Patient Care</td>
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<td>1530-1830</td>
<td>Athletic Training</td>
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</table>

### Example 5

*(Adapted from Children’s Hospital of Philadelphia Physical Therapy Pediatric Residency Program, 2009)*

**Sample Weekly Schedule**

<table>
<thead>
<tr>
<th></th>
<th>MONDAY</th>
<th>TUESDAY</th>
<th>WEDNESDAY</th>
<th>THURSDAY</th>
<th>FRIDAY</th>
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<tbody>
<tr>
<td>8:00 AM</td>
<td>LEND</td>
<td>LEND</td>
<td>Grand Rounds</td>
<td>Lecture</td>
<td>LEND PROJECT</td>
</tr>
<tr>
<td>TIME</td>
<td>Classroom</td>
<td>TIME</td>
<td>Classoom</td>
<td>TIME</td>
<td></td>
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<tr>
<td>---------</td>
<td>-----------</td>
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<td></td>
</tr>
<tr>
<td>9:00 AM</td>
<td>LEND</td>
<td>MENTOR</td>
<td>LEND</td>
<td>MENTOR</td>
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<tr>
<td></td>
<td>TIME</td>
<td>TIME</td>
<td>TIME</td>
<td>TIME</td>
<td></td>
</tr>
<tr>
<td>10:00 AM</td>
<td>MENTOR</td>
<td>OBSERVATION</td>
<td>OBSERVATION</td>
<td>OBSERVATION</td>
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<tr>
<td></td>
<td>TIME</td>
<td>TIME</td>
<td>TIME</td>
<td>TIME</td>
<td></td>
</tr>
<tr>
<td>11:00 AM</td>
<td>PATIENT CARE</td>
<td>PATIENT CARE</td>
<td>PATIENT CARE</td>
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<td></td>
</tr>
<tr>
<td>NOON</td>
<td>LUNCH</td>
<td>LUNCH</td>
<td>INSERVICE/STAFF MTG</td>
<td>LUNCH</td>
<td></td>
</tr>
<tr>
<td></td>
<td>LUNCH</td>
<td>LUNCH</td>
<td>LUNCH</td>
<td>LUNCH</td>
<td></td>
</tr>
<tr>
<td>1:00 PM</td>
<td>PATIENT CARE</td>
<td>PATIENT CARE</td>
<td>PATIENT CARE</td>
<td>PATIENT CARE</td>
<td></td>
</tr>
<tr>
<td>2:00 PM</td>
<td>PATIENT CARE</td>
<td>PATIENT CARE</td>
<td>PATIENT CARE</td>
<td>PATIENT CARE</td>
<td></td>
</tr>
<tr>
<td>3:00 PM</td>
<td>PATIENT CARE</td>
<td>PATIENT CARE</td>
<td>PATIENT CARE</td>
<td>PATIENT CARE</td>
<td></td>
</tr>
<tr>
<td>4:00 PM</td>
<td>ADMIN END 4:30</td>
<td>ADMIN END 4:30</td>
<td>ADMIN END 4:30</td>
<td>ADMIN END 4:30</td>
<td></td>
</tr>
<tr>
<td>5:00 PM</td>
<td>LECTURE/LAB/CLASSROOM</td>
<td>LECTURE/LAB/CLASSROOM</td>
<td>LECTURE/LAB/CLASSROOM</td>
<td>LECTURE/LAB/CLASSROOM</td>
<td></td>
</tr>
</tbody>
</table>
Evidence 3.1.2.C – Provide an outline of flow chart of the overall sequencing of content in the Program’s curriculum across the entire time period of the residency or fellowship, including both didactic and clinical experiences. Briefly explain the rationale behind the organization and sequencing of the curricular content.

Example 1

(Adapted from Cincinnati Children’s Hospital Medical Center Sports Medicine Biodynamics Center Orthopedic Physical Therapy Residency Program, 2010)

The following narrative describes the sequencing and integration of the curriculum components. Please also refer to the Module Content Outlines included in Evidence 3.1.2.D for a detailed outline of the curriculum components.

Orientation
The residency begins July 1st, or the Monday following July 1st. The first 2 weeks of the residency are designed as an orientation period to both Cincinnati Children’s Hospital Medical Center and the Sports Medicine Biodynamics Center. This orientation includes administration responsibilities, equipment, operations, and resident responsibilities.

Clinical Experiences
Clinical responsibilities will begin in the month of July. Throughout the year, the resident will participate in 32 hours per week of patient care in the clinic. Approximately 16 hours of this time is shared with the Residency director. Two hours of this weekly shared time is scheduled as “unopposed mentoring,” in which the resident provides care and the Residency Director observes his/her patient care and provides mentoring to the resident. While the resident’s caseload will consist of the broad spectrum of body regions, scheduling interventions will be made to assure that the resident is provided with evaluation and treatment opportunities that match the body region focus of the particular curriculum module that the resident is currently studying.

Didactic Experiences
Didactic education will occur throughout the year in several forms. Four modules of didactic and lab education are set up through the course of the year, each 3 months in duration. The 4 module curriculum includes topics in Spine, Hip/Knee, Shoulder/Upper Extremity and Foot/Ankle/TMJ. During that 3 month time, lectures will be delivered by physical therapists and physicians on topics of anatomy and pathoanatomy, differential diagnosis, evaluation, treatment, radiology findings, and case reports. In addition, clinical lab sessions will be incorporated on evaluation and treatment of various conditions. The resident’s learning is further supplemented with independent study materials, which are assigned with each module. Please refer to the Module Content Outlines found in Evidence 3.1.2.D, which serve as a “check off” list of the required didactic components of each module.

The resident will also have access to multiple other educational opportunities, including Cincinnati’s Sports Medicine Grand Rounds, Cincinnati Children’s Hospital’s Sports Medicine Fellowship Grand Rounds, Sports Medicine Journal Clubs, OrthoSurg/Radiology Sports Medicine Conference (Quarterly) and Ortho/Sports physical therapy problem conference. These opportunities will be utilized periodically to enhance the resident’s learning experience and also to meet any specific learning needs indentified by the resident and mentor.

The sequencing of these modules is specifically designed to match the goals of the residency as well as the needs of the patient population of the clinic. The body region focus of the first module is the Spine.
The rationale for this placement is that the Spine is the most common body region of this clinic’s patient population, so the resident will be best prepared to meet the needs of their clinic patient population for the entire year by beginning with the study of the spine. Also, the spine is dominant body region reported in surveys of orthopedic specialty practice and fills approximately 45% of questions of the OCS exam. Beginning with the spine allows the resident to have the most remaining time to further develop their skills in this critical area.

The knee is the second most treated body region in our clinic and is the focus of Module 2. Module 2 includes the study of hip/thigh, which is ideally placed to integrate it with the preceding focus of the spine.

Shoulder/UE in Module 3 which occurs from January- March serves to prepare the resident for the influx of throwing athletes coming into our clinic associated with spring baseball.

Module 4 consists of Ankle/Foot/TMJ and occurs during the remaining track season. It also parallels the clinical increase of patients with running injuries, which seems to occur as the outdoor weather improves. The curriculum component and observations associated with TMJ (Mandibular) dysfunction are less critical to our population and also take place in this final module.

**Additional Didactic Experiences**

Clinical Reasoning/Critical Inquiry is included as a component of the first module. It is critical to provide sufficient training in clinical reasoning at the onset of the residency, in order to establish a high expectation for the resident’s practice of this skill throughout the entire program. The resident’s growth and progress through the residency is vitally linked to their utilization and growth of clinical reasoning skills.

The resident is also required to complete and Integration Project, which “promotes the resident’s continued integration of practice, research, and scholarly inquiry consistent with the Program’s mission and philosophy.” (Interpretive Guideline, Credentialing Application document, January 2010). Examples of potential projects include the following: membership on an Evidence-Based Practice (EBP) team to develop a Clinical Practice Guideline for a specific condition, an individual research initiative such as case study/series that could be submitted as a poster presentation or for publication, and a CCHMC Performance Improvement project to enhance all areas of clinical practice. The scope of this project spans the entire presidency period. During the first quarter, the resident explores interest areas and considers project options. The resident uses the second quarter to make decisions and perform “project planning” (combining well with the leadership emphasis of the same quarter). The resident devotes the most time for significant progress on their project during the third quarter. Completion, implementation, and assessment of the project, then occurs during the fourth quarter. If the project is appropriate for submission as a poster/platform at CSM, it should be ready to submit the proposal by the typical deadline in May/June.

The residency places a special emphasis on the leadership development of the resident. The design of the curriculum includes a leadership training portion of the curriculum that occurs primarily during module two. The philosophy of this program is that an orthopedic specialist has the professional responsibility to serve as a leader in the field of physical therapy. The mission of this Program includes helping the resident gain awareness of their particular leadership strengths and providing opportunities for them to develop these skills. By doing this, the Program strives to prepare the resident for career-long service as a leader in their profession, in their place of employment, and in their community.

**Mentoring Experiences**
The resident has three hours of devoted mentoring time with the Residency Director each week. Two hours of this time are unopposed mentoring time in the clinic where the resident serves as primary patient care provider. The third hour is a weekly scheduled meeting, during which the resident and Residency Director discuss questions, evidence, and clinical reasoning directly related to patient care.

A broad scope of additional clinical observations and mentoring opportunities are provided to the resident. These experiences included observation in orthopedic department clinics, sports medicine department clinics, orthopedic surgery observation, SMBC research activities, and specialty clinic observation such as Runner’s clinic, Pain clinic, Rheumatology clinic. The resident is also encouraged to volunteer alongside an orthopedic/sports PT team member as they perform injury screenings in a community running clinic and to a local dance group. Please refer to the weekly “one-on-one Clinical Mentoring Schedule and Log” found in Evidence 3.1.2.D to examine the experiences that are required for the curriculum and others that are optional/supplemental.

**Example 2**

*(Adapted from Kaiser Permanente Los Angeles Movement Science Fellowship, 2009)*

Each fellow receives at least 272 hours of classroom/lab instruction, 135 hours of 1:1 supervision while treating patients, and 865 hours of clinical practice.

The sequence of the classroom instruction is demonstrated in the classroom/lab schedule is as follows:

<table>
<thead>
<tr>
<th>CURRICULUM AREA</th>
<th>CLASSROOM/LAB CONTENT</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Clinical Reasoning</strong></td>
<td>Skills workshop: Effective History Taking Strategies</td>
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<tr>
<td></td>
<td>Decision Making Models</td>
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<tr>
<td></td>
<td>Data Collection</td>
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<td></td>
<td>Data Interpretation</td>
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<tr>
<td></td>
<td>Treatment Planning</td>
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<td></td>
<td>Treatment Progression</td>
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<td></td>
<td>Patient Collaboration</td>
</tr>
<tr>
<td></td>
<td>Pain Sciences</td>
</tr>
<tr>
<td></td>
<td>Clinical Supervision/Mentoring Skills</td>
</tr>
<tr>
<td><strong>Movement Analysis and Motor Learning</strong></td>
<td>Motor Learning</td>
</tr>
<tr>
<td></td>
<td>Movement Analysis</td>
</tr>
<tr>
<td><strong>Movement Impairment System</strong></td>
<td>Movement System Balance I – Overview</td>
</tr>
<tr>
<td></td>
<td>Movement System Balance II – LQ</td>
</tr>
<tr>
<td></td>
<td>Movement System Balance III – UQ</td>
</tr>
<tr>
<td></td>
<td>Ergonomics</td>
</tr>
<tr>
<td><strong>Neuro-motor System</strong></td>
<td>Neuromotor System Rehab I – Assessment</td>
</tr>
<tr>
<td></td>
<td>Neuromotor System Rehab II – Treatment</td>
</tr>
<tr>
<td></td>
<td>Vestibular Assessment and Rehab</td>
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<tr>
<td></td>
<td>PNF procedures</td>
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<tr>
<td><strong>Clinical Biomechanics</strong></td>
<td>Clinical Biomechanics I – Normal</td>
</tr>
<tr>
<td></td>
<td>Clinical Biomechanics II – Pathological</td>
</tr>
<tr>
<td></td>
<td>Observational Gait Analysis</td>
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</tbody>
</table>
Instrumented Movement Analysis

Analysis and Contribution to the Scientific Literature

- Case Report Writing
- Analysis of Scientific Literature
- Independent Study and Consultation, Data Collection, Analysis, and Publication
- Case Presentations
- Research Presentations

### 2009 MOVEMENT SCIENCE FELLOWSHIP CLASS SCHEDULE

<table>
<thead>
<tr>
<th>Date</th>
<th>Day(s) of Week</th>
<th>Topics/Content of Instruction</th>
<th>Instructor(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jan 10</td>
<td>Saturday</td>
<td>Orientation to the program</td>
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</tr>
<tr>
<td></td>
<td>8 am – 5 pm</td>
<td>Skills workshop: Effective History Taking Strategies</td>
<td></td>
</tr>
<tr>
<td>Jan 11</td>
<td>Sunday</td>
<td>Clinical Reasoning: Decision Making Models</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Data Collection</td>
<td></td>
</tr>
<tr>
<td>Jan 17-18</td>
<td>Saturday and Sunday</td>
<td>Movement Analysis</td>
<td></td>
</tr>
<tr>
<td>Jan 31-Feb 1</td>
<td>Saturday and Sunday</td>
<td>Motor Learning</td>
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<tr>
<td>Feb 7</td>
<td>Saturday</td>
<td>Critical Analysis of Scientific Literature (at KPWLA)</td>
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<tr>
<td></td>
<td></td>
<td>Gait Biomechanics I</td>
<td></td>
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<tr>
<td>Feb 14</td>
<td>Saturday</td>
<td>Clinical Reasoning: Data Interpretation</td>
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<tr>
<td></td>
<td></td>
<td>Treatment Planning</td>
<td></td>
</tr>
<tr>
<td>Feb 27</td>
<td>Thursday</td>
<td>Movement Impairment Overview &amp; Patient Presentations</td>
<td></td>
</tr>
<tr>
<td>Feb 28-Mar 1</td>
<td>Saturday and Sunday</td>
<td>Movement Impairment System I</td>
<td></td>
</tr>
<tr>
<td>March 14-16</td>
<td>Sat, Sun &amp; Mon</td>
<td>Movement Impairment System II (Lower Quarter)</td>
<td></td>
</tr>
<tr>
<td>Mar 21</td>
<td>Saturday</td>
<td>Research Presentation Proposals</td>
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<tr>
<td></td>
<td></td>
<td>Gait Pathomechanics: Lower Extremity</td>
<td></td>
</tr>
<tr>
<td>March 28-30</td>
<td>Sat, Sun &amp; Mon</td>
<td>Movement Impairment System III (Upper Quarter)</td>
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<tr>
<td>April 4</td>
<td>Saturday</td>
<td>Skills Review</td>
<td></td>
</tr>
<tr>
<td>April 18</td>
<td>Saturday</td>
<td>Ergonomics, Anthropometrics &amp; Functional Kinetics</td>
<td></td>
</tr>
<tr>
<td>April 19</td>
<td>Sunday</td>
<td>Clinical Reasoning: Treatment Progression</td>
<td></td>
</tr>
<tr>
<td>May 2-3</td>
<td>Saturday and Sunday</td>
<td>Neuromotor Approach I (Evaluation)</td>
<td></td>
</tr>
<tr>
<td>May 16-17</td>
<td>Saturday and Sunday</td>
<td>Neuromotor Approach II (Treatment)</td>
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<tr>
<td></td>
<td></td>
<td>TBD</td>
<td>Clinical Biomechanics (at USC Gait Lab)</td>
</tr>
<tr>
<td>June 13</td>
<td>Saturday</td>
<td>Skills Review</td>
<td></td>
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<td>TBD</td>
<td>Observational Gait Analysis (at USC Gait Lab)</td>
</tr>
<tr>
<td>July 25-26</td>
<td>Saturday and Sunday</td>
<td>Vestibular Rehabilitation</td>
<td></td>
</tr>
<tr>
<td>Aug 1</td>
<td>Saturday</td>
<td>Clinical Reasoning: Patient Collaboration</td>
<td></td>
</tr>
<tr>
<td>Aug 2</td>
<td>Sunday</td>
<td>Pain Sciences</td>
<td></td>
</tr>
<tr>
<td>TBD</td>
<td>Friday</td>
<td>Western U – teaching assistants for Clare or Francisco</td>
<td></td>
</tr>
<tr>
<td>Aug 29</td>
<td>Saturday morning</td>
<td>Research Presentations/Consultation (at KPWLA)</td>
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</tr>
<tr>
<td>Aug 30</td>
<td>Sunday</td>
<td>Low Back Disorders/Skill Review</td>
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<tr>
<td></td>
<td></td>
<td>TBD</td>
<td>Instrumented Gait Analysis (at USC Gait Lab)</td>
</tr>
<tr>
<td>Sep 19-20</td>
<td>Saturday and Sunday</td>
<td>PNF Part 1</td>
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<tr>
<td>Nov 7-8</td>
<td>Saturday and Sunday</td>
<td>PNF Part 2</td>
<td></td>
</tr>
<tr>
<td>Nov 21</td>
<td>Saturday Morning</td>
<td>Research Presentations/Consultations (at KPWLA)</td>
<td></td>
</tr>
<tr>
<td>Dec 14-18</td>
<td>Monday-Friday</td>
<td>Last Scheduled Week of Clinical Practice</td>
<td></td>
</tr>
<tr>
<td>Dec 19</td>
<td>Saturday</td>
<td>Graduation Dinner</td>
<td></td>
</tr>
</tbody>
</table>

Classroom and Lab Instruction
All fellows are required to attend all of the didactic and lab instructional periods. These instructional periods are provided for the fellows most commonly in eight-hour blocks of time. Commonly, these eight-hour periods include a mix of lectures, discussion, demonstrations, and lab practice periods.

Module I – (Clinical Reasoning)
The clinical reasoning processes drives the selection of examination – and then – treatment procedures. Thus, with regard to sequencing, the instruction in clinical reasoning is emphasized prior to the evaluation and procedural training. Also with regard to sequencing, active approaches work best on patients who have the range of motion to allow movement. Thus, the consistent sequence of instruction for the fellows for every body region is: clinical reasoning principles as applied to that region, movement analysis followed by the safe and appropriate soft tissue mobilization/manipulations; followed by some therapeutic exercise, ergonomic training or movement re-education to prevent recurrence of the patient’s musculoskeletal disorder.

Module II (Movement Analysis and Motor Learning)
This module occurs near the beginning of the fellowship year to provide the fellows a common framework for analyzing and observing movement. Initiating the program with this module also provides a framework for the education provided in the supervised clinical practice/mentoring where the principles of motor learning in physical therapy patient care are applied. This module also builds on the clinical reasoning skills gained during the residency years with instruction/problem solving discussion on intervention strategies for patients with complex rehabilitation issues.

Module III (Movement Impairment System)
This module is based on the movement impairment model promoted by Shirley Sahrmann PT, PhD, FAPTA and are taught by Dr. Sahrmann and her associates from Washington University. This module provides an overview of the movement impairment concept followed by instruction focusing on specific movement impairments in the spine and upper and lower quarters. This module also includes instruction in principles of ergonomics and body proportions and their relationship to movement impairments that limit optimal performance of work, household, and recreational activities.

Module IV (Neuromotor System)
This module explores the interaction between the central nervous system and motor system in the production of movement, stability or controlled mobility. This approach is based on Vladimir Janda’s work on evaluation of posture, gain, muscle imbalances, muscle firing and movement patterns. Intervention strategies emphasized during the module is on sensorimotor training and neuromuscular and movement reeducation. This module also provides instruction in differentiation of balance disorders requiring sensorimotor training versus vestibular rehabilitation.

Module V (Clinical Biomechanics)
This module focuses on the importance of biomechanics with an emphasis on skills related to performing a biomechanical examination. Intervention strategies emphasized during this module is focused on normalization of impairments that create gait deviations while walking, running, jumping or other locomotor activities.

Module VI (Analysis and Contributions to the Scientific Literature)
The fellows also receive instruction in critical analysis and contribution to the scientific literature. The focus of this instruction is driven by one goal of this fellowship: to be contributors of the scientific literature in orthopaedic physical therapy. This instruction and consultation is provided by XXXXX, PT, PhD as well as the clinical faculty, who are available throughout the year to serve as consultants for the ongoing clinical trials that the fellows participate in each year. Near the end of the fellow’s year, they report their research activities to the residents, fellows, and clinical faculty.
Clinical Supervision

The core of the instructional content of this fellowship occurs during the one-on-one clinical supervision/mentoring from the clinical faculty that the fellow receives while treating patients. This clinical supervision occurs throughout the fellowship year. The instruction provided during the clinical supervision is closely linked to the instructional content provided during the classroom and lab portion of the fellowship. The clinical supervision occurs in three-hour blocks of time. During these periods, the format of the fellow’s schedule is as follows:

- Return Patient Appointment: 30 minutes
- Return Patient Appointment: 30 minutes
- Return Patient Appointment: 30 minutes
- New Patient Appointment: 60 minutes
- Return Patient Appointment: 30 minutes
- Review/Discussion Period

The return patient slots where the fellow has a clinical faculty present for supervision are coded in a manner that allows the fellow to choose the patients that he/she wishes to be seen during these slots. (These slots have become known as “mentor slots” because in the scheduling computer they appear as MNTR appointment slots in contrast to the normal RETR appointment slots.)

Example 3

(From St. Catherine’s Rehabilitation Hospital & Villa Maria Nursing Center Post-professional Residency in Geriatric Physical Therapy, 2009)

<table>
<thead>
<tr>
<th>Unit</th>
<th>Topic</th>
<th>Faculty</th>
<th>Assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Week 1</td>
<td>Orientation</td>
<td>XXXX</td>
<td>None</td>
</tr>
<tr>
<td>2 Week 2</td>
<td>Overview of Aging</td>
<td>XXXX</td>
<td>Staff Inservice</td>
</tr>
<tr>
<td>3 Week 3</td>
<td>MDS-RAI</td>
<td>XXXX</td>
<td>Journal Club/Critical Review of an Article</td>
</tr>
<tr>
<td>4 Week 4</td>
<td>Interpreting and Using Research in Clinical Practice</td>
<td>XXXX</td>
<td>Journal Club/Critical Review of an Article</td>
</tr>
<tr>
<td>5 Week 5</td>
<td>Healthcare Delivery Sites</td>
<td>XXXX</td>
<td>Journal Club/Critical Review of an Article</td>
</tr>
<tr>
<td>6 Week 7</td>
<td>Musculoskeletal Considerations</td>
<td>XXXX</td>
<td>Journal Club/Critical Review of an Article</td>
</tr>
<tr>
<td>7 Week 9</td>
<td>Neurological/Sensory Considerations</td>
<td>XXXX</td>
<td>Journal Club/Critical Review of an Article</td>
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<tr>
<td>8 Week 11</td>
<td>Cognitive/Psychiatric Considerations</td>
<td>XXXX</td>
<td>Case Presentation/Grand Rounds</td>
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<td>9 Week 13</td>
<td>Cardiac Considerations</td>
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<td>Case Presentation/Grand Rounds</td>
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<td>10 Week 14</td>
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</tr>
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<tr>
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<td>XXXX</td>
<td>an Article</td>
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<td>Staff Inservice Date TBA</td>
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<td>15</td>
<td>Geriatric Gait/Posture</td>
<td>XXXX</td>
<td>Case Presentations/ Grand Rounds</td>
</tr>
<tr>
<td>16</td>
<td>Balance/Fall Risk Assessment</td>
<td>XXXX</td>
<td>Presentation of Case Study/Grand Rounds</td>
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<tr>
<td>17</td>
<td>Functional Assessments</td>
<td>XXXX</td>
<td>Journal Club/Critical Review of an Article</td>
</tr>
<tr>
<td>18</td>
<td>Prosthetic Considerations</td>
<td>XXXX</td>
<td>Journal Club/Critical Review of an Article</td>
</tr>
<tr>
<td>19</td>
<td>Sexuality and Aging</td>
<td>XXXX</td>
<td>Journal Club/Critical Review of an Article</td>
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<tr>
<td>20</td>
<td>Principles of Adult Education</td>
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<td>Journal Club/Critical Review of an Article</td>
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<td>Ethical Considerations</td>
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<td>Frail Elderly</td>
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<td>Journal Club/Critical Review of an Article</td>
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<td>Medicare Regulation &amp; Administration</td>
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<td>Presentation of Case Study/Grand Rounds</td>
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<td>Consulting, Case Management, and Advocacy</td>
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<td>Admin. Proj. &amp; Case Report</td>
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<td>EXAM 3 AND LPE</td>
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<td>XXXX</td>
<td>Admin. Proj. &amp; Case Report</td>
</tr>
<tr>
<td>32</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The program is organized and sequenced in a way that prepares the residents with foundation knowledge early on, then progresses to more specialized knowledge later in the program. Specifically, age-related changes in the various body systems (e.g., musculoskeletal, cardiac, etc) are discussed individually early in the year. The content taught is applied to clinical cases where the resident is treating. This methodology and critical review of literature is taught early-on so that residents are better prepared to critically evaluate literature and present journal clubs/grand rounds in an effective manner throughout the course of the program. Clinical rotations begin with SNF/ECF and this rotation coincides with the sessions on the RAI/MDS. Residents then rotate to Rehab Hospital where the session on the IRF-PAI/FIM is presented. During the latter half of this rotation, residents begin an Administrative Project, placed in this portion of the curriculum because it does not interfere with other responsibilities and it falls after several months of clinical work when residents should be very familiar with facility operation and facility needs. The outpatient rotation occurs last as it is the setting in which the residents are able to practice most autonomously. The Evidence-Based Project is started during the final half of the program, and is not completed until the end of the program as it requires the most time to complete and residents are given ample time to select a topic/case. Residents participate in clinical education of other PT and

Application Resource Manual
APTA Clinical Residency and Fellowship Program Credentialing (2011)
PTA students throughout the program, but begin with first year students and progress to 2nd and 3rd year students (all with supervision). Journal Club and Grand Rounds content is based on content presented in either didactic courses or clinical rotations. Upon completion of the program, residents are expected to submit their Evidence-Based Projects (case study) and submit an application to sit for the GCS exam.
Evidence 3.1.2.D – Provide the course syllabi, including course description, educational objectives, requirements for successful completion, and teaching methods.

Example 1

(Adapted from St. Catherine’s Rehabilitation Hospital & Villa Maria Nursing Center Post-professional Residency in Geriatric Physical Therapy, 2009)

St. Catherine’s/Villa Maria Postprofessional Geriatric Residency
COURSE SYLLABUS
Unit on Patient Assessment Instrument & Functional Independence Measure
For Inpatient Rehabilitation Hospitals

General Description: Fundamental concepts of the PAI and FIM. An overview of the history of the FIM assessment instrument and more thorough presentation of its current use as a part of the PAI used in rehabilitation hospitals will be provided.

Faculty: XXXX, PT, MSPT, GCS

Teaching methods: Lecture, demonstration (computer), chart review, selected readings. Four hours of lecture/demonstration. 10 hours of self-study/readings/inservice preparation.

Unit Objectives: Upon completion of this session (unit), residents will be able to:
1. Integrate their basic understanding of geriatric patient assessment as it relates to the PAI/FIM.
2. Evaluate implications the PAI/FIM has on physical therapy practice patterns.
3. Discuss the quality of care issues that are a part of the PAI/FIM, including current CQI projects in place at St. Catherine’s.
4. Evaluate outcomes of programs developed as a result of CQI projects.
5. Provide a rationale as to how the FIM affects the physical therapy plan of care.
6. Integrate an awareness of suggested lengths of stay, the delivery of care, and cost of providing such services as it relates to physical therapy.
7. Demonstrate an awareness of the time requirements for completing a PAI, and how this impacts the delivery of rehabilitation services.
8. Interpret the meaning of a rehabilitation team’s assessments as they relate to the prospective payment system (PPS).

Course Outline:
1. Self-study, guided research, readings.
3. Self-study, readings.
4. Lecture: PAI/FIM and PPS, time frames, impact on delivery of rehabilitative services, impact on cost of care, outcome data management.
5. Self-study, inservice preparation with guidance as needed.
6. Staff educational inservice presentation.

Recommended Resources (partial list):
Method of Evaluation: Completion of an inservice provided to rehabilitation services employees on The PAI: Implications for Rehabilitation Professionals.

Grading Policy: Superior/Satisfactory/Unsatisfactory

**Example 2**

*(Adapted from University of St. Augustine for Health Sciences Orthopedic Residency, 2010)*

**Current Concepts of Orthopedic Physical Therapy**

**Course Description**
This course presents a thorough review of advanced concepts of anatomy and biomechanics of each body region, application of specific tests and measurements, musculoskeletal pathology, and effective treatment strategies. Nationally and internationally recognized experts draw on their vast experience to share evidence-based techniques in Orthopaedic Physical Therapy evaluation, assessment, and intervention. The monographs cover the entire body from head to toe, namely from cervical spine and temporomandibular joint to the foot and ankle. The first monograph describes the complex and multifaceted process of clinical reasoning involved in physical therapy management utilizing current evidence. Each monograph concludes with case scenarios that require clinical problem solving and allow you to compare your answers with the experts’ rationale.

**Objectives**
Upon completion of this course, the course participant will be able to understand the following as they relate to all aspects of physical therapy practice:

1. Define clinical reasoning as conceptualized in contemporary allied health research and literature and explain how clinical reasoning is a necessary tool in the appropriate application of evidence to practice.
2. Describe the clinically relevant anatomy, biomechanics, and pathomechanics of each region of the body.
3. Identify the pathogenesis, diagnosis, and intervention for selected dysfunctions, disorders, injuries, and lesions for each region.
4. Discuss the concept of differential physical therapy diagnosis and medical screening, including the presence of red or yellow flags and indications for referral to another health care provider.
5. Identify medical diagnosis and the associated physical therapy diagnosis related to traumatic, arthritic, and surgical procedures.
6. Identify and describe impairments and functional losses related to the given pathologies.
7. Be able to choose appropriate research evidence-based and/or rationale-based therapeutic interventions for rehabilitation for patients based on findings from self-report measures, the history, and physical examination.
8. Understand the role of clinical prediction rules in the development of classification-based treatment strategies.
9. Understand the risks and benefits associated with physical therapy interventions directed at specific areas of the body.
10. Compare and contrast rehabilitation progressions, prognosis, and outcomes for selected common pathologies for each area of the body.
11. Discuss the indications and contraindications for general and joint specific mobilization techniques of each joint system.
13. Understand and apply the concept of regional interdependence with physical therapy interventions.
14. Prepare a treatment program with progressions based on the principles of procedure and pathology modified rehabilitation of certain regions.
15. Discuss the relationship between impairment findings and functional limitations to disabilities as a guideline for treatment interventions.
16. Describe autonomous physical therapy practice in relationship to physical therapy patient management utilizing current evidence.
17. Correctly answer and explain rationale for all questions presented with the case scenarios for each body region.

Requirements for Successful Completion
Courses will be tested with a written multiple-choice exam. An exam will be given the Tuesday after each monolith is completed. The test will be completed and submitted electronically in a proctored environment. The resident must average a 70% for all weekly tests taken within a monolith. Failure to achieve 70% will result in a remediation plan implemented based on the determined weaknesses of the resident. Exams will be reviewed with the resident within one week of taking the exam with the exam author.

Grading System

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<tr>
<th>Letter Grade</th>
<th>Grading Scale</th>
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<tbody>
<tr>
<td>A</td>
<td>90-100</td>
</tr>
<tr>
<td>B+</td>
<td>85-89</td>
</tr>
<tr>
<td>B</td>
<td>80-84</td>
</tr>
<tr>
<td>C+</td>
<td>75-79</td>
</tr>
<tr>
<td>C</td>
<td>70-74</td>
</tr>
<tr>
<td>D+</td>
<td>65-69</td>
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<tr>
<td>D</td>
<td>60-64</td>
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<tr>
<td>F</td>
<td>&lt;69</td>
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</tbody>
</table>

Teaching Method
Independent Study and weekly discussion

Example 3
(Adapted from Utah Neurologic Physical Therapy Residency Program, 2010)

BIOCHEMICAL BASIS OF NEUROPHARMACOLOGY
PHTX 7270
SPRING SEMESTER, 2009

When: Wednesdays, 1:00-3:00pm
Where: 4100C in HSEB
Recommended Text: Molecular Basis of Neuropharmacology: A Foundation for Clinical Neuroscience (Nestler, EJ et al., Eds.; 2008, 2nd Ed.)
<table>
<thead>
<tr>
<th>Date</th>
<th>Instructor(s)</th>
<th>Topic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jan 14</td>
<td>W. Crowley</td>
<td>Neurons and glial cells (Chpt. 2)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Molecular mechanisms of exocytosis and endocytosis (Chpt. 3)</td>
</tr>
<tr>
<td>Jan 21</td>
<td>K. Keefe</td>
<td>Functional Neuroanatomy</td>
</tr>
<tr>
<td>Jan 28</td>
<td>K. Wilcox</td>
<td>Neurophysiological mechanisms (Chpt. 2)</td>
</tr>
<tr>
<td>Feb 4</td>
<td>K. Wilcox</td>
<td>Synaptic transmission (Chpt. 3) (Exam 1 available)</td>
</tr>
<tr>
<td>Feb 11</td>
<td>K. Keefe</td>
<td>Acetylcholine (Chpt. 6) (Exam 1 due)</td>
</tr>
<tr>
<td>Feb 18</td>
<td>K. Keefe</td>
<td>Catecholamines (Chpt. 6)</td>
</tr>
<tr>
<td>Feb 25</td>
<td>K. Wilcox</td>
<td>Excitatory Amino Acids (Chpt. 5)</td>
</tr>
<tr>
<td>March 4</td>
<td>A. Alex</td>
<td>Inhibitory Amino Acids (Chpt. 5) (Exam 2 available)</td>
</tr>
<tr>
<td>March 11</td>
<td>K. Keefe</td>
<td>Serotonin, histamine, melatonin (Chpt. 6) (Exam 2 due)</td>
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<td>No class</td>
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<td>March 25</td>
<td>K. Keefe</td>
<td>Neuropharmacology of affective disorders (Chpt. 14)</td>
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<td>April 1</td>
<td>G. Hanson</td>
<td>Neuropeptides (Chpt. 7) (Exam 3 available)</td>
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<td>Keefe/student</td>
<td>Neuropharmacology of schizophrenia (Chpt. 16) (Exam 3 due)</td>
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<td>April 22</td>
<td>Wilcox/student</td>
<td>Neuropharmacology of epilepsy (Chpt. 18)</td>
</tr>
<tr>
<td>April 29</td>
<td>Crowley/student</td>
<td>Neuropharmacology of pain (Chpt. 11)</td>
</tr>
<tr>
<td>May 6</td>
<td>Finals Week</td>
<td>Paper due by 5:00pm</td>
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</table>
Evidence 3.2.1.A – Identify the minimum and maximum amount of time allowed for a resident or fellow to complete the Program. Provide a summary of the amount of time previous residents or fellows took to complete the Program.

**Example 1**

*(Adapted from Glendale Adventist Medical Center’s Orthopedic Physical Therapy Residency, 2009)*

All residents begin the program on the first working day after January 1 of each year. The program is fifty weeks long. Should a resident require additional time to complete the Program a remediation period of 16 weeks (48 hours of clinical supervision and 272 hours of unsupervised clinical practice) will be granted in order to complete the program. As we are in our first year we do not currently have a summary of previous residents who complete the Program.

**Example 2**

*(From St. Catherine’s Rehabilitation Hospital & Villa Maria Nursing Center Post-professional Residency in Geriatric Physical Therapy, 2009)*

The minimum amount of time required to complete the residency is 12 months. The maximum amount of time to complete the residency is 15 months.

Procedure: The residency is completed full-time unless specific accommodations have been made with the program director. Matriculation is to include 12 months of clinical experience, including didactic training.

**Completion of Projects:**

Residents must have completed all aspects of the residency to receive a certificate of completion. This includes clinical rotations, exams, projects and assignments. It is expected that residents will complete all residency related tasks within the 12 month time-frame. In the event a resident has completed all assignments and clinical components of the program successfully, but has not completed the evidence-based project and/or the administrative project by the time the clinical rotations are finished, he/she will be allowed up to (but not exceeding) 3 additional months to complete the projects. Only then will a certificate of completion be awarded. Any additional time a resident takes to complete these projects does not constitute “time in the residency” and the resident is no longer considered an employee of St. Catherine’s/Villa Maria. The employer/employee relationship ends when the clinical components are completed.

**Completion of Clinical Competencies:**

Residents are evaluated three times a year as to their performance in the program. Each assessment period, residents develop an action plan to address any deficits. Residents are expected to correct deficits (with assistance as needed). In the unlikely even a resident progresses as expected until the final rotation, at which time deficits are noted that warrant further attention; the resident may be asked to continue in the clinical portion of the program for up to, but not exceeding three months, during which time he/she would be given ample time and mentoring to correct the deficit(s). If the resident is unable to correct the deficit(s) within the allotted time, he/she will not be awarded a certificate of completion. Should the program faculty feel that the resident would be unable to correct these deficits during a three month extension, the resident will not receive a certificate of completion. During this “remediation” time, the resident would not be paid by St. Catherine’s/Villa Maria.
*To date, all residents have completed the program within its allotted time of 12 months. (One current resident will require additional time due to personal medical reasons).

**Example 3**

*(From Hospital for Special Surgery Sports Physical Therapy Clinical Residency, 2009)*

The Hospital for Special Surgery Sports Physical Therapy Residency Program must be completed within a minimum of 1500 hours, and in no fewer than 12 months and no more than 15 months.

XXX XXXX, the 200X Sports Physical Therapy Resident, completed the program in 12 months with a total of 1801 hours.

**Example 4**

*(From Kaiser Permanente Los Angeles Movement Science Fellowship, 2009)*

All fellows begin the program on the first working day after January 1 of each year. The program is fifty weeks long. Fellows who successfully completed the program do it within this fifty-week period. In the past 6 years, there have been no fellows who did not complete the requirements to successfully complete the program. If an individual was not able to meet the requirements in the normal period time, a plan of remediation will be discussed in order to allow for the fellow to complete the program.
Evidence 3.2.1.B – Utilize Form 3.2.1.B to provide a list of all residents or fellows who have graduated in the past two to three years. Include initiation and completion date, and number of hours required for completion. Explain discrepancies.

Example

(Form provided in part 4 of application: Forms)

Form 3.2.1.B

Name of Clinical Residency/Fellowship Program:

Program Graduates

<table>
<thead>
<tr>
<th>Name</th>
<th>License #</th>
<th>State</th>
<th>Date Started (Month/year)</th>
<th>Date Ended (Month/year)</th>
<th>No. of Hours in Program</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tr>
</tbody>
</table>
Evidence 3.2.2 – Use Form 3.2.2 to list the number of hours dedicated to each instructional method used to achieve the performance outcomes. Provide the average number of one-on-one mentoring hours for the previous year. For multi-site Programs, a separate form is required for each clinical site.

Example 1

(Form provided in Part 4 of application: Forms)

Form 3.2.2

Name of Clinical Site:
*Provide a separate form for each clinical site

<table>
<thead>
<tr>
<th>Instructional Method</th>
<th>Total Hours in Program</th>
</tr>
</thead>
<tbody>
<tr>
<td>Classroom Instruction (List Courses)</td>
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</tr>
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<td></td>
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<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Journal Club</td>
<td></td>
</tr>
<tr>
<td>Research Activities</td>
<td></td>
</tr>
<tr>
<td>Home Study</td>
<td></td>
</tr>
<tr>
<td>Grand Rounds</td>
<td></td>
</tr>
<tr>
<td>Clinical Mentoring</td>
<td></td>
</tr>
<tr>
<td>• 1:1 clinical mentoring/instruction from clinical faculty while treating patients</td>
<td></td>
</tr>
<tr>
<td>• 1:1 patient/client related planning/discussion/review of diagnostic tests, evaluation, plan of care, etc.</td>
<td></td>
</tr>
<tr>
<td>Clinical Practice (mentor accessible onsite)</td>
<td></td>
</tr>
<tr>
<td>Clinical Observation</td>
<td></td>
</tr>
<tr>
<td>Athletic Venue Coverage</td>
<td></td>
</tr>
<tr>
<td>Other: (Please list)</td>
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</table>

TOTAL HOURS IN PROGRAM
**Example 2**

*(Adapted from The Jackson Clinics Orthopedic Physical Therapy Residency Program, 2009)*

<table>
<thead>
<tr>
<th>Instructional Method</th>
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<tr>
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<td>Research Activities</td>
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<td>Home Study – Resident directed learning</td>
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<tr>
<td>Grand Rounds</td>
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<tr>
<td>Clinical Mentoring</td>
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</tr>
<tr>
<td>• 1:1 clinical mentoring/instruction from clinical faculty while treating patients</td>
<td>100</td>
</tr>
<tr>
<td>• 1:1 patient/client related planning/discussion/review of diagnostic tests, evaluation, plan of care, etc.</td>
<td>50</td>
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<tr>
<td>Clinical Practice (mentor accessible onsite)</td>
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<tr>
<td>Clinical Observation</td>
<td>96</td>
</tr>
<tr>
<td>Athletic Venue Coverage</td>
<td></td>
</tr>
<tr>
<td>Other: (Please list)</td>
<td></td>
</tr>
</tbody>
</table>

**TOTAL HOURS IN PROGRAM** 2312

**Example 3**

*(From St. Catherine’s Rehabilitation Hospital & Villa Maria Nursing Center Post-professional Residency in Geriatric Physical Therapy, 2009)*

<table>
<thead>
<tr>
<th>Instructional Method</th>
<th>Hours</th>
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<td>Overview of Aging</td>
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<tr>
<td>MDS-RAI</td>
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<tr>
<td>Interpreting and Using Research in Clinical Practice</td>
<td>1.5</td>
</tr>
<tr>
<td>Healthcare Delivery Sites</td>
<td>2.0</td>
</tr>
<tr>
<td>Musculoskeletal Considerations</td>
<td>1.5</td>
</tr>
<tr>
<td>Neurological/Sensory Considerations</td>
<td>1.5</td>
</tr>
<tr>
<td>Cognitive/Psychiatric Considerations</td>
<td>1.5</td>
</tr>
<tr>
<td>Cardiac Considerations</td>
<td>1.5</td>
</tr>
<tr>
<td>------------------------</td>
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</tr>
<tr>
<td>Pulmonary Considerations</td>
<td>1.5</td>
</tr>
<tr>
<td>Psychosocial and Caregiving Issues</td>
<td>1.5</td>
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<tr>
<td>Speech, Language, and Communication Considerations</td>
<td>1.5</td>
</tr>
<tr>
<td>IRF/PAI Payment Considerations in RH/OP</td>
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<td>Geriatric Gait/Posture</td>
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<td>Balance/Fall Risk Assessment</td>
<td>1.5</td>
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<td>Functional Assessments</td>
<td>1.5</td>
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<tr>
<td>Prosthetic Considerations</td>
<td>1.5</td>
</tr>
<tr>
<td>Sexuality and Aging</td>
<td>1.5</td>
</tr>
<tr>
<td>Principles of Adult Education</td>
<td>1.5</td>
</tr>
<tr>
<td>Ethical Considerations</td>
<td>2.0</td>
</tr>
<tr>
<td>Frail Elderly</td>
<td>1.5</td>
</tr>
<tr>
<td>Medicare Regulation &amp; Administration</td>
<td>2.0</td>
</tr>
<tr>
<td>Integumentary and Wound Care</td>
<td>1.5</td>
</tr>
<tr>
<td>Health Promotion and Wellness</td>
<td>1.5</td>
</tr>
<tr>
<td>Incontinence</td>
<td>1.5</td>
</tr>
<tr>
<td>Environmental Adaptation</td>
<td>1.5</td>
</tr>
<tr>
<td>Consulting, Case Management, and Advocacy</td>
<td>2.0</td>
</tr>
<tr>
<td>Journal Club</td>
<td>13.0</td>
</tr>
<tr>
<td>Research Activities</td>
<td>169</td>
</tr>
<tr>
<td>Self-Study (didactic)</td>
<td>168</td>
</tr>
<tr>
<td>Grand Rounds</td>
<td>6.0</td>
</tr>
<tr>
<td>Clinical Mentoring</td>
<td></td>
</tr>
<tr>
<td>*1:1 mentoring/instruction from clinical faculty while treating patients</td>
<td>156</td>
</tr>
<tr>
<td>*1:1 patient/client related planning/discussion/review of diagnostic tests, evaluation, plan of care, etc.</td>
<td>52</td>
</tr>
<tr>
<td>Clinical Practice (mentor accessible onsite)</td>
<td>1374</td>
</tr>
<tr>
<td><strong>Total Hours in Program</strong></td>
<td><strong>2024</strong></td>
</tr>
</tbody>
</table>

**Example 4**

*(From Army-Baylor University Doctoral Fellowship in Orthopaedic Manual Physical Therapy, 2009)*

<table>
<thead>
<tr>
<th>Instructional Method</th>
<th>Total Hours in Program</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Classroom Instruction (List Courses)</strong></td>
<td></td>
</tr>
<tr>
<td>OMPT evaluation and treatment (4 courses)</td>
<td>220</td>
</tr>
<tr>
<td>Anatomy and Biomechanics</td>
<td>90</td>
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<tr>
<td>Physiology (1 course)</td>
<td>45</td>
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<tr>
<td>Differential Diagnosis</td>
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<tr>
<td>Radiology</td>
<td>45</td>
</tr>
<tr>
<td>Nutrition and Pharmacology</td>
<td>45</td>
</tr>
<tr>
<td>Ortho/Sports Medicine/Surgery</td>
<td>30</td>
</tr>
<tr>
<td><strong>Journal Club</strong></td>
<td></td>
</tr>
<tr>
<td>Critical review of literature integrated in all courses above</td>
<td>N/A: incorporated in hrs above</td>
</tr>
<tr>
<td><strong>Research Activities</strong></td>
<td></td>
</tr>
<tr>
<td>EBP and Research Design (1 course)</td>
<td>250</td>
</tr>
<tr>
<td>Quantitative Evaluation/Statistics (1 course)</td>
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</tr>
<tr>
<td>Activity</td>
<td>Hours</td>
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<tr>
<td>-------------------------------------------------------------------------</td>
<td>-------</td>
</tr>
<tr>
<td>Field Research (1 course)</td>
<td></td>
</tr>
<tr>
<td>Advanced Professional Paper Project (1 course)</td>
<td></td>
</tr>
<tr>
<td>Individual Project Comprehensive Literature Review (1 course)</td>
<td></td>
</tr>
<tr>
<td>Group Project Written Project (1 course)</td>
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<tr>
<td><strong>Home Study</strong></td>
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<tr>
<td>Program Pre-reading</td>
<td></td>
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<tr>
<td>Research Project</td>
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<tr>
<td>Tutorial and Mentorship Preparation</td>
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<tr>
<td>Lecture Preparation</td>
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<tr>
<td>Weekend Skills Practice</td>
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<td><strong>Grand Rounds</strong></td>
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<tr>
<td>Tutorials (12 hrs/month for 18 months)</td>
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</tr>
<tr>
<td><strong>Clinical Mentoring</strong></td>
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</tr>
<tr>
<td>• 1:1 clinical mentoring/instruction from clinical faculty while treating patients</td>
<td></td>
</tr>
<tr>
<td>• 1:1 patient/client related planning/discussion(review of diagnostic tests, evaluation, plan of care, etc.)</td>
<td></td>
</tr>
<tr>
<td><strong>Clinical Practice (mentor accessible onsite)</strong></td>
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<tr>
<td><strong>Clinical Observation</strong></td>
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<tr>
<td><strong>Athletic Venue Coverage</strong></td>
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</tr>
<tr>
<td>Not applicable</td>
<td></td>
</tr>
<tr>
<td>Other: (Please list)</td>
<td></td>
</tr>
<tr>
<td><strong>TOTAL HOURS IN PROGRAM</strong></td>
<td>3120 hours</td>
</tr>
</tbody>
</table>
Evidence 4.1.1 – Describe the process for regular and ongoing evaluation of the Program’s goals as stated in 1.2.1.A. Include how often the goals are reviewed, what would trigger a review, who is responsible for the review, etc.

Example 1

(Adapted from The Jackson Clinics Orthopedic Physical Therapy Residency Program, 2009)

The entire clinical faculty and program director meet after each of the three midyear clinical performance weeks for an overall evaluation of the program mission, objectives, and goals. Regarding the goals, we utilize a variety of evaluation tools to accomplish this objective. The program director and clinical faculty meet to review the goals of the program relating to the quality of residents and their level of learning by utilizing the weekly measurement forms and the three midyear evaluation forms. The program’s self assessment of achieving our program goals rests primarily on the midyear and final evaluation of the residency program by the residents as listed in 4.1.2.B.

At this time the residents’ clinical performance is reviewed, the faculty performance is reviewed and the clinical mentor’s performance is reviewed. The primary tools for the evaluations are the assessment forms that the residents fill out on the clinical faculty, the instructors, and the program. The residents are evaluated using the weekly performance tools and the midyear clinical performance tools.

Example 2

(From Hospital for Special Surgery Sports Physical Therapy Clinical Residency, 2009)

The program goals and objectives are regularly reviewed as stated below. The program director, with assistance from the program faculty and the Rehabilitation Department Residency and Fellowship Advisory Team, is responsible for regular and ongoing review of the program goals and objectives. If a change is indicated, the program director and faculty will develop a plan of action to implement the program changes.

- The physical therapy faculty of the Sports Physical Therapy Residency Program meets annually in February of each year to review the programs mission, goals, and objectives. The feedback reported from the prior year’s resident is discussed. Informal, on-going discussions with faculty are held throughout the year as well. Suggestions are made and process improvement plans are developed as needed. The Program Director also seeks feedback from physician and ancillary faculty. In addition, the Program Director and XXXX XXXXX, PT, SCS meet on a monthly basis to assess program goal attainment.

- The Rehabilitation Department Residency and Fellowship Advisory Team meets monthly and discusses any issues, including program goals and objectives, raised by faculty, fellows, residents, lecturer or any staff member.

- Any problems or issues related to the program goals and objectives, raised by a faculty member, fellow, lecturer or other staff member, would trigger a review by the program director and faculty.

- The publication of a revised APTA Specialties’ Description of Specialty practice for Sports Physical Therapy and the revision or addition of APTA documents such as the Guide to Physical
Therapy Practice would trigger a review of the program goals and objectives by the program director and faculty.

Example 3

(Adapted from St. Catherine’s Rehabilitation Hospital & Villa Maria Nursing Center Post-professional Residency in Geriatric Physical Therapy, 2009)

The program evaluates its performance relative to the program goals on an ongoing basis via regular faculty meetings and advisory committee meetings. Graduate outcome data is collected and summarized annually for the advisory committee for review and revision to the program as needed. An unscheduled review of the program would be triggered by the knowledge of failure of the GCS exam by a program graduate or by failure of work performance in a subsequent job of a program graduate. The P&P for the committee is below:

The Committee will be comprised of clinical faculty, academic faculty and at least one CHS corporate officer. There will be a minimum of five committee members who should reflect the diversity of the faculty and staff of St. Catherine’s/Villa Maria and the Residency Program. Members will be invited to the committee by the Program Director.

The committee will meet at least annually for planning and development of activities, including revision to the curriculum, based on outcome measures (Graduate Performance Feedback, pass rate on GCS exam, graduate achievement of program goals and objectives). The committee will also revise policies and procedures as needed, review program goals and objectives, as well as admission and completion criteria. Additional meetings may be held as needed and will be called by the Program Director and arranged by the Program Coordinators.

Example 4

(Adapted from Glendale Adventist Medical Center’s Orthopedic Physical Therapy Residency, 2009)

The program coordinator and program director meet quarterly to formally review the program goals, to make sure the goals are being met, and if the goals are not being met, to discuss the plan for remediation. The “Quarterly Checklist Form” provided will be used to assess whether or not the goals are being met.
Evidence 4.1.2.A – Describe the process for ongoing faculty evaluation. Faculty evaluation plan should include observation of a mentoring session by the program director.

Example 1

(From TIRR Memorial Hermann Neurologic Physical Therapy Residency Program in collaboration with Texas Woman’s University and University of Texas Medical Branch at Galveston, 2009)

The process for the program’s faculty evaluation is as follows:

Each institution (Texas Woman’s University, University of Texas Medical Branch at Galveston, and TIRR Memorial Hermann) has its own method for acknowledging the meritorious performance of staff and faculty members and annual performance appraisals are conducted by each institution for its respective employees.

1. The TIRR Memorial Hermann system uses performance appraisals per policy to provide formal and constructive feedback to an employee regarding his/her performance over the past year. Annual merit increase is made at the time of the annual performance appraisal. Copies of the annual performance appraisal are kept in each employees personnel file.

2. Constructive feedback is provided on an informal basis throughout the year as needed by peers, resident director and/or the resident.

3. The resident will provide feedback to the mentor(s) and faculty at each site within the TIRR Memorial Hermann Neurologic Physical Therapy Residency Program via the Module Evaluation Form and/or Clinical Mentor Evaluation Form at the conclusion of each module, course and clinical site experience; this information will be shared with the mentor/faculty member and may be included for annual performance appraisals.

4. The residency program director will be present for observations of mentor and resident interactions (Look-Ins) and didactic coursework/modules throughout the residency curriculum in order to provide feedback to the faculty/mentor.

5. At the conclusion of the residency the resident will complete an Exit Interview with the Residency Advisory Council.

Note: For independent study courses, a secondary course evaluation will be required by the respective university providing the independent study course for credit.

Example 2

(Adapted from Army-Baylor University Doctoral Fellowship in Orthopaedic Manual Physical Therapy, 2009)

Fellows complete clinical mentorship effectiveness forms (every 6-8 weeks block of mentorship) and instructor effectiveness forms every 4-6 months (at least once per semester for academic faculty). The forms are provided to the faculty by the program director. The program director discusses the results with each faculty member and recommendations for change are made as necessary. The program director also observes faculty regularly during clinical mentorship and didactic instruction (1-2 times per semester). The program director is evaluated by the chief of the Physical Therapy Service and the chairman of the Department of Orthopaedic and Rehabilitation.

All military faculty receive an annual Officer Evaluation Report (Army) or Officer Performance Report (Air Force). This report addresses current job performance, potential for increased responsibility,
promotion in military rank, and additional military and civilian education. Civilian employees receive a similar annual performance rating.

**Example 3**

*(Adapted from Kaiser Permanente Los Angeles Movement Science Fellowship, 2009)*

The faculty are evaluated by the 1) fellow, 2) program coordinator, 3) Department Administrator, and 4) other clinical faculty.

The fellows evaluate the clinical faculty with regards to their performance as a clinical supervisor. They provide the program coordinator with informal verbal feedback and formal feedback using the “Clinical Faculty Evaluation Form” provided in *Evidence 4.1.2.B*.

Where the clinical faculty provide classroom/lab instruction, the fellows evaluate the clinical faculty member’s performance as an instructor using the “Guest Lecturer Evaluation Form” provided in *Evidence 4.1.2.B*. The program coordinator attends the clinical mentoring, classroom and lab classes provided by the faculty and guest lecturers. This allows the program coordinator to also evaluate the clinical faculty member’s performance while teaching. It also enables the program coordinator the ability to provide feedback to clinical faculty on how his/her instruction interfaces with the didactic instruction provided by the other instructors.

The program coordinator forwards the results gained from the Clinical Faculty and Guest Lecturer evaluation forms to their Department Administrator. The Department Administrator uses this information in the clinical faculty’s annual review using Kaiser Permanente’s “Criteria-Based Performance Evaluation.” This evaluation system has ten Performance Standards and 59 criteria that the clinical faculty is judged by the Department Administrator as either “below” the standard, “meets” the standard, or “exceeds” the standard. Note that Performance Standard Number 10 is specifically designed to evaluate “Clinical Specialist Physical Therapist.” The definition of the performance levels is provided below:

- **Below:** Performance does not meet one or more criteria of the standard. Must be supported by a comment in the “Areas of Performance Needing Improvement” section.
- **Meets:** Performance is fully acceptable and all standards are met.
- **Exceeds:** Performance consistently exceeds departmental standards. Must be supported by a comment in the “General Summary and Areas of Exceptional Performance” sections.

**Example 4**

*(Adapted from St. Catherine’s Rehabilitation Hospital & Villa Maria Nursing Center Post-professional Residency in Geriatric Physical Therapy, 2009)*

Faculty and staff of the residency program are evaluated regularly with regards to teaching skills, professional activities, and service. Faculty who are also employees of St. Catherine’s/Villa Maria are evaluated as a part of their annual performance appraisals. In addition, residents evaluate faculty as part of their evaluation of the Program.
Related forms:
- St. Catherine’s/Villa Maria Job Description/Competency Based Performance Evaluation for Physical Therapists
- Faculty Evaluation (Lecture/Lab) Form
- Interim Course Evaluation
- Geriatric Residency in Physical Therapy Final Course Evaluation
- Faculty Assessment
- Peer Teaching Evaluation Form
- Mentor Evaluation Form
Evidence 4.1.2.B – Provide blank forms utilized in the clinical and didactic faculty evaluation process.

Example 1

(Adapted from Army-Baylor University Doctoral Fellowship in Orthopaedic Manual Physical Therapy, 2009)

Instructor Effectiveness Form

Date: _______________ Course: _______________ Faculty: _______________

1. **Overall Course Rating** (Circle):
   - 5-Superior
   - 4-Excellent
   - 3-Good
   - 2-Fair
   - 1-Poor

For the statements below, please mark the number which best describes your response:

5-Strongly Agree  4-Agree  3-Neutral  2-Disagree  1-Strongly Disagree

**Objectives:**

2. Course objectives were clearly communicated. _____

3. Instruction met the course objectives. _____

**Teaching Methods:**

4. Course material was presented in an organized manner. _____

5. Instructor made students feel free to ask questions and express ideas. _____

6. Instructor displayed fair and equitable treatment of each student. _____

7. Instructor provided prompt feedback on test performance and assignments. _____

8. Test questions/assignments were appropriate for the material taught. _____

**Content:**

9. Course was presented at an appropriate level. _____

10. Course was coordinated well with the overall curriculum. _____

11. The instructor appeared knowledgeable and presented the current material. _____

12. The material presented was relevant to me as a future specialist in advanced orthopaedic and manual physical therapy. _____

Comments:
13. Strengths of this instruction/instructor.

14. Areas for improvement for this instruction/instructor.

15. Other constructive suggestions for improvement.

Example 2

(Adapted from St. Catherine’s Rehabilitation Hospital & Villa Maria Nursing Center Post-professional Residency in Geriatric Physical Therapy, 2009)

MENTORING EVALUATION FORM

Date: _______________________

Mentor: _______________________

The mentor (please circle appropriate number using the following scale):

Agree=5, Somewhat agree=4, Neutral=3, Somewhat disagree=2, Disagree=1

Is able to identify the needs of the patients. 1 2 3 4 5

Is able to identify my needs as a resident. 1 2 3 4 5

Demonstrates excellent clinical reasoning skills. 1 2 3 4 5

Is able to recognize areas of improvement for my clinical reasoning and patient management skills. 1 2 3 4 5

Is on time and fully present during our clinical supervision time. 1 2 3 4 5

Provides feedback in a professional and considerate manner. 1 2 3 4 5

Understands the performance outcomes in the residency program. 1 2 3 4 5

Please answer the following questions:

The aspects most valuable to me during my clinical mentorship periods are:

I would have a better experience if the following changes could be made:

Other comments (use back if necessary):
GERIATRIC RESIDENCY IN PHYSICAL THERAPY  
St. Catherine’s/Villa Maria  
FINAL COURSE EVALUATION  
(for Academic Courses Taught Off-Site)

COURSE NAME:________________________________________________________

INSTRUCTOR(S): _____________________________________________________________

YEAR: ___________        SEMESTER:  F_____     S_____     SSI_____     SSII_____

Please respond to the following questions on this paper.

1. Best features of this course. What I appreciated and/or enjoyed most. Why:

2. What I would have the professor change or do differently to be more effective in achieving the goals of the course:

3. How did class size effect your learning?
   A. Lecture:
   B. Lab:

4. Did this course meet you expectations as a postprofessional resident? Why or why not?

5. Do you feel the content of this course can be applied in advanced practice in geriatrics?

6. Did the course augment your clinical experiences in the geriatric residency program?
7. Additional Comments:

Thank you for your thoughtful and honest feedback!

Example 3

(Adapted from Evidence in Motion Orthopedic Residency and Orthopaedic Manual Physical Therapy Fellowship Programs, 2009)

Clinical Mentored Practice: Resident or Fellow Assessment of Mentor’s Performance Form 04

Purpose: To provide a mechanism for the resident/fellow to give feedback to the clinical mentor.

Residents:

1. Use: The results of this assessment will be discussed between the student and the clinical mentor at least on a QUARTERLY BASIS and then submitted to the EIM. You will receive a notification from EIM that the form is due. However, the form may be used more frequently if needed based on the judgment of the clinical mentor.

2. Once completed, both you and your mentor need to sign the document and then scan and e-mail your form to Evidence In Motion Office (orthores@evidenceinmotion.com). If your CMC is also your mentor, then send directly to the EIM office for review by EIM faculty. It is your responsibility to get this form with signatures to the EIM office.

Fellows:

1. Use: The results of this assessment will be discussed between the fellow and the fellow mentor (FAAOMPT) at least once per every 20 hours of documented mentorship time.

2. Once the form is completed, both the fellow and fellow mentor (FAAOMPT) need to sign the document and scan and e-mail the form to the Evidence In Motion office (ompt@evidenceinmotion.com), and the Director of the Fellowship Program.

3. You will not receive notification from EIM that the form is due. It is your responsibility to get this form with signatures to the EIM office.
Clinical Mentored Practice: Resident or Fellow Assessment of Mentor’s Performance Form 04

Resident/Fellow Name: _______________________

Mentor Name: _______________________  Date:___________

Quality of Feedback:

Level of Supervision (too much; too little; appropriate):

Clinical Decision-Making Framework:

Technical Expertise:

Other:

Signatures

Resident/Fellow: ________________________________

Mentor:________________________________________
Evidence 4.1.3.A – Describe the ongoing process used to evaluate the Program's curriculum and to make appropriate revisions. Include a description of the mechanisms used for communication (eg, regular meetings, conference calls) and those individuals involved. For multi-site Programs, include the processes for assuring that the curriculum is being applied consistently across the practice settings in the overall assessment plan.

Example 1

(From Army-Baylor University Doctoral Fellowship in Orthopaedic Manual Physical Therapy, 2009)

Development and revision of the program’s curriculum are the responsibility of the program director. The faculty, individually and as a group, continually evaluate the curriculum to remain current with the orthopaedic manual physical therapy practice, APTA Credentialing Criteria, AAOMPT standards, and the mission of BAMC. The mechanisms of communication include email, phone calls, and regular meetings. Program mission, philosophy, and curriculum are discussed in a more formal setting at the annual faculty strategic planning conference/retreat. Additionally, specific curriculum issues may be addressed as they arise on a daily basis or at weekly officer staff meetings. Curriculum changes are approved by consensus of the faculty with ultimate approval of the program director.

Information for changes in curriculum is gathered from the following sources:

a. Fellow feedback evaluation forms for specific classes/instructors and clinical mentorship;
b. Fellow evaluation of the program forms at midterm and end of program;
c. Fellow evaluation of the program in professional development portfolios;
d. Faculty feedback from clinical mentorship;
e. Graduate survey of graduates, employers, and patients;
f. Communication with subject matter experts and guest lecturers;
g. Faculty discussion;
h. DASP for OMPT (AAOMPT, 2008)

Fellows perform a written evaluation of the program and faculty at the mid-term and at the end of the program. This feedback is used by the director and clinical/academic faculty to evaluate the effectiveness of the program regarding curriculum, clinical education, mentorship, and training, as well as to institute changes based on strengths and weaknesses identified by fellows. Fellows are highly encouraged to give feedback throughout the 18-month program.

Faculty feedback is considered an ongoing process since the director and primary clinical faculty work in the same clinic, which promotes daily informal exchange of ideas. Formal discussion is done at the annual strategic planning conference/retreat and after graduation, or whenever an issue arises. Academic faculty are given the opportunity to provide feedback throughout the program, during the interaction with the program director on research projects in addition to course teaching, share teaching in the entry-level DPT program, and coordinate regularly in teaching military continuing education courses. All faculty are encouraged to provide feedback at any time during the program. Most academic faculty work in another building on the Army installation about 1-2 miles from the clinic, therefore, formal or informal discussions are possible at any time. Email and phone conferences have also been an excellent source of communication for faculty, but face-to-face meetings are regular, feasible, and preferred.
**Example 2**

*(Adapted from Glendale Adventist Medical Center’s Orthopedic Physical Therapy Residency, 2009)*

There is ongoing informal communication between the director and coordinator of the program, clinical faculty, and the residents. This allows the program coordinator and director to assess whether each of the above named individuals are having their needs met. Part of the role of the program coordinator is to have adequate “face time” with the clinical faculty, instructors and residents of this program. It is the job description of the program director to assure clinical faculty, instructors and residents have this time allotted in their schedules.

As part of our ongoing review process we have also established ongoing formal communication. This includes monthly “Physical Therapists Clinical Faculty Meetings.” All clinical faculty involved in the program attend these monthly meetings. For these meetings the director and coordinator formulate an agenda with input from the meeting attendees. The goals of these meetings are to review curriculum, clinical skills required of the resident, discuss evidence-based practice and to have an organized, open-forum for clinical faculty to discuss ways to improve the program. Minutes are taken by the program coordinator and sent to all clinical faculty and to the program director.

In addition, the program director meets quarterly with the coordinator and the resident. The purpose of these meetings is to allow the resident to address any concerns he/she may have with the curriculum and to communicate formal feedback to the leadership of the program.

There is also an annual Clinical Faculty meeting at the beginning of the year sponsored by Kaiser Permanente. Clinical faculty members from Kaiser Permanente and from Glendale Adventist Medical Center are invited to attend. The program coordinator attends this meeting.

The final level of communication is for the program director to communicate the results of the above-mentioned meetings to the Director, Rehabilitation Services as needed. Currently, the program director (Manager, Therapy & Wellness Center) meets weekly with the Director, Rehabilitation Services.

**Example 3**

*(From The Jackson Clinics Orthopedic Physical Therapy Residency Program, 2009)*

See 4.1.1 above. The residents and staff attending the resident course offerings fill out a course evaluation form. The curriculum director in conference with the directors of the program evaluates these forms to ensure that quality instruction is taking place. Instructors are required to provide syllabus and course objectives which are reviewed for content. If there is a problem identified with the instructor or instructional content then the curriculum director is responsible for contacting the instructor to discuss and make modifications in future presentations.

**Example 4**

*(From St. Catherine’s Rehabilitation Hospital & Villa Maria Nursing Center Post-professional Residency in Geriatric Physical Therapy, 2009)*

The clinical faculty meet regularly (at least once a month) to discuss curriculum issues as they arise. In addition, email communication is used frequently among all faculty. The Advisory Committee meets at least annually to review the entire curriculum, make and approve changes, and consult with faculty as needed. Please see functions of Advisory Committee in the policy/procedure included in Evidence 4.1.1.
**Example 5**

(From Hospital for Special Surgery Sports Physical Therapy Clinical Residency, 2009)

There is ongoing, informal communication between the program director and the department directors, section manager, faculty, and the resident. This process allows adjustment in the curriculum in an ongoing fashion to assure that the needs of all the involved individuals are being met. Communication is accomplished primarily face-to-face due to the close working proximity of all these individuals. Communication also takes place through email, the hospital’s intranet system, and by phone. In addition, staff faculty members of the Sports Rehabilitation & Performance Center meet weekly at the section staff meeting. At that time, they have the opportunity to raise and discuss any issues related to the curriculum or other aspects of the program.

A more formal curriculum review occurs annually (in February) at the conclusion of each residency year. The program director meets with the faculty to discuss feedback received from Sports Resident (see “Sports Physical Therapy Resident Feedback Form” and “Faculty Evaluation Form” attached on subsequent pages), faculty, department administrators, and graduates. The previous year’s Sports resident’s documented achievement of program goals (e.g. competency and performance assessments, written and practical examinations) are also reported on and discussed. Proposed changes to the curriculum are discussed. The program director is responsible for updating all involved individuals on changes made to the curriculum affecting their role in the program. In addition, the program director discusses curriculum changes with the Rehabilitation Department Residency and Fellowship Advisory Team which meets monthly.
Evidence 4.1.3.B – Describe an example of a change made in the curriculum as a result of the ongoing review process (This may not be applicable to a new Program).

Example 1

(From The Jackson Clinics Orthopedic Physical Therapy Residency Program, 2009)

Due to course evaluations, the foot/ankle course by “Tim” will be expanded to two days next year.

Example 2

(Adapted from St. Catherine’s Rehabilitation Hospital & Villa Maria Nursing Center Post-professional Residency in Geriatric Physical Therapy, 2009)

As a result of the curricular review process, early on, the faculty realized that some material being taught in the former curriculum was now considered “entry-level” as the result of the transition to entry-level DPT degrees. Therefore, the lineage with transitional DPT courses had to be eliminated. As a result, the faculty developed courses, lectures, and additional didactic content that was specific to the advanced training and practice of a geriatric PT. It was determined that the material would be taught in-house, rather than partnering directly with a school for this material. Some outside faculty is used in teaching this material, however the majority of the material is taught by in-house faculty. The curriculum was scrutinized by a consultant in educational curricular development (XXXX, PT, MS, EdD, FAPTA). The curriculum was also linked, topic by topic, to the DSP. The result was a new curriculum which was presented to the Advisory Committee, approved by them, and subsequently implemented.

Example 3

(From Army-Baylor University Doctoral Fellowship in Orthopaedic Manual Physical Therapy, 2009)

A major recent program change was in the research curriculum. Previous emphasis was on the fellows being participants in group, faculty-led projects. At the 2007 annual strategic planning conference, based on input from recent fellowship graduates and faculty, along with discussions with the Baylor Deans, the program formally delineated a program research agenda and proposed a curricular shift to a primary emphasis on individual doctoral projects with secondary emphasis on group projects. Currently, fellows now complete an individual research project (prospective, IRB-approved protocol) and defend this project at their oral research defense, while still participating in larger faculty-led group projects. In support of this, a new course (Evidence Based Practice and Research Design, PHT 5230) was approved by Baylor University and added to the curriculum in first semester to guide the fellow in formulating a research question and developing their individual research project protocol. Evidence of the effectiveness of this change is provided by all projects for the last graduating class being accepted for platform presentations during the research portion of the 2009 AAOMPT national conference.

Example 4

(From Hospital for Special Surgery Sports Physical Therapy Clinical Residency, 2009)

An example of a change made in the 2009 program curriculum was the additional of several formal lectures to better reinforce the learning potential for certain content areas of the curriculum. Feedback from the 2008 Sports Resident and observations made by the program director and XXX, PT, DPT, led to the addition of didactic lectures to the Sports Education Lecture Series on “Assessment & Management of
Internal Injuries”, “Facial & Dental Injuries in Sports” and “The Disabled Athlete”. These additions are expected to strengthen the curriculum in the content area of Internal Injuries in Sports, On-Field management/Emergency Response and Special Populations respectively.

Example 5

(Adapted from Glendale Adventist Medical Center’s Orthopedic Physical Therapy Residency, 2009)

As a result of our recent meetings, our resident and mentors provided feedback regarding our preparation forms. In response to the feedback provided, we have altered our preparation form to make it more efficient for both the resident and the mentor to maximize their 1:1 mentor time.
Evidence 4.2.1 – Describe the mechanisms for determining the resident's or fellow's initial competence and safety within the clinical setting upon entry into the Program.

Example 1
(From St. Catherine’s Rehabilitation Hospital & Villa Maria Nursing Center Post-professional Residency in Geriatric Physical Therapy, 2009)

Upon entry in the program, resident’s initial competence and safety within the clinical setting is evaluated using the following criteria:

1. Licensure by the State of Florida, including completion of Florida required HIV/AIDS education, and Prevention of Medical Errors
2. Completion of the Florida Laws and Rules Examination
3. Current CPR certification
4. Must be competitive in areas of learning (letters of recommendation, statement of intent)
5. Completion of orientation to the facility
6. Completion of orientation to the residency program
7. Completion of the Resident Self-Assessment Tool
8. Observation of clinical skills by program faculty

Example 2
(From Hospital for Special Surgery Sports Physical Therapy Clinical Residency, 2009)

The following mechanisms are utilized to assess and ensure the resident’s initial competency and safety within the clinical setting.

All residents accepted into the program have the following credentials and experience:
- Graduation from an accredited Physical Therapy program
- Current Physical Therapy licensure in New York State
- One of the following: a current ATC designation, a current license as an EMT, or certification as an Emergency Responder
- Minimum of 2 or more years of experience, including 2 or more years of sports physical therapy experience OR one (1) year of sports physical therapy experience and one (1) year of experience as a certified athletic trainer (ATC) in a full-time setting.

OR

- Successful completion of HSS Sports Physical Therapy rotation to include attainment of clinical competency in Sports Physical Therapy

On entry into the program, the resident completes a knowledge inventory survey and the APTA Sports Physical Therapy Self-Assessment Tool for physical therapists. These instruments are reviewed with the resident by the program director. Any area’s deemed weak are given early attention via assigned readings, one-to-one mentoring, case review, etc.

The resident receives a thorough orientation to the hospital, Rehabilitation Department, Sports Rehabilitation & Performance Center, and the Sports Physical Therapy Clinical Residency program upon entry into the program. The first week of the program is dedicated to physical therapy observation. The
program director and/or the resident’s primary supervisor/mentor utilize the “Initial Hire Orientation/Competency Form” to educate and assess the resident during the first 6 to 8 weeks of the program to ensure that all basic standards of competency are met. During his period, the resident receives one-to-one mentoring and is closely supervised by faculty physical therapists while providing patient care. The resident continues to receive supervision throughout the program as new skills and diagnoses are introduced.

**Example 3**

*(Adapted from Kaiser Permanente Los Angeles Movement Science Fellowship, 2009)*

The following mechanisms assist in ensuring the fellow’s initial competence and safety within the clinical setting:

1. All fellows accepted into the program successfully completed an APTA accredited (or equivalent if foreign trained) professional physical therapy curriculum.
2. All fellows accepted into the program have a current license to practice from the Physical Therapy Board of California.
3. Acceptance requirements are that the fellow has two years of clinical experience in orthopaedic physical therapy prior to initiating the program.
4. The application and selection process includes either 1) an observation of the applicant performing a mock initial evaluation and treatment on a faculty member, or 2) a written/verbal recommendation from a member of the clinical faculty of either the Kaiser Permanente Southern California Orthopaedic Physical Therapy Residency or the Kaiser Permanente Fellowship program or from an alumni or either of these three programs that has worked extensively with the applicant.
5. All fellows are required to attend the Kaiser Permanente new employee orientation that includes topics such as universal precautions, fire and disaster safety, and handling of hazardous materials.
6. All employees (including the fellows) at Kaiser Medical centers are required to be current with their CPR – Basic Life Support certification.
7. A clinical faculty member begins clinical supervision of the fellow soon after the fellow initiates patient care activities at Kaiser Permanente.

**Example 4**

*(Adapted from Glendale Adventist Medical Center’s Orthopedic Physical Therapy Residency, 2009)*

The following mechanisms assist in ensuring the resident’s initial competence and safety within the clinical setting:

1. All residents accepted into the program have successfully completed an APTA accredited (or equivalent if foreign trained) professional physical therapy curriculum.
2. All residents accepted into the program have a current license to practice from the Physical Therapy Board of California.
3. If the applicant is newly graduated, a letter of recommendation from a clinical instructor is requested.
4. The application and selection process includes an observation of the applicant performing an initial evaluation and treatment on a ‘mock’ patient.
5. All residents are required to attend the Glendale Adventist Medical Center new employee orientation that includes topics such as infection control, fire and life safety, disaster orientation that includes topics such as infection control, fire and life safety, disaster preparedness and hazardous materials handling.
6. All employees (including the residents) of Glendale Adventist Medical Center are required to be current with their American Heart Association CPR for the Healthcare Provider.
7. A clinical faculty member begins direct clinical supervision of the resident immediately after the resident begins patient care activities.

Example 5

*(From Army-Baylor University Doctoral Fellowship in Orthopaedic Manual Physical Therapy, 2009)*

The following mechanisms ensure initial competency and safety within the clinical setting:

1. All fellows accepted into the program have successfully completed an APTA-accredited professional physical therapy curriculum and have current licensure to practice Physical Therapy.
2. All fellows must have a minimum of 4 years practice in orthopaedic physical therapy.
3. All fellows attend the New Hospital Employee Orientation on topics such as fire safety, risk management, quality improvement, infection control, etc. Fellows also have a ½ day orientation to clinical policies and procedures, work flow, patient flow, equipment. Fellows sign all clinical policies and procedures at orientation and annually after that.
4. All fellows must have a current BLS certification.
5. All fellows must apply to the Credentials Committee and be granted clinical privileges at BAMC.
6. One week after starting patient care, clinical mentorship begins with a minimum of 4 hours per week for each fellow. Clinical faculty are available full-time on-site during all clinical practice time.
Evidence 4.2.2.A – Describe the process used to evaluate the resident’s or fellow’s advancing level of competence and safety within an area of specialized practice, consistent with the practice description.

Example 1

(From The Jackson Clinics Orthopedic Physical Therapy Residency Program, 2009)

During the year there are weekly performance reviews, three times yearly comprehensive performance reviews, three time yearly meetings of clinical faculty and Resident directors to discuss performance, plus two written and oral exams. The three yearly performance reviews are performed by the curriculum director. They consist of 6 hours each of observation of the Resident’s performance, grading performance based on the form contained in 4.2.2.B, followed by a comprehensive review of the performance with suggestions for improvement.

Example 2

(From Army-Baylor University Doctoral Fellowship in Orthopaedic Manual Physical Therapy, 2009)

Assessing competency is an ongoing process. Written and verbal feedback are provided during clinical mentorship, supervised practical lab and review sessions. Fellows are expected to be able to explain, demonstrate, and teach examination and treatment procedures at any given time throughout the program. Fellows are also graded on written assignments and oral presentations.

Weekly feedback is provided by the clinical faculty during clinical mentorship periods, usually once per week for 4 hours minimum. Feedback is provided on all areas of the examination through the intervention process to include communication, time management, and documentation. The intention of this formative evaluation is to provide the fellow instant feedback regarding current skill level and, especially, areas and methods to improve to the next level of skill. In addition to this instant feedback, a summative evaluation is provided at the end of a 6-8 week period of mentorship. This allows the fellow to receive feedback on how they have progressed through a longer period of mentorship when patients have been followed for several weeks, often through the entire patient management cycle to discharge. Feedback is given in 10 clinical practice domains and allows the fellows to assess their progress on a larger scale. Final summative evaluation is provided at the end of each semester for a grade when 2 or more block summative evaluations are available to review.

The Clinical Mentorship Preparation Form is completed by the fellow for every return patient that the clinical faculty is seeing with the fellow. This form ensures that the fellow is prepared for clinical mentorship, quickly familiarizes the clinical mentor with the fellow’s and patient’s concerns and patient management strategy, and enhances mastery of the clinical reasoning model.

Two comprehensive written examinations for the clinical curriculum are given during the program, one at the midterm (spine focused) and one as a final examination (peripheral joint focused). Clinical faculty review the written examinations to insure objectives are met and to insure clarity, fairness, consistency in rationale, and a comprehensive nature to each exam. Additionally, a written exam is given for each clinical region during the month the region is first instructed. Additional written examinations for didactic courses form a substantial portion of the grade in Radiology, Differential Diagnosis, EBP and Research Design, and Quantitative Evaluation (Statistics).
The two formal comprehensive practical “Live Patient” examinations given during the program include a midterm (a patient with primarily spinal dysfunction) and a final examination (a patient with a primarily peripheral joint dysfunction). Each formal comprehensive examination consists of the initial examination (Monday) and two follow-up appointments (Wednesday and Friday). The program director and other clinical faculty serve as examiners. The program director and the other clinical faculty discuss and agree on the criteria and procedures for the examination and perform independent evaluations of one examination and two follow-up visits.

Specific “technique” exam (consisting of testing of 5 techniques) are given for each body region during the program (9 exams), at midterm (comprehensive spine technique exam), and near the end of the program (comprehensive peripheral joint technique exam). If a fellow fails a technique exam (<80%), he/she is not allowed to see patients with primary complaints in that region until he/she successfully retests. Likewise, failure to pass the comprehensive midterm and final exams results in remediation. Any fellow found to be unsafe during clinical mentorship receives immediate feedback and correction from the clinical faculty. Fellow evaluation and progression is ongoing on a daily basis. All evaluation procedures and treatment techniques are videotaped for use as training tools for the fellows and to establish standards for both the faculty and fellows. Clinical faculty discuss and agree on criteria/procedures for the examination and both faculty score the examinations independently to insure consistency. Evaluation of examination and treatment techniques is considered an ongoing process. Written and verbal feedback are provided during clinical mentorship and practical lab sessions throughout the program.

A graded oral clinical reasoning board is given after the first semester to provide the fellow with feedback on their level of integration of clinical reasoning skills required to master concepts in the upcoming semesters. A graded comprehensive clinical oral board is also required at the end of the program and must be passed to graduate. A fellow who fails to pass the comprehensive clinical oral board exam will be given the opportunity to sit for a retest within a week of the initial exam. A fellow who fails to pass the second iteration of this board exam will not be eligible to graduate.

The grading scheme for all coursework is as follows:

<table>
<thead>
<tr>
<th>Percentage Grades</th>
<th>Baylor GP Equivalent</th>
</tr>
</thead>
<tbody>
<tr>
<td>A = 90 – 100</td>
<td>A = 4</td>
</tr>
<tr>
<td>B = 80 – 89.9</td>
<td>B = 3</td>
</tr>
<tr>
<td>C = 70 – 79.9</td>
<td>C = 2</td>
</tr>
<tr>
<td>F = 0 – 69.9</td>
<td>F = 0</td>
</tr>
</tbody>
</table>

Results of all written, practical, clinical and oral examinations are placed on file by the program director. The fellow may review his/her exams at any time during the academic year by requesting them from the fellowship director. Immediate feedback is typically provided following an oral or practical examination.

Fellows also start a professional development portfolio as a self-reflection and development tool, and formal process to organize feedback given from multiple personal and professional dimensions throughout the program. This portfolio is reviewed with the program director 2-3 times per semester, and after major testing events as needed.

Further feedback is provided on an ongoing basis with a minimum of two formal evaluation/counseling sessions: one at midterm and one at the end of the program. Additional counseling sessions are scheduled as needed. The intent of ongoing feedback is to provide for continued, individual opportunities for growth, development, and guidance as well as to identify early on, areas needing improvement. If areas needing improvement are identified, the faculty and fellow will meet to consider an appropriate plan of
action. The program director and clinical faculty are on site and interact with all fellows on a daily basis, both informally and formally through class instruction and/or mentorship.

Upon completion of the program, Army students will receive a final, formal, summative assessment in the form of an Army Academic Efficiency Report (AER). A similar report for the other uniformed service members will be given. The rating may address overall completion of program requirements and some or all of the areas listed below:

- Oral and written communication
- Leadership skills
- Contribution to group work
- Clinical research ability
- Interpersonal relations with patients and families: communication skills, ability to establish rapport, demonstration of caring and understanding of patient/family
- Interpersonal relations with other members of the health team: utilization of contributions of others; supervises effectively, teaches effectively, contributes to team effort; has the ability to give and take advice gracefully
- Personal qualities: ability to recognize strengths and areas for improvement; successful management of pressure situations, awareness of own limits
- Clinical and technical knowledge: ability to express advanced knowledge and make judgments through appropriate verbal and written clinical reasoning; ability to develop excellent evaluation strategies and treatment programs.
- Clinical and technical skills (including various types of testing and clinical procedures which include mobilization/manipulation of spinal and peripheral joints)
- Readiness for specialty practice in advanced orthopaedic manual physical therapy
- Potential, overall performance, promotion potential, and potential for future assignments

Example 3

(Adapted from St. Catherine’s Rehabilitation Hospital & Villa Maria Nursing Center Post-professional Residency in Geriatric Physical Therapy, 2009)

Summary of Resident Evaluation

On admission, residents complete the Resident Self-Assessment Tool (RSAT).

Weekly, residents receive written and verbal feedback on performance after each mentoring session using the Mentoring Tracking Form.

After each journal club, grand rounds, or inservice presentation, residents receive written and verbal feedback using the Resident Teaching Evaluation Form.

Residents receive written and verbal formal evaluations by program faculty using the Resident Clinical Performance Evaluation at the end of each clinical rotation (3 times/year). The tool is based on the Geriatrics DSP prepared by the Specialty Council on Geriatric Physical Therapy and members of the Geriatric Section of the American Physical Therapy Association.

Residents receive three (3) Live Patient Exams (LPE’s) at the end of each clinical rotation.

Residents must also present an inservice to all rehab staff after the completion of the RAI-MDS and IRF-PAI units. These are graded as pass/fail.
Residents must submit a completed administrative project (pass/fail).

Residents must submit an evidence-based project or case study for publication in proper format (pass/fail).

In addition, residents receive performance evaluations by the physical therapy department manager or initial hire, after three months, and after one year.

The following policy and procedure applies:

<table>
<thead>
<tr>
<th>SUBJECT:</th>
<th>FORMULATION DATE: 10/01/02</th>
<th>APPROVED BY:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resident Evaluation and Remediation</td>
<td>REVISION DATE: 12/15/08</td>
<td>Greg Hartley, PT, MSPT, GCS</td>
</tr>
</tbody>
</table>

Residents complete a Resident Self-Assessment Tool (RSAT) within the first week of the program. This tool is reviewed by program coordinators and appropriate goals are set, if needed.

Residents are evaluated using a revised version of the Clinical Skills Performance Evaluation Tool for Geriatrics (APTA Publication Number E-55) called the Resident Clinical Performance Evaluation (RCPE). This is completed three times per year. Residents must receive a “satisfactory” rating in each of the components of this tool by the completion of the residency program. At the completion of each rotation, the program mentor(s) complete the RCPE. It is summarized by the mentor(s) and Program Coordinator(s). Residents must then develop a written action plan detailing how each area marked as “unsatisfactory” will be addressed in the coming rotation. The action plan is to include specific learning objectives which will be reviewed and revised (if needed) by the faculty. Any revisions will be discussed with the resident. Residents are expected to show improvement from rotation to rotation, with a minimum of 2.5 after the first rotation, 3.0 after the second rotation, and 3.5 after the third. Those who do not will be offered educational advisement where a more detailed action plan will be developed (with the Program Director’s input), including specific behavioral and learning objectives with time frames for accomplishment. This will be done on a case-by-case basis. Residents who fail to meet expected outcomes (achievement of a 3.5-4.0 on the total score) in the final rotation of the residency will be offered up to three additional months to satisfy the requirement(s) if the majority of faculty agree that the resident has the potential to make the necessary improvements within the time frame. (See Policy and Procedure for “Time Allowed to Complete Residency”).

Residents will also complete a Live Patient Exam (LPE) for each setting – Skilled Nursing Facility, Rehabilitation Hospital, and Outpatient. Residents will complete the exam at the end of each rotation and must pass each exam (≥2.0) before moving to the next setting. Students who do not pass the exam will be offered up to two extra weeks in that setting with no less than 4 hours of mentoring before retaking the exam. Students who fail the exam a second time will be referred to the Program director for education advisement. (See Policy and Procedure on “Time Allowed to Complete Residency”).

All residents will complete a written exam at the end of each rotation (3 in total) based on the didactic content provided up to that point. The exam will be composed of test questions written by the course instructors for each unit and submitted to the program coordinators for final approval and test construction. Residents must answer all questions without the use of additional materials, i.e. texts, notes, and will be given up to 90 minutes to complete the examination. Residents must score a grade of 80% or higher to pass. Those who do not attain a passing score will be given remedial education and allowed to retake the exam once. If the resident does not attain 80% or better the second time, a detailed remedial plan will be developed by the program director. (See Policy and Procedure on “Time Allowed to Complete Residency”).
Residents also receive weekly written feedback related to mentoring sessions. Residents receive informal verbal feedback on an ongoing basis.

Residents must prepare a case report or similar written product suitable for publication in a peer reviewed journal or presentation at a state or national professional conference. This project is graded as Pass/Fail by the Program Director.

Residents must prepare an administrative project to be agreed upon by the Residency Program Director/Coordinators and the Director of Rehabilitation. This project is graded as Pass/Fail by the Program Director.

Example 4

*(From Kaiser Permanente Los Angeles Movement Science Fellowship, 2009)*

The following mechanisms assist in ensuring the fellow’s advancing level of competence and safety within the clinical setting:

1. Daily/Weekly Evaluation and Feedback Forms
   
   a) *CI Prep Form:* This form is filled out by the fellow, prior to each clinical supervision period, for each patient. This form 1) ensures that the fellow is prepared for the clinical supervision period, 2) quickly familiarizes the clinical faculty with the patient’s concerns as well as the fellow’s patient management strategy up to this point, and 3) facilitates mastery of the clinical reasoning model.
   
   b) *Initial Evaluation Feedback Form:* This form is filled out during clinical supervision periods by the clinical faculty during the initial evaluation of a patient. It has sub-headings for subjective assessment, objective assessment, treatment assessment, and documentation. Fellows receive feedback as unsatisfactory, satisfactory, superior.
   
   c) *Return Visit Feedback Form:* This form is filled out during clinical supervision periods by the clinical faculty during the follow-up visits of patients. This form contains sections for evaluating the fellow’s performance of their subjective examination, physical examination, intervention, post treatment reassessment, and patient management/clinical reasoning. Fellows receive feedback as unsatisfactory, satisfactory, superior.
   
   d) *Short Clinic Reasoning Form:* This form is filled out during supervision periods by the fellow prior to the onset of the objective examination to facilitate planning, sequencing, and clinical reasoning of the objective examination.

2. Performance of Examination and Treatment Procedures
   
   a) All fellows must perform satisfactory on two technique exams. One exam will cover the Movement Impairment System model and the other is the Neuro-Motor System model.
   
   b) The fellow is expected to demonstrate a minimal level of competence for 100% of the procedures that are listed on the *Movement Science Skill List.* All of the procedures listed on this assessment tool are demonstrated during the laboratory education session of this fellowship.
3. Clinical Skills Performance

The fellow’s clinical skills are assessed using the *Movement Science Clinical Skills Performance Evaluation* tools during seven different evaluation periods of the fellowship year. Fellows must successfully pass **five** of the **seven** performance evaluations, one of which must be a single patient.

4. Written Examinations

The fellows must successfully pass two written examinations. The two written examinations are completion and evaluation of the long clinical reasoning form as part of the single patient clinical evaluation period.
Evidence 4.2.2.B – Provide didactic and clinical performance outcome assessment tools (eg, testing materials, examinations, checklists).

Example 1

2003 APTA CLINICAL SKILLS PERFORMANCE EVALUATION TOOL – ORTHOPEDIC
(Partial example—entire document is available for purchase through the APTA Services Center at 800/999-2782, x3395. Clinical Skills Performance Evaluation Tools also available for Cardiopulmonary, Clinical Electrophysiologic, Geriatric, Neurologic, Pediatric, and Sports Physical Therapy.)

Directions for the Clinical Supervisor:

1. Read each competency aspect.
2. Place an “X” in the box that BEST describes the observed behavior (unsatisfactory, satisfactory, or superior performance) on this aspect of the competency.
3. After marking each item associated with the competency aspect, record PT’s overall rating: (1) Unsatisfactory, (2) Satisfactory, or (3) Superior Performance, as the box indicates.
4. Once you have completed the entire Evaluation Tool, complete the “Summary Form” by copying each rating to the Summary Form. You will then have a global perspective for each competency and the description of advanced clinical practice.

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

<table>
<thead>
<tr>
<th>Directions: Place an “X” in the box that BEST describes behavior observed for aspect of the competency.</th>
<th>Unsatisfactory Performance 1</th>
<th>Satisfactory Performance 2</th>
<th>Superior Performance 3</th>
</tr>
</thead>
</table>

1. Ability to Obtain a History

a. Ability to develop a patient profile.

(1) Physiological data (eg, age, sex, height, weight).

(2) Functional level data (eg, nature and frequency of occupational, recreational, and other daily living activities; movement stresses; lifestyle).

(3) Psychosocial factors (eg, family/social systems offering support or stress; mental/behavioral status; cultural influences; financial resources or health insurance factors that influence treatment options; compensation or litigation status).

(4) Health promotion or disease prevention behaviors incorporated into daily activities.

Rate PT’s overall performance for the competency and record rating: (1) Unsatisfactory, (2) Satisfactory, (3) Superior. Overall Rating 3
**Example 2**

*(Adapted from The Ohio State University Medical Center Physical Therapy Residencies, 2009)*

**Operational Definitions for Assessment of Examination and Treatment**

- The goal of the OSUMC Residency Programs is to produce physical therapists that demonstrate mastery clinical skills and an advanced knowledge in the area of specialized physical therapy.
- The operational definitions will be used for the following assessments:
  - Generic Abilities
  - Assessment of Examination
  - Assessment of Treatment
  - On the Field Skills (Sports Residency Program)
  - Wellness Assessment (Sports Residency Program)
- Given that this is a post-professional training program, we expect our residents to practice at a safe and professional level with appropriate communication and initiative at all times. If any concerns arise or the faculty does not feel the resident is utilizing their skills at this level, please contact the program’s coordinator or director immediately to discuss remediation strategies.

<table>
<thead>
<tr>
<th>Scoring is as follows:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Unsatisfactory</td>
<td>Requires &gt;5 cues from evaluator to continue task</td>
</tr>
<tr>
<td></td>
<td>Fails to include important tests and measures</td>
</tr>
<tr>
<td></td>
<td>Does not use appropriate psychomotor skills</td>
</tr>
<tr>
<td></td>
<td>Demonstrates unsafe techniques</td>
</tr>
<tr>
<td></td>
<td>Gives no rationale for selection of tests and measures</td>
</tr>
<tr>
<td></td>
<td>Inefficient time management</td>
</tr>
<tr>
<td></td>
<td>Inappropriate clinical decision making process</td>
</tr>
<tr>
<td>Entry-level clinician</td>
<td>Requires 2-5 cues from evaluator</td>
</tr>
<tr>
<td></td>
<td>Completes test and measures efficiently</td>
</tr>
<tr>
<td></td>
<td>Selects appropriate test and measures and implements in a safe manner</td>
</tr>
<tr>
<td></td>
<td>Able to discuss evidence behind test and measures a majority of the time</td>
</tr>
<tr>
<td></td>
<td>Able to reflect and identify areas of improvement and strength</td>
</tr>
<tr>
<td>Certified Specialist</td>
<td>Requires &lt;2 cues from evaluator</td>
</tr>
<tr>
<td></td>
<td>Completes test and measures efficiently</td>
</tr>
<tr>
<td></td>
<td>Discusses specific research to rationalize test and measurers utilized (sensitivity/specificity, clinical prediction rules, NNT, etc)</td>
</tr>
<tr>
<td></td>
<td>Able to reflect and identify areas of improvement and strength as well as strategies to enhance skills</td>
</tr>
<tr>
<td></td>
<td>Utilizes specific knowledge of pathology and/or patient population to modify treatment and/or examination. (i.e. limited mobility expectations of rTSA vs traditional TSA, etc).</td>
</tr>
</tbody>
</table>
**Example 3**

*(From The Jackson Clinics Orthopedic Physical Therapy Residency, 2009)*

Written examinations are in the process of being assembled. We have asked faculty to submit questions and answers. The following are the performance evaluations we use weekly and three times per year.

### THE JACKSON CLINICS ORTHOPEDIC PHYSICAL THERAPY RESIDENCY

#### Daily/Weekly Feedback Form

<table>
<thead>
<tr>
<th>RESIDENT:</th>
<th>DATE:</th>
</tr>
</thead>
<tbody>
<tr>
<td>PATIENT:</td>
<td></td>
</tr>
</tbody>
</table>

#### EXAMINATION TASKS

<table>
<thead>
<tr>
<th>Skill Level</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Identify Problems/Concerns</td>
<td></td>
</tr>
<tr>
<td>Obtain Symptom History</td>
<td></td>
</tr>
<tr>
<td>Screen for Disease/Complications</td>
<td></td>
</tr>
<tr>
<td>Administer Tests and Measures</td>
<td></td>
</tr>
<tr>
<td>Community/work integration</td>
<td></td>
</tr>
<tr>
<td>Level of Pain</td>
<td></td>
</tr>
<tr>
<td>Posture/structural assessment</td>
<td></td>
</tr>
<tr>
<td>Gait/balance assessment</td>
<td></td>
</tr>
<tr>
<td>Integumentary tissue quality</td>
<td></td>
</tr>
<tr>
<td>Circulatory assessment</td>
<td></td>
</tr>
<tr>
<td>Sensory integrity</td>
<td></td>
</tr>
<tr>
<td>Reflex integrity</td>
<td></td>
</tr>
<tr>
<td>Active range of motion</td>
<td></td>
</tr>
<tr>
<td>Motor function/coordination</td>
<td></td>
</tr>
<tr>
<td>Joint integrity</td>
<td></td>
</tr>
<tr>
<td>Muscle Performance</td>
<td></td>
</tr>
</tbody>
</table>

#### EVALUATION TASKS

<table>
<thead>
<tr>
<th>Skill Level</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Interpret Data from History</td>
<td></td>
</tr>
<tr>
<td>Develop Working Hypothesis</td>
<td></td>
</tr>
<tr>
<td>Determine Appropriateness of PT</td>
<td></td>
</tr>
<tr>
<td>Plan Tests and Measures (i.e., P.E.)</td>
<td></td>
</tr>
<tr>
<td>Respond to Emerging Data from P.E.</td>
<td></td>
</tr>
<tr>
<td>Interpret Data from Physical Exam</td>
<td></td>
</tr>
<tr>
<td>Correlate History &amp; P.E. Findings</td>
<td></td>
</tr>
<tr>
<td>Identify Cause of Problem</td>
<td></td>
</tr>
<tr>
<td>Select Intervention Approach</td>
<td></td>
</tr>
<tr>
<td>Respond to Emerging Data from Rx</td>
<td></td>
</tr>
</tbody>
</table>

#### DIAGNOSIS TASKS

<table>
<thead>
<tr>
<th>Skill Level</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Establish Diagnosis</td>
<td></td>
</tr>
<tr>
<td>Determine Intervention Approach</td>
<td></td>
</tr>
</tbody>
</table>

#### PROGNOSIS TASKS

<table>
<thead>
<tr>
<th>Skill Level</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Predict Optimal Level of Function</td>
<td></td>
</tr>
<tr>
<td>Establish Plan of Care</td>
<td></td>
</tr>
<tr>
<td>Choose Assessment Measures</td>
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</table>

#### INTERVENTION TASKS

<table>
<thead>
<tr>
<th>Skill Level</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Provide Patient Education</td>
<td></td>
</tr>
<tr>
<td>Implement Therapeutic Exercise Instruction</td>
<td></td>
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</tbody>
</table>
Implement Functional Training
Implement Manual Therapy Procedures
Administer Protective/Assistive Devices

OUTCOMES REVIEW
Review Outcomes Related to Prevention
Review Functional Limitations Outcomes
Review Disability Remediation Outcomes
Review Patient Satisfaction Outcomes

Orthopedic Physical Therapy Procedures Performance Assessment Tool

Name of Resident: ________________    Year of Residency: ________________

<table>
<thead>
<tr>
<th>BODY AREA</th>
<th>Clinical Evaluator/Date</th>
<th>SUPERIOR PERFORMANCE</th>
<th>SATISFACTORY PERFORMANCE</th>
<th>UNSATISFACTORY PERFORMANCE</th>
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<tbody>
<tr>
<td>PELVIC GIRDLE</td>
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<tr>
<td>March Test – Post. and Ant. Rotation of the Innominates</td>
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<tr>
<td>PSIS/ASIS Palpation for Symmetry</td>
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<tr>
<td>Long Posterior SI Ligament Palpation</td>
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<tr>
<td>Short Posterior SI Ligament Palpation</td>
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<tr>
<td>Sacrotuberous Ligament Palpation</td>
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<tr>
<td>Innominate Isometric Mobilization (using hip flexors/extensors)</td>
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<tr>
<td>Innominate Isometric Mobilization (using hip adductors/extensors)</td>
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<tr>
<td>Innominate Posterior Rotation</td>
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<tr>
<td>Innominate Anterior Rotation</td>
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<tr>
<td>Innominate Inferior Translation</td>
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<tr>
<td>Iliacus STM</td>
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<tr>
<td>Iliacus Contract/Relax</td>
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<tr>
<td>Lumbopelvic Region Manipulation</td>
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<tr>
<td>LUMBAR</td>
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<tr>
<td>Lumbar Side Bending</td>
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<tr>
<td>Unilateral PAs</td>
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<tr>
<td>TP Assessment in Flexion/Extension</td>
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<tr>
<td>Quadratus Lumborum Palpation</td>
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<tr>
<td>Psoas Palpation</td>
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<tr>
<td>Repeated Movements Examination</td>
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<tr>
<td>Sciatic Nerve Tension Test</td>
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<tr>
<td>Lower Quarter Neuro Status Exam</td>
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<tr>
<td>Slump Test</td>
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</tbody>
</table>

Scores
0 = Not Acceptable
1 = Minimal Level of Competence
2 = Superior Level of Competence
3 = Exceptional Level of Competence

JACKSON CLINICS ORTHOPEDIC PHYSICAL THERAPY RESIDENCY
<table>
<thead>
<tr>
<th>THORACIC</th>
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<tbody>
<tr>
<td>Thoracolumbar Fascia STM</td>
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<tr>
<td>Spinal Groove STM</td>
</tr>
<tr>
<td>Quadratus Lumborum STM</td>
</tr>
<tr>
<td>Lumbar Sidebending/Rot. in Neutral</td>
</tr>
<tr>
<td>Lumbar Sidebending/Rot. in Flexion</td>
</tr>
<tr>
<td>Lumbar Sidebending/Rot. in Extension</td>
</tr>
<tr>
<td><strong>TP Symmetry in Flexion</strong></td>
</tr>
<tr>
<td><strong>TP Symmetry in Extension</strong></td>
</tr>
<tr>
<td><strong>Unilateral PA - Using Thumbs</strong></td>
</tr>
<tr>
<td><strong>Unilateral PA - Using Pisiform</strong></td>
</tr>
<tr>
<td><strong>Rib Ant/Post Positional Symmetry</strong></td>
</tr>
<tr>
<td><strong>Rib Sup/Inf Positional Symmetry</strong></td>
</tr>
<tr>
<td><strong>Rib AP Pressures</strong></td>
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<tr>
<td><strong>Rib PA Pressures</strong></td>
</tr>
<tr>
<td><strong>Thoracic Rotation SNAG</strong></td>
</tr>
<tr>
<td><strong>Contract/Relax of Extensors and SBndrs</strong></td>
</tr>
<tr>
<td><strong>Rotation/Sidebending in Flexion</strong></td>
</tr>
<tr>
<td><strong>Contract/Relax of Segmental SBndrs</strong></td>
</tr>
<tr>
<td><strong>Contract/Relax of Flexors and SBndrs</strong></td>
</tr>
<tr>
<td><strong>Rotation/Sidebending in Extension</strong></td>
</tr>
<tr>
<td><strong>Rib Posterior Glide w/ Isometric Mob</strong></td>
</tr>
<tr>
<td><strong>Rib Anterior Glide w/ Isometric Mob</strong></td>
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<table>
<thead>
<tr>
<th>UPPER THORACIC</th>
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</thead>
<tbody>
<tr>
<td><strong>TP Symmetry in Flexion/ Extension</strong></td>
</tr>
<tr>
<td><strong>Contract/Relax of Extensors and SBndrs</strong></td>
</tr>
<tr>
<td><strong>Unilateral Pas (sup/ant glides using TPs)</strong></td>
</tr>
<tr>
<td><strong>Rotation in Neutral (using adj. SP’s)</strong></td>
</tr>
<tr>
<td><strong>Rotation in Neutral (neutral gap)</strong></td>
</tr>
<tr>
<td><strong>Contract/Relax of Flexors and SBndrs</strong></td>
</tr>
<tr>
<td><strong>Rotation/Sidebending in Extension</strong></td>
</tr>
<tr>
<td><strong>Scaleni STM</strong></td>
</tr>
<tr>
<td><strong>1st Rib Inferior Glide</strong></td>
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<table>
<thead>
<tr>
<th>CERVICAL</th>
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</thead>
<tbody>
<tr>
<td><strong>Ext., SBing and Rot. to the Same Side</strong></td>
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<tr>
<td><strong>Upper Quarter Neuro Status Exam</strong></td>
</tr>
<tr>
<td><strong>Acc Mvt Tests – Ant/Superior Glide</strong></td>
</tr>
<tr>
<td><strong>Acc Mvt Tests – Segmental Sdbnding</strong></td>
</tr>
<tr>
<td><strong>Posterior Cervical Myofascia STM</strong></td>
</tr>
<tr>
<td><strong>Cervical NAG</strong></td>
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<tr>
<td><strong>Cervical SNAG</strong></td>
</tr>
<tr>
<td><strong>Cervical Superior/ Anterior Glide</strong></td>
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<tr>
<td><strong>Cervical Rotation in Neutral</strong></td>
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<tr>
<td><strong>Contract/Relax of Extensors/SBndrs</strong></td>
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<tr>
<td><strong>Sidebending/Rotation in Flexion</strong></td>
</tr>
<tr>
<td><strong>Contract/Relax Flexors/SBndrs</strong></td>
</tr>
<tr>
<td><strong>Rotation/Sidebending in Extension</strong></td>
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### UPPER CERVICAL

<table>
<thead>
<tr>
<th>Test Description</th>
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<tbody>
<tr>
<td>Vertebrobasilar Insufficiency Eval</td>
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<tr>
<td>Alar Ligament Integrity Test</td>
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<tr>
<td>Sharp-Purser Ligament Integrity Test</td>
</tr>
<tr>
<td>Suboccipital Myofascia STM</td>
</tr>
<tr>
<td>C1 Lateral Translation</td>
</tr>
<tr>
<td>C1 Anterior Glide/Occipital Post Glide</td>
</tr>
<tr>
<td>Occiput/C1 Contract/Relax of Segmental Extensors and SBndrs</td>
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<tr>
<td>Occipital Distraction</td>
</tr>
<tr>
<td>C1/C2 Contract/Relax</td>
</tr>
<tr>
<td>C1/C2 Rotation</td>
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### SHOULDER

<table>
<thead>
<tr>
<th>Test Description</th>
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<tbody>
<tr>
<td>Supra/Infra/Biceps Man. Resist. Tests</td>
</tr>
<tr>
<td>Supra/Infra/Biceps Tend. Palp/Provoc.</td>
</tr>
<tr>
<td>Glenohumeral E/R &amp; I/R ROM Exam</td>
</tr>
<tr>
<td>Glenohumeral Internal Rotation ROM</td>
</tr>
<tr>
<td>Glenohumeral Flex &amp; Abd ROM Exam</td>
</tr>
<tr>
<td>GH Acc Mvmt Tests:Post &amp; Ant Glides</td>
</tr>
<tr>
<td>A/C Acc Mvts Tests: Ant/Post Glides</td>
</tr>
<tr>
<td>Median Nerve Tension/Stretch Test</td>
</tr>
<tr>
<td>Radial Nerve Tension/Stretch Test</td>
</tr>
<tr>
<td>Ulnar Nerve Tension/Stretch Test</td>
</tr>
<tr>
<td>Muscle Length Tests: Pect. Minor</td>
</tr>
<tr>
<td>Pect. Major</td>
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<tr>
<td>Lats/Teres Maj.</td>
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### SHOULDER TREATMENT

<table>
<thead>
<tr>
<th>Test Description</th>
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<tbody>
<tr>
<td>Shoulder Elevation MWM</td>
</tr>
<tr>
<td>Subscapularis STM</td>
</tr>
<tr>
<td>Humeral Anterior Glide</td>
</tr>
<tr>
<td>Shoulder Flexors/Int. Rotators C/R</td>
</tr>
<tr>
<td>Internal Rotation MWM</td>
</tr>
<tr>
<td>Infraspinatus STM</td>
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<tr>
<td>Humeral Posterior Glide</td>
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### ELBOW

<table>
<thead>
<tr>
<th>Test Description</th>
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<tbody>
<tr>
<td>Ext. Carpi Radialis Brevis and ECRL Manual Resistive Test</td>
</tr>
<tr>
<td>Extensor Tendons Palp/Provocation</td>
</tr>
<tr>
<td>Elbow Valgus Stress Test</td>
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<tr>
<td>Elbow Acc Mvt Test: Ulnar Distraction</td>
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<tr>
<td>Radioulnar Accessory Mvt Tests:</td>
</tr>
<tr>
<td>Radial Posterior Glide</td>
</tr>
<tr>
<td>Radial Anterior Glide</td>
</tr>
<tr>
<td>Radial Distraction</td>
</tr>
<tr>
<td>Elbow Flexion MWM</td>
</tr>
<tr>
<td>Ulnar Distraction</td>
</tr>
<tr>
<td>Elbow Extension MWM</td>
</tr>
<tr>
<td>Radial Posterior Glide</td>
</tr>
<tr>
<td>Wrist Accessory Movement Tests:</td>
</tr>
<tr>
<td>---------------------------------</td>
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<tr>
<td>Ulnomeniscotriquetral Joints</td>
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<tr>
<td>Radiocarpal Joints</td>
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<tr>
<td>Intercarpal Joints</td>
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<tr>
<td>Ulnar Anterior &amp; Posterior Glides</td>
</tr>
<tr>
<td>Forearm Pronation MWM</td>
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<tr>
<td>Wrist Extension MWM</td>
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<tr>
<td>Scaphoid/Lunate Volar Glide</td>
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<tr>
<td>Wrist Flexion MWM</td>
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<tr>
<td>Hamate or Capitate Volar Glide</td>
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<tr>
<td>Proximal Carpal Row Ulnar Glide</td>
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<tr>
<td>Intercarpal Dorsal/Volar Glides</td>
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<table>
<thead>
<tr>
<th>Hand</th>
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<tbody>
<tr>
<td>1st MP Valgus Stress Test</td>
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<tr>
<td>Interphalangeal MWM</td>
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<tr>
<td>Phalanx Volar Glide</td>
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<tr>
<td>Phalanx Dorsal Glide</td>
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<table>
<thead>
<tr>
<th>Hip</th>
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<tbody>
<tr>
<td>Extension ROM</td>
</tr>
<tr>
<td>External Rot ROM at 90° of hip flexion</td>
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<tr>
<td>External Rot ROM at 0° of hip flexion</td>
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<tr>
<td>Internal Rot ROM at 90° of hip flexion</td>
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<tr>
<td>Internal Rot ROM at 0° of hip flexion</td>
</tr>
<tr>
<td>Abduction ROM</td>
</tr>
<tr>
<td>Hip Flexor Muscle Length: One Joint</td>
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<tr>
<td>Hamstring Muscle Length</td>
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<tr>
<td>SLR/Hip Adduction</td>
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<tr>
<td>Piriformis Stretch Tests</td>
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<tr>
<td>Piriformis Palpation/Provocation</td>
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<tr>
<td>Stretch Tests: Lateral Hamstring</td>
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<tr>
<td>Medial Hamstrings</td>
</tr>
<tr>
<td>Rectus Femoris</td>
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<tr>
<td>Hip Adductors</td>
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<tr>
<td>Resistive Tests: Lateral Hamstring</td>
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<tr>
<td>Medial Hamstrings</td>
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<tr>
<td>Hip Adductors</td>
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<tr>
<td>Piriformis STM</td>
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<td>-----------------------------------------------</td>
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<tr>
<td>Piriformis Contract/Relax</td>
</tr>
<tr>
<td>Trochanteric Bursa Palp/Provocation</td>
</tr>
<tr>
<td>Lateral thigh/iliotibial band STM</td>
</tr>
<tr>
<td>Lateral knee/iliotibial band STM</td>
</tr>
<tr>
<td>Psoas STM</td>
</tr>
<tr>
<td>Rectus Femoris Contract/Relax</td>
</tr>
<tr>
<td>Gluteus Maximus/Medius STM</td>
</tr>
<tr>
<td>Hip External Rotators STM</td>
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<tr>
<td>Hip External Rotators Contract/Relax</td>
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<tr>
<td>Hip Rotation MWM</td>
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<tr>
<td>Femoral Anterior Glide</td>
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**KNEE**

<table>
<thead>
<tr>
<th>Lachman’s Test</th>
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<tbody>
<tr>
<td>Valgus Stress Test</td>
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<tr>
<td>Hyperflexion Test</td>
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<tr>
<td>Hyperextension Test</td>
</tr>
<tr>
<td>McMurray’s Test</td>
</tr>
<tr>
<td>Iliotibial Band Palpation/Provocation</td>
</tr>
<tr>
<td>Pes Anserine Palpation/Provocation</td>
</tr>
<tr>
<td>Peroneal Nerve Tension Test</td>
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<tr>
<td>Common Peroneal N. Palp/Provocation</td>
</tr>
<tr>
<td>Patella Medial/Lateral Glide</td>
</tr>
<tr>
<td>Patellar Tendon Palpation/Provocation</td>
</tr>
<tr>
<td>Patella Medial Glide</td>
</tr>
<tr>
<td>Knee Flexion MWM</td>
</tr>
<tr>
<td>Tibial Anterior Glide</td>
</tr>
<tr>
<td>Fibular Posterior/Medial Glide</td>
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<tr>
<td>Fibular Anterior/Lateral Glide</td>
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**ANKLE**

<table>
<thead>
<tr>
<th>Ant. Talofibular Lig. Palp/Provocation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inversion Stress Test (Talar Tilt)</td>
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<tr>
<td>Anterior Drawer</td>
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<tr>
<td>Tibial Nerve Tension Test</td>
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<tr>
<td>Tibial N. Provocation in Tarsal Tunnel</td>
</tr>
<tr>
<td>Posterior Medial Calf STM</td>
</tr>
<tr>
<td>Posterior Lateral Calf STM</td>
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<tr>
<td>Fibular Posterior Glide</td>
</tr>
<tr>
<td>Fibular Anterior Glide</td>
</tr>
<tr>
<td>Distal Tibiofibular MWM</td>
</tr>
<tr>
<td>Ankle Dorsiflexion MWM</td>
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<tr>
<td>Talar Posterior Glide</td>
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<tr>
<td>Talar Posterior Glide MWM</td>
</tr>
<tr>
<td>Ankle Plantarflexion MWM</td>
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<tr>
<td>Talar Anterior Glide</td>
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**FOOT**

<table>
<thead>
<tr>
<th>MT Accessory Movement Tests:</th>
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<tbody>
<tr>
<td>Talus – Navicular</td>
</tr>
<tr>
<td>Navicular – 1st Cuneiform</td>
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<tr>
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</tr>
<tr>
<td>Calcaneus – Cuboid</td>
</tr>
<tr>
<td>Navicular/3rd Cuneiform – Cuboid</td>
</tr>
<tr>
<td>1st MTP Extension ROM</td>
</tr>
<tr>
<td>1st MTP Accessory Movement Test: Dorsal Glide of Proximal Phalanx</td>
</tr>
<tr>
<td>Tibial Internal Rotation/Foot Pronation</td>
</tr>
<tr>
<td>Tibial External Rotation/Foot Supination</td>
</tr>
<tr>
<td>Longitudinal Mid Tarsal Joint Mobility with Calcaneal Eversion and Inversion</td>
</tr>
<tr>
<td>Oblique Mid Tarsal Joint Mobility with Calcaneal Eversion and Inversion</td>
</tr>
<tr>
<td>Calcaneal Lateral Glides</td>
</tr>
<tr>
<td>Navicular Dorsal/Plantar Glides</td>
</tr>
<tr>
<td>Cuboid Dorsal/Plantar Glides</td>
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</table>

### Clinical Performance Evaluation Tool

**Name of Resident:**

**Evaluation Period:** First Mid-Year or Second Mid-Year or Final **Date:**

<table>
<thead>
<tr>
<th>First Name of Patient</th>
<th>Observations/Comments/Feedback</th>
<th>Corresponding Practice Dimension(s)</th>
</tr>
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<tbody>
<tr>
<td></td>
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### APTA’S Clinical Skills Performance Evaluation Tool

**Summary:** Of the ___ practice dimensions that I observed related to the APTA’s Clinical Skills Performance Evaluation Tool, you were Superior or Satisfactory on ___ of the areas and Unsatisfactory on ___ of the areas. Thus, you performed satisfactorily on ___% of the skills observed (___ divided by ___ times 100).

**Passing Criteria:** Overall Cumulative Total: Total of 225 percentage points on three Clinical Performance Evaluations

The Passing Criteria is based on the following performance expectations:

- **1st Clinical Performance Evaluation:** Satisfactory or Superior Performance on 60% of Practice Dimensions Observed
- **2nd Clinical Performance Evaluation:** Satisfactory or Superior Performance on 75% of Practice Dimensions Observed
- **3rd Clinical Performance Evaluation:** Satisfactory or Superior Performance on 90% of Practice Dimensions Observed
Attaining a Cumulative Total for the 1st and 2nd Mid-Year Clinical Performance Evaluations of less than 130 percentage points will place the resident on probation and result in the resident being required to add an additional 16 weeks and a 4th Clinical Performance Evaluation to his/her residency program.

Summary Comments:

Areas to work on in the upcoming week/months:

1. 
2. 
3. 

Example 4

(Adapted from Army-Baylor University Doctoral Fellowship in Orthopaedic Manual Physical Therapy, 2009)

Mentorship Summative Assessment Form
Army-Baylor University Doctoral Fellowship in Orthopaedic Manual Physical Therapy

Fellow Name: _____________________
Mentor Name: ____________________
Dates of Mentorship: ______________

Purpose: To provide a mechanism for faculty to student feedback over the course of a block of mentorship time (not individual sessions), and faculty to faculty communication.

Use: The results of this assessment will be discussed between the fellow and the clinical mentor/program director during individual counseling. The results are available for other mentors to review when assuming mentorship responsibilities for that student.

Communication Skills:

Hypothesis Development:

Treatment Progression:

Discharge Planning:
Exercise Prescription:

Technique Performance:

Critical Thinking:

Effective Use of Time:

Problem Solving:

Documentation:

Operational Definitions:

Communication Skills: The ability to communicate effectively (i.e. speaking, body language, reading, writing, listening) with the patient. This may include but is not limited to effectively using open-ended questions, effectively utilizing information gathered from the patient to plan the examination and treatment, and effectively instructing exercises to enhance compliance.

Hypothesis Development: The ability to gather information from the examination and synthesize that information to develop a working hypothesis for the patient’s presentation. The area of dysfunction should be defined as specifically as possible so that the most appropriate treatment can be established. Along with an accurate assessment of all areas of concern the process should include accurate assessment of the severity, irritability, nature, stage, and stability (SINSS) of the presentation.

Appropriate Treatment Progression: The ability to establish an appropriate initial treatment according to the working hypothesis and the SINSS of the patient. Also, the ability to appropriately progress the treatment according to patient response and additional information gathered during the examination process.

Discharge Planning: The indication that the treatment is appropriately aimed at the patient eventually being able to function at a level that; has met the goals of the therapist and the patient; and requires no additional clinic visits.

Exercise Prescription: The indication that prescribed exercises are individualized to each patient according to presentation of dysfunctions, success of treatment and patient’s response to the exercise.
Materials that are utilized to reinforce the exercises are also an important aspect of the exercise prescription.

**Technique Performance:** The ability to perform treatment techniques demonstrating proper patient positioning, hand placement, body mechanics and performance of different grades.

**Critical Thinking:** The ability to question logically; to identify, generate, and evaluate elements of logical argument; to recognize and differentiate facts, illusions, assumptions, and hidden assumptions; and to distinguish the relevant from the irrelevant.

**Effective Use of Time:** The ability to obtain the maximum benefit from a minimum investment in time and resources.

**Problem Solving:** The ability to recognize and define problems, analyze data, develop and implement solutions, and evaluate outcomes.

**Documentation:** The ability to clearly and accurately document the patient/client encounter in written form. The ability to complete all mentorship preparation paperwork to communicate patient progress and desired areas of focus which need to be addressed during the mentorship session.

**Example 5**

*(Adapted from St. Catherine’s Rehabilitation Hospital & Villa Maria Nursing Center Post-professional Residency in Geriatric Physical Therapy, 2009)*

Post-Professional Residency Program in Geriatric Physical Therapy at St. Catherine’s Rehabilitation Hospital and Villa Maria Nursing Center

Resident Teaching Evaluation Form

Resident Name: ___________________ Topic/Course: _________________  Date: ______

**Type of Observation:** (Circle one [or more] of the following):

<table>
<thead>
<tr>
<th>Lecture</th>
<th>Journal Club</th>
<th>Seminar</th>
<th>Conference</th>
<th>Grand Rounds/Case study</th>
<th>One-on-One</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff Inservice</td>
<td>Prof/Scientific Paper Presentation</td>
<td>Laboratory</td>
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</table>

Evaluate the above resident in each of the following categories using the following scale:

- 3 = Excellent / Outstanding
- 2 = Satisfactory/Acceptable
- 1 = Poor / Unacceptable
- NA = Not applicable

1. Knowledge of subject matter.   NA 1 2 3
2. Incorporates the behavioral objectives of the learning unit.   NA 1 2 3
3. Interest and enthusiasm in teaching.   NA 1 2 3
4. Material/presentation is well organized.   NA 1 2 3
5. Presentation relevant to audience.   NA 1 2 3
6. Stimulates interest in subject matter.   NA 1 2 3
7. Explains concepts well, even when new or difficult.   NA 1 2 3
8. Overall evaluation of this teacher.  

Comments of Observer:

Person performing this assessment:

_________________________________  ____________  
Name       Date

Resident signature (affirming this has been reviewed with them):

_________________________________  ____________  
Name       Date

St. Catherine’s Rehabilitation Hospital and Villa Maria Nursing Center  
Postprofessional Residency in Geriatric Physical Therapy

Mentoring Tracking Form

Resident’s Name: _________________________________________________________  
Date of mentoring: ________________________________________________________  
Total number of hours spent in mentoring session this date: ________________________  
Mentor’s Name(s): ________________________________________________________

Mentoring occurred in the following setting(s) (circle):

Rehab Hospital     SNF/ECF     Outpatient     LTC

Other (list): _______________________________________________________________

In the table below, document every patient that you received mentoring with today:

<table>
<thead>
<tr>
<th>Patient Initials</th>
<th>Medical Dx</th>
<th>PT Diagnosis</th>
<th>PT Practice Pattern</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

In the space below, complete the following information for two (2) of the patients with whom you received mentoring today:
**Patient #1:**

Patient Initials: ______________  Medical Diagnosis: ____________________________

Patient’s primary disability and related functional limitations, impairments, and contributing factors:

______________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

PT Diagnosis(es):

___________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

**Patient #1 continued:**

PT Practice Pattern(s):

Current management includes:

Socioeconomic and payer considerations:

Hypothesis(es) for this treatment session:

Outcome of the consultation/treatment and recommendations for further treatment:

**Patient #2:**

Patient Initials: ______________  Medical Diagnosis: ____________________________

Patient’s primary disability and related functional limitations, impairments, and contributing factors:

______________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

PT Diagnosis(es):

___________________________________________________________

PT Practice Pattern(s):

Current management includes:

Socioeconomic and payer considerations:

Hypothesis(es) for this treatment session:
Outcome of the consultation/treatment and recommendations for further treatment:

_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

Comments from resident: (Summarize areas of strength and areas for improvement. Identify specific areas for future exposure when applicable...based on the Geriatric Physical Therapy Clinical Skills Checklist):

_____________________________________________________________________________________
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Comments from mentor: (Summarize the resident’s performance as an expert in geriatric physical therapy. Mention areas of strength, and areas for improvement).

_____________________________________________________________________________________
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This feedback form has been reviewed by:

___________________________  ______________________________
Signature of Mentor     Signature of Resident
SC/VM Geriatric Residency Patient Tracking Form

Resident Name: ______________________________

Week Beginning (Sunday’s Date): _______________

<table>
<thead>
<tr>
<th>Patient Name (last, first)</th>
<th>Practice Pattern</th>
<th>Age</th>
<th>Minutes treated: Sunday</th>
<th>Mon</th>
<th>Tues</th>
<th>Wed</th>
<th>Thurs</th>
<th>Fri</th>
<th>Sat</th>
<th>Mentoring (Y/N)</th>
</tr>
</thead>
<tbody>
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</tbody>
</table>
Evidence 4.2.2.C – Provide samples of patient/client functional outcome measures used in the Program as part of the program/student evaluation process.

Example 1

(From Hospital for Special Surgery Sports Physical Therapy Clinical Residency, 2009)

The client/patient self-reported outcome measures most commonly used by the sports PT resident and faculty in the HSS Sports Physical Therapy program are listed below. Blank samples are provided as appendix 4.2.2.C. “Patient Outcome Measures”.

- Disabilities of the Arm, Shoulder and Hand (DASH)
- Knee Injury and Osteoarthritis Outcome Scores (KOOS)
- Lower Extremity Functional Scale (LEFS)
- Modified Oswestry Low Back Pain Disability Questionnaire

Example 2

(From The Jackson Clinics Orthopedic Physical Therapy Residency, 2009)

We use a variety of functional outcome tools including Neck Disability Index, Oswestry, Roland Morris, Lysholme, Hip Function Assessment, Shoulder Function Assessment, Foot Ankle Disability Index, Elbow/Wrist/Hand Disability Index. These are all very commonly used forms and I will gladly provide samples if requested.

Example 3

(Adapted from St. Catherine’s Rehabilitation Hospital & Villa Maria Nursing Center Post-professional Residency in Geriatric Physical Therapy, 2009)

Please see Appendix 6 for copies of the patient/client functional outcome measures used in the Program. Outcome measures include the FIM, Minimum Data Set (MDS), Timed Up and Go Test, Geriatric Depression Scale (SHORT Form), Tinetti Assessment Tool, and the Berg Balance Scale.

Example 4

(Adapted from Army-Baylor University Doctoral Fellowship in Orthopaedic Manual Physical Therapy, 2009)

Please see Evidence Tab 4.2.2.C. Included are the GROC, ODI, NDI, WOMAC, SPADI, and Patient Specific Functional Scale.
Evidence 4.2.2.D – Describe how the data compiled from the performance measures are used to assess the resident's or fellow's performance and impact the resident’s or fellow’s plan of study.

**Example 1**

*(From Army-Baylor University Doctoral Fellowship in Orthopaedic Manual Physical Therapy, 2009)*

Monthly peer review sessions are completed on all physical therapy staff members providing direct patient care, to include the fellows. Outcome assessment tools such as those mentioned in Evidence 4.2.2.C are part of the peer review process. Each fellow receives feedback from other staff members as well as faculty regarding patient outcomes. Clinical faculty also assess these outcome measures during clinical mentorship and during tutorial sessions.

Fellows track a minimal data set on all their patients, with a primary outcome tool of the Global Rating of Change (GROC) and then region specific tools such as the ODI, NDI, and SPADI. They formally review their collective outcomes in their Professional Development Portfolio, which is reviewed with the program director. This provides an opportunity for the fellows and program director to assess outcomes. In an example from the last graduating class, one observation was minimal changes in the outcome measure in the shoulder region (measured on SPADI) for several patients of one fellow. This was combined with an overall lower number of shoulder evaluations over the 6 month period compared to other fellows. The program director and clinic chief were then able to prioritize scheduling additional shoulder patients for this fellow, who also tried to plan follow-up with these patients during mentorship days. Consistent, larger scale changes (exceeding the minimal clinically important difference) were observed at the next portfolio review session.

Lastly, fellows use a variety of functional outcome measures for the clinical research project they complete during the program. The results of their treatment are formally analyzed. These data serve as the ultimate objective scientific assessment of any provider’s clinical performance. Prior research conducted by the program has demonstrated the effectiveness of the treatment approach taught in the program and have been published in several peer-reviewed journals (*Annals of Internal Medicine, JOSPT, Physical Therapy, Spine)*.

**Example 2**

*(Adapted from St. Catherine’s Rehabilitation Hospital & Villa Maria Nursing Center Post-professional Residency in Geriatric Physical Therapy, 2009)*

Residents are assessed on the performance measures as described in the “Resident Evaluation and Remediation” policy included in Evidence 4.2.2.A. Plans of study are revised according to this policy.

St. Catherine’s Rehabilitation Hospital and Villa Maria Nursing Center does not currently track patient/client outcomes by a specific therapist. Due to the complexities of staffing a seven day-a-week, 365 day-a-year hospital-based clinic, it is normal for patient’s to have multiple therapists during their stay in the facility. There are also physical therapist’s assistants who see patient’s after a physical therapist has evaluated them. Again, it would be impossible to link patient/client outcome to just a single therapist. Having said that, the residents are “concentrated” in a specific area of the hospital for extended periods. For example, residents spend several months in SNF, then rotate to rehab hospital, then rotate again to outpatient. Even with these “concentrations”, there are other therapists involved in the care of each patient.
However, the facility does track outcomes. The FIM is used for patients in the rehabilitation hospital, the MDS (with its crucial indicators) is used for the skilled nursing facility and long-term care units. In the outpatient clinic, multiple assessment tools are used to document improvement/outcome, including the Berg Balance Scale, Tinetti Gait and Balance Scales, and Timed Up-and-Go Test. Patient satisfaction surveys are used in all areas. Data from the satisfaction surveys, FIM reports, and Medicare (CMS) ratings for Nursing Homes is shared with all staff on a monthly basis.

In addition, mentors are constantly involved in assuring the residents achieve optimum clinical outcome with their patients. Mentoring is frequent enough to monitor this closely. Additionally, residents practice in an “open” clinic (without walls), where mentors and other staff members are continually present. Even if structured mentoring is not occurring, the residents have access to mentors and other staff at all times (and mentors supervise clinical decisions on a daily basis).

Samples of common tools used are included in Appendix 6. Residents are expected to learn how to use these performance-based tools, interpret data and results via their use, and make changes to care delivery as a result of measured outcomes. Residents who fail to make practice changes as a result of performance measures are remediated per facility and residency program policy.

**Example 3**

*(From Hospital for Special Surgery Sports Physical Therapy Clinical Residency, 2009)*

During weekly case review and/or one-to-one mentoring sessions, the sports resident formally meets with a physical therapy faculty member and/or the program director to discuss his/her caseload. Due to the close proximity of the clinical treatment area and staff office, physical therapy faculty are readily available to informally review the sports resident’s caseload as needed. Verbal feedback is provided.

Assessment of performance is based utilizing the following assessment tools:

- Chart review
  - Documented patient/client outcome measures as those provided as Evidence 4.2.2.C
  - Document functional limitations
  - Goal Setting
    - Functional, Objective, Realistic
- Direct observation of patient care provided during weekly one-to-one mentoring time
- Discussion with the sports resident during formal case review or mentoring sessions or informally during the course of the work day to assess clinical reasoning skills and clinical knowledge

Verbal feedback is always provided. Written assessment is provided at 6 weeks into the academic year using the Initial Hire Orientation/Competency Form, at 6 months using the mid-year performance appraisal and at the end of the academic year using the Residency Final Evaluation Form.

**Example 4**

*(Adapted from Glendale Adventist Medical Center’s Orthopedic Physical Therapy Residency, 2009)*

Self-report questionnaires, such as the above-mentioned patient measures in Evidence 4.2.2.C, are used by the clinical faculty and residents to provide an objective measure to contrast with or complement the data collected during the resident’s history and physical examination of his/her patient. These measures are also often used where the resident suspects that a patient’s examination, diagnosis, and intervention may result in a case report.
Evidence 4.2.3 – Describe the Program’s remediation process and the criteria for dismissal if remediation efforts are unsuccessful.

Example 1

(Adapted from St. Catherine’s Rehabilitation Hospital & Villa Maria Nursing Center Post-professional Residency in Geriatric Physical Therapy, 2009)

<table>
<thead>
<tr>
<th>SUBJECT:</th>
<th>FORMULATION DATE: 10/01/02</th>
<th>APPROVED BY:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resident Evaluation and Remediation</td>
<td>REVISION DATE: 12/15/08</td>
<td>Greg Hartley, PT, MSPT, GCS</td>
</tr>
</tbody>
</table>

Residents complete a Resident Self-Assessment Tool (RSAT) within the first week of the program. This tool is reviewed by program coordinators and appropriate goals are set, if needed.

Residents are evaluated using a revised version of the Clinical Skills Performance Evaluation Tool for Geriatrics (APTA Publication Number E-55) called the Resident Clinical Performance Evaluation (RCPE). This is completed three times per year. Residents must receive a “satisfactory” rating in each of the components of this tool by the completion of the residency program. At the completion of each rotation, the program mentor(s) complete the RCPE. It is summarized by the mentor(s) and Program Coordinator(s). Residents must then develop a written action plan detailing how each area marked as “unsatisfactory” will be addressed in the coming rotation. The action plan is to include specific learning objectives which will be reviewed and revised (if needed) by the faculty. Any revisions will be discussed with the resident. Residents are expected to show improvement from rotation to rotation, with a minimum of 2.5 after the first rotation, 3.0 after the second rotation, and 3.5 after the third. Those who do not will be offered educational advisement where a more detailed action plan will be developed (with the Program Director’s input), including specific behavioral and learning objectives with time frames for accomplishment. This will be done on a case-by-case basis. Residents who fail to meet expected outcomes (achievement of a 3.5-4.0 on the total score) in the final rotation of the residency will be offered up to three additional months to satisfy the requirement(s) if the majority of faculty agree that the resident has the potential to make the necessary improvements within the time frame. (See Policy and Procedure for “Time Allowed to Complete Residency”).

Residents will also complete a Live Patient Exam (LPE) for each setting – Skilled Nursing Facility, Rehabilitation Hospital, and Outpatient. Residents will complete the exam at the end of each rotation and must pass each exam (≥2.0) before moving to the next setting. Students who do not pass the exam will be offered up to two extra weeks in that setting with no less than 4 hours of mentoring before retaking the exam. Students who fail the exam a second time will be referred to the Program director for education advisement. (See Policy and Procedure on “Time Allowed to Complete Residency”).

All residents will complete a written exam at the end of each rotation (3 in total) based on the didactic content provided up to that point. The exam will be composed of test questions written by the course instructors for each unit and submitted to the program coordinators for final approval and test construction. Residents must answer all questions without the use of additional materials, i.e. texts, notes, and will be given up to 90 minutes to complete the examination. Residents must score a grade of 80% or higher to pass. Those who do not attain a passing score will be given remedial education and allowed to retake the exam once. If the resident does not attain 80% or better the second time, a detailed remedial plan will be developed by the program director. (See Policy and Procedure on “Time Allowed to Complete Residency”).
Residents also receive weekly written feedback related to mentoring sessions. Residents receive informal verbal feedback on an ongoing basis.

Residents must prepare a case report or similar written product suitable for publication in a peer reviewed journal or presentation at a state or national professional conference. This project is graded as Pass/Fail by the Program Director.

Residents must prepare an administrative project to be agreed upon by the Residency Program Director/Coordinators and the Director of Rehabilitation. This project is graded as Pass/Fail by the Program Director.

Residents will be dismissed from the program for any of the following reasons:

- Failure to abide by Florida Physical Therapy Practice Act
- Failure to abide by the American Physical Therapy Association’s Code of Ethics/Conduct
- Failure to abide by the policies of St. Catherine’s Rehabilitation Hospital & Villa Maria Nursing Center or the policies of the Residency Program
- In the event a resident does not meet the employment requirements of the residency, he/she will be dismissed from the residency program.
- Failure to achieve a score of “satisfactory” or better in each of the rotations required as a part of the residency program
- At the discretion of the Program Director (for reasons not listed above)

DUE PROCESS:

As employees of St. Catherine’s/Villa Maria, residents are subject to the same policies governing dismissal, termination, and grievance as any employee at St. Catherine’s/Villa Maria.

Example 2

(From Army-Baylor University Doctoral Fellowship in Orthopaedic Manual Physical Therapy, 2009)

The program follows the policies and procedures of the Allied Health Education Committee (AHEC), part of the Graduate Medical Education department in the hospital. References for the Due Process Policy and the Procedures for Addressing Trainee Concerns and Grievances are provided in the student handbook and available online to the fellows (Appendices B and D, respectively, of the Army-Baylor University Policy and Procedures Manual).

In brief, remediation is a three-tire process. It begins with program level remediation (program only, AHEC is informed), then progresses on to formal academic probation (AHEC committee level event), and finally termination (Hospital level event).

Program level remediation is initiated in the event a fellow is not performing to the standard expected by the program director and/or faculty. A faculty board will convene to review the fellow’s performance and potential courses of action. The faculty will meet with the fellow to discuss the results of the faculty board and courses of action. Courses of action may include, but are not limited to: extra reading/research assignments, additional case study homework assignments, additional written, oral, and/or practical
examinations, and additional clinical mentorship time. During this time the fellow will be assigned a faculty mentor to assist him/her and consult with.

Academic probation is discussed in detail in the Due Process Policy referenced. The following excerpt is taken from this policy to describe the criteria for dismissal if remediation efforts are unsuccessful.

Termination is the most serious academic action the AHEC can impose and means the program director and training committee feel the trainee will be unable to obtain the Knowledge, Skills, and Attitudes in the professional domains necessary to be a fully independent practitioner in their specialty. Termination will normally be considered only after a period of AHEC approved academic probation, but may be considered after a single incident of gross negligence or willful misconduct. A recommendation for termination must be approved by a two-thirds majority vote of the AHEC voting members present.

A. Recommendation for termination must be based upon one of the following:
   1. Failure to satisfactorily correct deficiencies while on academic probation.
   2. Regression or failure to satisfactorily progress after removal from prior academic probation.
   3. When continuation in training presents a hazard to patients or the trainee.
   4. Any evidence of gross negligence, willful misconduct or professional dishonesty. This may be a pattern of past performance or may reflect a single act. Under these circumstances the trainee may be placed on administrative duties and removed from patient care responsibilities until resolution of the termination process. Termination under these circumstances requires notification of appropriate hospital authorities.
   5. Failure to meet significant military/professional milestones or requirements (determined by Service Regulation and Policy) despite documented attempts at remediation.
   6. Other circumstances that indicate to the program director and the training committee that the trainee cannot be successful in achieving the goals and objectives of the program.

Example 3

(From Hospital for Special Surgery Sports Physical Therapy Clinical Residency, 2009)

Remediation Process for Hospital for Special Surgery Rehabilitation Department Residency and Fellowship Programs

Residents/fellows are instructed in the criteria for successful completion of all program requirements. If a resident or fellow fails to successfully complete any required competency, performance review, examination or project in the established timeframes, or fails to conduct him/herself in a professional manner, the following remediation process is initiated.

1. Program Director discusses the identified issue with all involved faculty to clarify the deficiency.
2. Program Director discusses the issue with the Rehabilitation Department and action to correct the deficiency.
3. Program Director discusses identified issue and action plan with resident/fellow.
4. Action plan is initiated to include:
   a. Identification of area(s) needing development or improvement
   b. Detailed objective and measurable steps to be taken for each identified area, specifying responsibilities of resident/fellow and faculty members, and available resources. Types of steps that may be indicated include, for example:
      1) Additional lectures, readings and/or assignments
      2) Additional lab sessions to address specific clinical skills
      3) Additional co-treatment sessions to address area(s) of clinical deficiency
4) Change in format for supervisor of case review sessions
5) Increased frequency of case review sessions
6) Additional written and/or practical examinations

c. Timeframes, including milestones if appropriate
d. Signatures of Program Director and resident/fellow

5. The remediation process is complete once the resident/fellow successfully completes the action plan.
6. In the event that a resident/fellow does not successfully complete the action plan, he/she is subject to dismissal.

Appeals Process

Should a resident or fellow wish to appeal an evaluation of their performance on any aspect of the program requirements, he/she should first meet with the individual who completed the evaluation and the Program Director. If they are unable to reach a resolution, the resident/fellow may file a written appeal with the Vice President of Rehabilitation. The Vice President will meet with the resident or fellow and will consult with the Rehabilitation Department Residency and Fellowship Advisory Team to determine and report the results.

Attendance Policy

The attendance policy for all employees of Hospital for Special Surgery is described in policy number 2.02 of the Human Resources Policy and Procedures Manual. Should a problem of absenteeism or tardiness be identified, the following actions are taken.

1. Program Director discusses attendance issue with the Rehabilitation Department Residency and Fellowship Advisory Team to plan and document course of action.
2. Program Director discusses attendance issue with resident/fellow.
3. Program Director will follow policy 2.02 procedures of oral warning, written warning, suspension and discharge for excessive occurrences.

Example 4

(From Kaiser Permanente Los Angeles Movement Science Fellowship, 2009)

Unsatisfactory performance on any of the seven “Fellowship Performance/Completion Requirements” will result in the fellow being counseled by the program coordinator regarding the impact of the demonstrated unsatisfactory performance on the fellow’s ability to successfully complete the program. If the fellow performs unsatisfactorily on two clinical performance evaluations prior to “Evaluation Period #3,” he/she will receive verbal and written confirmation that improved performance is required to successfully complete the program. It will be communicated to the fellow that if the fellow’s performance remains unsatisfactory, and he/she does not perform satisfactorily on any of the remaining “Fellowship Performance/Completion Requirements,” the fellow will not receive a certificate of completion of the program for that year. In this case, the Department Administrator of the facility that employs the fellow retains the option to allow the fellow (if the fellow so chooses) to remain employed as a fellow in order to attempt to successfully complete the program in the subsequent year.
Evidence 4.3.1.A – Provide a list of the measures used to evaluate the clinical abilities and characteristics of the Program's graduates, and cross-reference with the Program goals listed in Evidence 1.2.1.A.

Example 1

(Adapted from St. Catherine’s Rehabilitation Hospital & Villa Maria Nursing Center Post-professional Residency in Geriatric Physical Therapy, 2009)

Graduate Performance Feedback for Employers

Facility Name: ____________________  Date: _________________  Faculty: ____________

Person interviewed is:  ____Employer  ____Co-Worker  ____Employee of a residency graduate

The residency graduate has been at this facility for: _________ months, ________ years.

Year of graduation from residency program: ____________

Interview Guide:
We are interested in knowing more about how St. Catherine’s/Villa Maria Geriatric Residency Graduates perform in the clinical setting. Compare the residency graduate to your “ideal PT” with particular regard to independent function and geriatric expertise. Comment on strengths and weaknesses, which you have observed. Consider the following areas:

<table>
<thead>
<tr>
<th>STRENGTHS</th>
<th>WEAKNESSES</th>
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<tbody>
<tr>
<td>Professional behavior (i.e., interaction, legal/ethical practice):</td>
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<tr>
<td>Knowledge of basic sciences as it applies to geriatric client management:</td>
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<tr>
<td>Communication (with patients, families, colleagues, other health providers):</td>
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<tr>
<td>Screening and evaluation of the geriatric patient:</td>
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<tr>
<td>Clinical management of the geriatric patient (examination, evaluation, diagnosis, prognosis, and intervention):</td>
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<tr>
<td>Education of patient, family, and staff as it relates to the management of the geriatric client:</td>
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</tbody>
</table>
Administrative skills relative to geriatric client management (dealing with third party payers, program development, creative and innovative uses of resources):

Consulting skills (Patient care treatment teams, patients, families, community organizations):

Application of new research and information to clinical practice and staff development, and demonstration of professional growth:

When the SC/VM residency graduate began employment at your facility, how much experience did the graduate have in general physical therapy practice?

_______ years/_______ months

When the SC/VM residency graduate began employment at your facility, how much experience did the graduate have in geriatric physical therapy practice?

_______ years/_______ months

In your opinion, how well is the graduate prepared to function independently as a geriatric physical therapist? Specifically, what are weaknesses and strengths in overall preparation?

How well is the graduate prepared to serve as a mentor to other physical therapists or physical therapy interns?

Were there any particular areas of weakness or deficits in their preparation to enter the field as a geriatric physical therapist?

Are there any characteristics that identify the “SC/VM Residency Graduate” (strengths or weaknesses in other areas not identified above)?

Example 2

(Adapted from Army-Baylor University Doctoral Fellowship in Orthopaedic Manual Physical Therapy, 2009)
Please refer to Appendix 4.3.1.B for actual graduate survey form.

Goal: *Attract the best students and faculty*

Performance Outcomes:

1. Each fellow will complete the 60 semester hour doctoral-level curriculum with at least a grade of “B” (80%) for each class.
2. Each fellow will earn the DScPT degree from Baylor University after successfully completing an oral defense of an individual research project and a comprehensive oral board exam.

Goal: *Demonstrate value to the: Department of Defense (DoD), Army Medical Command (MEDCOM), the Army Medical Specialist Corps, Brooke Army Medical Center, Department of Orthopaedics & Rehabilitation (DOR), Baylor University, and the civilian profession*

Performance Outcomes:

1. Fellows will successfully complete the program’s military-unique curriculum by attending the Joint Operational Deployment Course.
2. Army graduates will be fully deployable and able to serve as PROFIS (combat support) physical therapists in Combat Support Hospitals or Brigade Combat Teams for humanitarian, peacekeeping, or combat missions when necessary. Graduates of other Services will be fully deployable and able to serve the needs of their respective organizations.

Goal: *Produce master clinicians*

Performance Outcomes:

1. Demonstrate a satisfactory performance (80%) on the written clinical examinations given at midterm and at the end of the year.
2. Demonstrate a satisfactory performance (80%) on the practical/technique examinations given for each body region and at the midterm and end-of-year comprehensive techniques examinations.
3. Demonstrate a satisfactory performance (80%) on the formal “Live Patient” initial patient examination and two follow-up appointments given at the midterm and at the end of the year.
4. Design and implement physical therapy interventions that address the key impairment(s) and result in an improvement of the functional limitation(s) and disability in patients with musculoskeletal disorders consistent with best available evidence.
5. Each fellow will complete 150+ hours of 1:1 mentorship with a clinical faculty who is a fellow in the AAOMPT. Each fellow will complete at least 40 hours of tutorial (case review sessions) with a clinical faculty who is a fellow in the AAOMPT and residency/fellowship trained.

Goals: *Produce publishing researchers*

Performance Outcomes:

1. Submit and defend a research protocol for the Institutional Review Board (IRB).
2. Submit an abstract of individual project for presentation at the AAOMPT annual conference.
3. Submit a final manuscript of the research project for publication in a peer-reviewed journal.
4. Submit a written report of an assigned area of responsibility in a group project to the project primary investigator (PI).
Goal: Produce clinical and academic educators

Performance Outcomes:

1. Demonstrate the skills to be an effective adult educator through the academic and clinical instruction of entry-level physical therapists from local civilian programs and/or the Army-Baylor Doctoral Program in Physical Therapy.
2. Teach in the Advanced Clinical and Operational Practice Course, Joint Operational Deployment Course, Texas Physical Therapy Association chapter meetings, and the Army-Baylor entry-level DPT program.

Goal: Promote advancement in the field of orthopaedic manual therapy and professional development by supporting the APTA and AAOMPT mission, vision and standards of ethical practice

Performance Outcomes:

2. Be an active member of the APTA and the Orthopaedic Section of the APTA.

Example 3

(Adapted from AllStar Therapy Geriatric Residency Program, 2010)

The surveys that are sent out to both past residents and their employers are geared to help identify if our corporate and program goals are being met as identified in 1.2.1.A.

Geriatric Resident Post-Graduate Performance Survey

AllStar Therapy is interest in feedback about your advanced practice following completion of our Geriatric Residency Program. We are interested in knowing if our goals as an organization and program have been met with your advanced training. Your feedback is very important to us and will assist us with information necessary for ongoing development of our program.

We thank you for taking the time to complete this survey.

AllStar Therapy Geriatric Residency Program Director

Person Performing Survey: _____________________________  Date: ________________________
Place of Current Employment: ______________________________________________________
Employer Address: _________________________________________________________________
Supervisor: _______________________________________________________________________

We have your permission to contact your present employer for feedback on your performance?
Yes □  No □
Contact Information for employer (phone/email): _______________________________________
Start Date of Employment: ______________   Completion date of residency program: ____________

<table>
<thead>
<tr>
<th>Feedback</th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Neutral</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>I am offering an exceptional model of patient/client management</td>
<td></td>
<td></td>
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<tr>
<td>representative of advanced clinician</td>
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<tr>
<td>My training prepared me to sit for the ABPTS GCS examination</td>
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<tr>
<td>Did you sit for the examination: Yes □  No □</td>
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</tbody>
</table>
Did you pass the examination:  Yes □ No □
I am seen as a mentor and motivator to other clinicians who I currently work with
I regularly provide advanced education and training throughout my facility in the area of geriatrics
I am a consultant/advocate for my peers in performance and outcomes
I perform and demonstrate regular education to community and professional colleagues on my area of specialty
I have continued with my ongoing education in the advancement and expansion of my professional development/scope of practice
I participate in regular research projects that will continue to support the practice of evidence based care
I have submitted an abstract for presentation or published research that I have performed

Please provide us with any additional comments:
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________
Evidence 4.3.1.B – Describe how the information collected from Program graduates is used to evaluate and modify the Program. If the Program is new, describe how the information will be used.

Example 1

(From St. Catherine’s Rehabilitation Hospital & Villa Maria Nursing Center Post-professional Residency in Geriatric Physical Therapy, 2009)

Within 12 months of completion of the program, a “Resident Outcome Survey” and “Employer Performance Feedback” is completed (where applicable). In addition, residents sitting for the Geriatric Specialty Exam (given by ABPTS) are contacted personally by program faculty regarding their performance on this exam. The information gathered from both of these items is shared with the Advisory Committee and then used to evaluate and modify the Program accordingly. It is expected that 100% of graduates who sit for the GCS exam administered by the ABPTS will pass.

Example 2

(From Army-Baylor University Doctoral Fellowship in Orthopaedic Manual Physical Therapy, 2009)

One year after the program, graduates, their employers, and patients are asked to complete a written survey to assist in determining the effectiveness of the program with regards to their roles in clinical research, clinical education, and provision of highly effective care within their regional medical commands. Please see Evidence Tab 4.3.1.B for a copy of the graduate’s survey. This survey is a combination of program specific questions and also adapted from a survey published in the peer-reviewed literature (Smith et al. Orthopaedic Residency Training: A Survey of the Graduates’ Perspective. *JOSPT* 1999;29:635-655). This survey update is discussed in evidence 4.3.1.C as one of the program improvement initiatives.

The results of these surveys are evaluated and discussed during formal annual strategic planning conferences/retreats as a major agenda item. Additionally, the information is used in preparation of annual learning assessment reports to Baylor University. Lastly, these results are part of the ongoing informal discussions between the program director and the clinical/academic faculty, along with the clinical and department leadership.

Example 3

(Adapted from AllStar Therapy Geriatric Residency Program, 2010)

As a new program we have not had the ability to obtain feedback from past residents. However, it is anticipated that with information shared in the post graduation surveys, discussions regarding the findings will be shared at the Program Review Board’s bi-annual meeting. This information may be utilized to identify any modifications to the program.
Evidence 4.3.1.C – Describe an example of how the Program has been modified as a result of the information received from graduates (not applicable for new Programs).

Example 1

(From Army-Baylor University Doctoral Fellowship in Orthopaedic Manual Physical Therapy, 2009)

One of the primary feedbacks from the graduate surveys was that it was difficult to read (layout/format), some items seemed not applicable, and other information thought important was not included. As a result of this, the program director and faculty (and recent graduates still in the area) reviewed the past survey along with proposed changes at the annual strategic planning meeting. After further edits were made, the survey was approved by the director and faculty and will be sent to the recent graduating class (Dec 2008) at their one year graduation anniversary. Feedback from this initiative will be submitted as part of the next annual report to the APTA.

Example 2

(From St. Catherine’s Rehabilitation Hospital & Villa Maria Nursing Center Post-professional Residency in Geriatric Physical Therapy, 2009)

To date, 100% of program graduates have taken and passed the ABPTS Geriatric Specialty Certification Exam. Also, program outcome data indicated that program graduates are involved in clinical research, teaching in entry-level PT programs, and participate in professional associations at the local, state, and national level. Graduates have presented posters at CSM’s, and published articles. This data is reviewed at least annually by the Program Director and Advisory Committee. Thus far, changes to the program have been the result of resident request, faculty request, or on the advice of consultants with the intent of improving outcomes even more. No changes have been necessary due to failure to achieve goals. The program has continually met its goals.

See most recent minutes from the Advisory Committee meeting of November 7, 2008 which demonstrated review of policy and procedures, review of the curriculum, review of program outcomes, and the budget (following pages).