

# Guiding Principles for Best Practices in Geriatric Physical Therapy

## Academy of Geriatric Physical Therapy Task Force on Best Practice

In alliance with the Academy's [Mission and Vision](#), the physical therapy care of older adults encompasses the entirety of the aging person within their unique environment and throughout their aging process. We believe the Physical Therapist/Physical Therapist Assistant (PT/PTA) must advocate to reduce health disparities and health care inequities, improve access to health care services, and address the health, wellness, and preventative health care needs of people. Concurrently, the physical therapist must consider the influence and effects of a person's environment consistent with the American Physical Therapy Association's Code of Ethics<sup>1</sup>. The pervasive culture of ageism also requires advocacy in terms of lobbying efforts for improved access, appropriate payment, negotiation with providers about optimal practices, and referral to appropriate community programs and resources. Through this advocacy, the PT/PTA team is integral to optimizing the aging process.

Best practice care requires value-based care. Value based care is defined as the health outcomes achieved per dollar spent and reflective of the patient's experience of care<sup>2</sup>. Physical therapists are accountable for providing best practice care which is safe, effective, patient/client-centered, timely, and efficient.<sup>3</sup> Accountability includes a lifelong dedication to learning and a recognition that as knowledge and cultural understanding evolves, so must one's practice.

Evidence-based practice is the foundation of best practice care. Evidence-based practice is care based on the best available evidence, the patient/family's values, and the clinical reasoning and experience of the therapist<sup>4</sup>. Evidence-based care is translated and communicated with a person-centered framework<sup>5</sup> and with an anti-ageist attitude<sup>6</sup>. Best practices are intentional care that considers value, optimal communication, interprofessional collaboration, consideration of the continuum of care, and sound assessment and intervention techniques and skills. Best practices are to be strived for and are in continual evolution. The following are guiding principles for Best Practices in providing geriatric physical therapy.

### **Principle 1: Utilize person centered care to elicit and prioritize the individual's preferences, values, and goals to drive the plan of care.**

Person-centered care is one of the six pillars from the Institute of Medicine that supports quality health care<sup>3</sup>. The PT and PTA should recognize the uniqueness of each individual when establishing a therapist-client relationship. During the initial episode of care, there must be efforts made to promote a person-centered approach based on trust, mutual respect and understanding to ensure that the patient/client is empowered to be an active participant and driver of their care. Conversations must be initiated to understand the patient's unique values, goals, and preferences for the delivery of care and to ensure a successful and meaningful plan of care. The therapist needs to advocate to address barriers and promote successful implementation of the person-centered plan and provide resources when appropriate. Patient empowerment should be emphasized during and outside of the therapy session.

**Action steps:**

1. The patient is the primary driver of their plan of care. Key elements of this collaboration are to
  - a. use shared decision making to create agreed upon individualized, meaningful goals to ensure patient engagement<sup>7</sup>.
  - b. Inquire about the patient's desires for and extent of involvement of individuals important to them (i.e. caregivers, family, friends) in the creation of this plan of care<sup>7,8</sup>.
  - c. Provide patient time and preparation to consider goal and rehabilitation plan of care options<sup>7</sup>
  - d. Avoid ageist practices including paternalism, persuasion, and coercion during the goal setting process<sup>9</sup>
2. Create an authentic patient-client relationship based on mutual trust, respect, active listening, being wholly present during the therapy session, acknowledgment of patient's concerns and viewpoints, and the use of clear effective communication strategies<sup>10</sup>.
3. Establish an environment that encourages self-efficacy during each encounter<sup>10</sup>.
4. Foster patient autonomy through education about their outcomes and promotion of self-monitoring. E.g. Monitor and communicate clinical measurements and provide context by comparing those numbers against a sample of a similar population. Use of strategies such as "people like me" charts to encourage patient monitoring<sup>11</sup>.
5. Promote patient engagement with individualized, higher intensity intervention programs that directly relate to the patient's stated goals<sup>12</sup>.
6. Utilize proactive risk management, including assessing positive risk of an activity for the individual in the medical, physical, psychological, and social domains. "Care providers and health professionals have both a duty to uphold the basic rights and freedoms of their resident, and a duty of care to protect them from foreseeable harm. It is important to recognize that it is not possible to eliminate risk entirely, and that it is essential that residents are given the freedom of choice and the right to make their own decisions, on everything from how they want to be cared for, to how they want to spend their free time."<sup>13</sup>

**Principle 2: Strive for anti-ageist practice**

Anti-ageist practice resists the powerful stereotypes that demean individuals because of their age. Without overcoming these stereotypes there is greater risk for sub-standard care, increased healthcare costs and shorter life span for patients who internalize ageist beliefs.<sup>14,15, 16</sup> An anti-ageist attitude is a proactive stance of valuing the aging adult, supporting the person's intentional aging, and empowerment to make informed decisions within the individual's value system and available resources.

**Action steps:**

1. Assess your implicit bias for age and other factors (e.g. [Harvard Implicit Bias](#))
2. Avoid images and language that portray youth as positive and age as negative (suggested reading: [Gendron TL et al, The Language of Ageism: Why We Need to Use Words Carefully. Gerontologist. 2016; 56\(6\): 997-1006](#)).
3. Use [Framing Strategies](#) when advocating for policy issues to reduce ageism.
4. Key questions for reflection - Are you honoring dignity in others? Are you valuing the unique qualities/experiences of others? Are you open to lessons that live within each of us regardless of ability or age? (eg. [Anti-Ageism Quick Guide: Changing the Conversation](#))

**Principle 3: Conduct a holistic assessment and evaluation utilizing sound outcome measures that help inform the treatment plan and relate to the patient's stated goals.**

A physical therapist's assessment is comprehensive and identifies the movement deficits and risk for frailty that impact the patient's ability to accomplish their personal goal(s). It should also contain domains of health promotion, prevention, and rehabilitation across the lifespan.

**Action Steps:**

1. A comprehensive history should contain at least the following information:
  - a. Falls/Balance- detailed hx of falls, imbalance, concern about falling, or modifications of activities secondary to balance concerns
  - b. Current level of functional mobility including: can they get up off the ground, walk a ¼ mile without stopping, cross the street in time, and climb a flight of stairs
  - c. General health rating- how do they rate their health and what is the reasoning behind their rating
  - d. Medication- current, recent changes, side effects
  - e. Continence- any issues with bowel or bladder, such as incontinence, rushing to the bathroom, feeling like they need to go but being unable to go, or constipation.
  - f. Vision and hearing- are they getting regular assessments or have they or someone else noticed any difficulties.
  - g. Mental Health- ask if the patient has been feeling down, depressed, and or anxious
  - h. Detailed participation in physical activity and exercise and other lifestyle behaviors
  - i. Social network and support
  - j. Societal roles (e.g. occupation, work, community activities, household activities, etc)
  - k. Environmental factors- are there any environmental factors that impact their ability to complete their goals such as access to food, technology, shelter and safety.
2. Perform functional mobility examination that aligns with the patient's stated goals and minimally includes the following measures identified as critical at the time of this publication:
  - a. Mobility: Usual and fast walking speed.
  - b. Strength: 30-second sit to stand and hand grip dynamometry
  - c. Balance: appropriate and challenging measure. For example, with lower level patients the Four Stage Balance Test, and for higher level patients the Four Square Step Test.
  - d. Endurance: 6-minute walk test or 2-minute step test. To maintain the outcome measure's fidelity and ability to apply its psychometric properties, do not modify the standardized methodologies published in the original manuscript.
3. Before implementing new outcome measures, critically appraise the literature and the outcome measure's psychometric properties [Center for Evidence Based Medicine](#)
4. Provide regular re-assessment/examination to ensure patient's goals are updated and remain consistent with their preferences<sup>8</sup>.

**Principle 4: Provide positive outcomes of physical therapy care by completing intervention(s) that are based on the best available evidence.**

Interventions must be informed by best available evidence, then implemented with appropriate challenge, relevance, and creativity to empower the patient and to achieve what matters most to the patient.

#### Action Steps

1. Use high intensity exercise whenever possible for strength, balance, endurance, and functional training. Prescription of high intensity exercise is intentional and requires monitoring<sup>17</sup>.
2. Provide and advocate for appropriate dosage and challenge - for example most studies cite that over 50 hours of progressive and challenging balance activities are needed to obtain optimal balance outcomes<sup>18</sup>.
3. Design unique programs that fit the individual's needs based on goals and abilities, time commitment, travel concerns, financial limitations, and available resources.
4. Exercises should be progressive, creative, variable, and challenging to enhance outcomes and patient engagement.

#### **Principle 5: Prioritize physical activity to promote health, well-being, chronic disease management, and enhance mobility.**

Physical activity is the cornerstone of health and continued mobility and quality of life. And yet, only 8%<sup>19</sup> of older adults participate in the recommended 150 minutes of moderate-intense physical activity and two sessions/week of strengthening exercise<sup>20</sup>. Every effort should be made to mitigate sedentary behaviors and promote physical activity appropriate to individuals' abilities and readiness to participate.

#### Action Steps:

1. Examine bouts of sedentary time and physical activity levels (e.g. [Exercise Is Medicine Health Care Providers' Action Guide](#))
2. Design physical activity programs that align with the patient's abilities, desires, interest, environment, and access.
3. Utilize and create relationships with community resources to assist patients in the continuum of care (e.g. [National Council On Aging](#), [Agency On Aging](#), [APTA Geriatrics Partnership Materials](#)).
4. Engage caregivers and other members of the patient's social network where appropriate to improve physical activity levels<sup>20</sup>.

#### **Principle 6: Champion interprofessional collaborative practice that is inclusive of patients and their caregivers.**

Physical Therapists and Physical Therapist Assistant working with older adults integrate their clinical expertise into a collaborative patient-informed management plan as equal partners with the patient, their caregivers as appropriate, and other health care team members bridging across all transitions of care.

#### Action Steps:

1. Understand, respect, and utilize the different strengths and roles of the health care team members.

2. Engage in clear closed loop communication with the patient, caregivers, and other healthcare team members bridging across all transitions of care.
3. Promote clarity by exchanging information with the patient, caregivers, and other healthcare team members to create an environment that promotes shared decision making.
4. Advocate for all team members to be accountable for patient needs and be available to ask and answer questions regarding the patient's management plan, especially when patient safety is at risk.
5. Consider the patient's preferences, values, and beliefs in formulation of the patient-centered management plan to provide positive patient outcomes.

**Task Force Members:**

Dale Avers, PT, DPT, PhD, FAPTA  
Cathy Ciolek, PT, DPT, FAPTA\* (co-chair)  
Michelle Criss, PT, DPT, PhD  
Carole Lewis, PT, DPT, MPH, PhD, FAPTA\*  
Kenneth Miller, PT, DPT \* (co-chair)  
Traci Norris, PT, DPT\*  
William Staples, PT, DPT, DHSc\*  
Veronica Southard, PT\*  
Ellen Strunk, PT, MS\*  
Mariana Wingood, PT, DPT\*

\*Denotes Board Certified Clinical Specialist in Geriatric Physical Therapy

---

<sup>1</sup> APTA. Code of Ethics for the Physical Therapist | APTA. HOD S06-20-28-25. 2020.

<sup>2</sup> Porter ME, Teisberg EO. Redefining Health Care: Creating Value-Based Competition on Results. 2005. Brighton, MA: Harvard Business School Press

<sup>3</sup> Crossing the Quality Chasm: A New Health System for the 21st Century. Washington, DC: Institute of Medicine of the National Academies, 2001

<sup>4</sup> Sackett DL, Rosenberg WMC, Gray JAM, Haynes RB, Richardson WS. Evidence based medicine: what it is and what it isn't. *BMJ*. 1996;312(7023):71-72.

<sup>5</sup> McCormack B, McCance T. Person-Centered Practice in Nursing and Health Care: Theory and Practice. 2nd Ed. 2017 John Wiley & Sons, West Sussex, UK

<sup>6</sup> Burnes D, Sheppard C, Henderson CR, et al. Interventions to reduce ageism against older adults: A systematic review and meta-analysis. *Am J Public Health*. 2019;109(8):e1-9.

<sup>7</sup> Rose A, Soundy A, Rosewilliam S. Shared decision-making within goal-setting in rehabilitation: a mixed methods study. *Clinical Rehabilitation*. 2019;33(3):564-574.

<sup>8</sup> American Geriatrics Society Expert Panel on Person-Centered Care. Person-Centered Care: A definition and essential elements. *JAGS* 2016;64:15-18.

<sup>9</sup> Gibson BE, Terry G, Setchell J, et al. The micropolitics of caring: tinkering with person-centered rehabilitation. *Disability and Rehabilitation*. 2020;42(11):1529-1538.

<sup>10</sup> Terry G, Kayes N. Person centered care in neurorehabilitation; a secondary analysis. *Disability and Rehabilitation* 2020;42(16):2234-2343.

<sup>11</sup> Kittelson AJ, Hoogeboom TJ, Schenkman M, Stevens-Lapsley JE, van Meeteren N. Person-centered care and physical therapy: a "people like me" approach. *PT* 2019;100(1):99-106.

- 
- <sup>12</sup> Gustavson AM, Malone DJ, Boer RS, Forster JE, Stevens-Lapsley JE. JAMA Netw Open. 2019;2(7):e198199.
- <sup>13</sup> Croft J. (2017) Enabling positive risk taking for older people in the care home. *Nursing and Residential Care* 19(3):515-519
- <sup>14</sup> Levy BR, Slade MD, Change ES, Kannoth S, Wang SY. Ageism amplifies cost and prevalence of health conditions. *Gerontologist* 2020;60(1):174-181.
- <sup>15</sup> Nelson TD. Promoting healthy aging by confronting ageism. *Amer Psych* 2016;71(4):276.-282.
- <sup>16</sup> Wurn S, Diehl M, Kornadt AE, Westerhof GJ, Wahl H-W How do views on aging affect health outcomes in adulthood and late life? Explanations for an established connection. *Dev Rev* 2017;46:27–43
- <sup>17</sup> Avers D, Brown M. White Paper: Strength training for the older adult. *JGPT* 2009;32(4):148-158.
- <sup>18</sup> Shubert TE. Evidence based exercise prescription for balance and falls prevention: a current review of the literature. *JGPT* 2011;34:100-108.
- <sup>19</sup> Kruger J, Carlson SA, Buchner D. How active are older Americans?. *Prev Chronic Dis*. 2007;4(3):A53.
- <sup>20</sup> U.S. Department of Health and Human Services. *Physical Activity Guidelines for Americans, 2nd edition*. Washington, DC: U.S. Department of Health and Human Services; 2018.