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PROPOSAL FOR A CLINIC BASED MODEL OF PHYSICAL THERAPIST CONSULTATION IN A GERIATRIC OUTPATIENT CLINIC

Rania Karim, PT, DPT, GCS; Patricia A. Higgins, RN, PhD; Thomas R. Hornick, MD

ABSTRACT

Purpose: The purpose of this article is to describe the role of a certified geriatric physical therapist (PT) in a geriatric outpatient clinic. **Methods:** This pilot study used a model in which a geriatric certified doctor of physical therapy (DPT) provided consultations one afternoon a week for patients in the Outpatient Geriatric Clinic at the Louis Stokes Cleveland Veterans Affairs Medical Center (VAMC). Data collection included reason for referral, DPT's interventions, and clinicians' and patients' perceptions. **Results:** Over 7 months, the DPT consulted on 25 male patients ranging from 65 to 91 years, with a mean age of 80. The majority of patients were classified into the neuromuscular category (64%) and received a home exercise program (60%). The addition of the PT consult service in the Geriatric Outpatient Clinic was well received by the multidisciplinary team. **Conclusion:** In addition to their traditional roles, physical therapists now have an opportunity to engage directly in primary care. The model described serves as an example of autonomous practice and the net result is increased quality of care, improved patient satisfaction, and increased knowledge about the profession of physical therapy on behalf of the referring clinician. The findings from this study provide support for the use of this model in settings other than the VAMC's managed care setting.

Key Words: physical therapist, physical therapist consultation, geriatric outpatient clinic, multidisciplinary

The American Physical Therapy Association (APTA) recognizes 5 professional roles: management of patients/clients, administration, education, research, and consultation.¹ The first 4 roles are well established; the fifth role, consultation, is less known. The purpose

of this article is to describe the role of one type of physical therapy consultant, a certified geriatric physical therapist (PT), in a Geriatric Outpatient Clinic.

The APTA defines consultation as expert advice in which the physical therapist "applies highly specialized knowledge and skills to identify problems, recommend solutions, or produce a specified outcome or product in a given amount of time." Autonomous practice "is characterized by independent self-determined, professional judgment and action." In a recent special interest report on autonomous practice, Hardage et al³ noted that autonomous practice has the potential to occur in all settings and professional roles.

Nationally, physical therapists serve as members of multidisciplinary teams and as consultants in specialty clinics for conditions such as Parkinson's disease, Amyotrophic Lateral Sclerosis, Post Polio, and falls. Physical therapy consultation in specialty clinics that provide primary care, however, is less used and studied. Only one publication was found that studied utilization of PT consultation in a primary care clinic.⁴ In this observational study from Norway, primary care providers (PCPs) were encouraged to use a one-time physical therapy consultation service.⁴ During the 7-month period, 59 participating PCPs requested 352 physical therapy consultations.⁴ The PCP reasons for consults varied, from requesting consultation for a specific problem to requesting consultation when they were uncertain about the benefit of physical therapy for a particular patient.⁴ The majority of consultations were for younger patients (93% were < 65 years) who presented with a problem whose duration was >1 week, with 57% of patients categorized as having problems with >12 weeks duration.⁴ Hendricks et al noted PCPs reported overall satisfaction with the PT consultation service and further, PCPs indicated

they changed their management decisions based on PT recommendations. No patient outcomes were reported.

This model of care was piloted at the Louis Stokes Cleveland Veterans Affairs Medical Center (LSCVAMC) in Ohio, a tertiary care hospital affiliated with Case Western Reserve University. Its 248 beds serve over 100,000 veterans annually. The Geriatric Outpatient Clinic at the LSCVAMC is an academic primary care clinic with approximately 100 patient visits/week. The multidisciplinary clinic team consists of primary care providers [physicians and nurse practitioners (NP), supervised medical students, residents, fellows, and allied health trainees], a licensed social worker, registered nurses, geropsychologists, doctors of pharmacy, and dietitians. Most staff members have special training in geriatrics. The patients seen in clinic are predominantly male (96%) and the average age is 85 years. New patients are seen by a licensed social worker and a psychologist, and then by a geriatrician. In July 2011, the first author, a geriatric certified doctor of physical therapy (DPT), joined the team and began providing consultations one afternoon a week for patients referred by the geriatrics team. Referrals for a physical therapy consultation could be generated by any member of the team. While this information was not formally recorded, the majority of referrals came from the NPs or the MDs. Occasionally, after performing chart reviews or listening to team members present the case, the physical therapist would initiate the consultation request.

PATIENTS REFERRED FOR CONSULTS

Over seven months, the DPT consulted on 25 male patients ranging from 65 to 91 years, with a mean age of 80. The reasons for consults varied and were often multifactorial. The history of falls/fall risk constituted the majority of con-

sult requests (56%). Other reasons centered on issues with physical activity, including decreased endurance and request for exercise recommendations (24%), musculoskeletal complaints (12%), and neurological conditions (8%). Using the APTA's practice pattern categories to organize reasons for referral, 64% of the patients' diagnoses fall under the neuromuscular category, 24% cardiopulmonary, 12% musculoskeletal, and 0% integumentary; see Figure 1.

THE PHYSICAL THERAPY CONSULTATION

Typically consults were performed either in the time period when the resident was presenting the case to the geriatrician, or after the geriatrician saw the patient. Consultations ranged in time from 15 to 45 minutes. Regardless of the patient's diagnostic category, providers most often asked two questions when making a referral:

- Should the patient be using an assistive device?
- What is the most appropriate setting for continued physical therapy?

Interventions consisted primarily of falls prevention education, functional mobility training, therapeutic exercises, and gait training. Consultation outcomes included:

- Home exercise program (60% patients)

- Recommendation for durable medical equipment (40%)
- Additional physical therapy services were requested for 44% of the patients: 28% outpatient PT, 16% home care

The PT provided multiple recommendations for many patients and entered notes into the Computerized Patient Record System.

CLINICIANS' PERCEPTIONS

The addition of the PT consult service in the Geriatric Outpatient Clinic was well received by the multidisciplinary team. A survey sent to the NPs and MDs using the PT consult services (N= 4) provided insight into their thoughts and opinions. All comments were positive and demonstrated an appreciation for the service. One clinician viewed the PT consult service as a form of triage to determine which patients need more intensive therapy. Another clinician reflected back on previous acute care experiences where the physical therapist served on the multidisciplinary team, providing their input either at daily or weekly rounds; “(I have) practiced in settings where PT is more available and have seen it benefit the patients greatly.” This clinician thought the benefits of the PT consultation services also extended to the students and residents rotating in the clinic: “(I) think it is wonderful,

including for training of residents and students.” All the clinicians also made reference to the benefits the PT consult service has for the patients, “appreciating the ability to evaluate patients at clinic visit,” recognizing that “patients don't often want to travel for extra/frequent appointments, so this helps to gain their cooperation.” Patients were not directly surveyed but clinicians stated that they received “very positive feedback from patients” and that “patient families have been very appreciative of expert geriatric physical therapy advice.”

CLINICIAN REASONS FOR NOT USING PT CONSULT SERVICE

While the service is well received, the number of consults generated was lower than expected. Three main reasons were cited in the survey for underutilization. First, clinicians were concerned that PT consult would cause a disruption in the clinicians' workflow, particularly given the shortage of available exam rooms. Second, there was concern about the limitations of a one-time physical therapy consult without prompt and/or sufficient follow-up. Third, a belief was held by clinicians that certain patients fall into a gray zone of service needs. For these patients, home care PT was perceived as lacking the ability to reach appropriate intensity due to lack of equipment and/or safety issues, and outpatient PT was not feasible due to transportation issues. Other causes for underutilization of the PT consult service included: forgetting that PT was available for consults even though the PT was physically present in the clinic one afternoon a week, the futility of working with patients with severe dementia, or patients who had not benefited from prior PT treatment for the particular impairment.

DISCUSSION

Comparison of Types of Referrals

Interestingly, the reasons patients were referred for a PT consult in the geriatrics primary care clinic differed from two earlier studies. Hendricks et al⁴ reported that 97.5% of study consults were due to complaints of the musculoskeletal system. Similarly, Miller⁵ reported that when physical therapists (n=118) classified 10 of their geriatric patients, the breakdown of diagnostic categories was: musculoskeletal (71%), neuromuscular (17%), cardiopulmonary (8%), and integumentary (4%). In con-

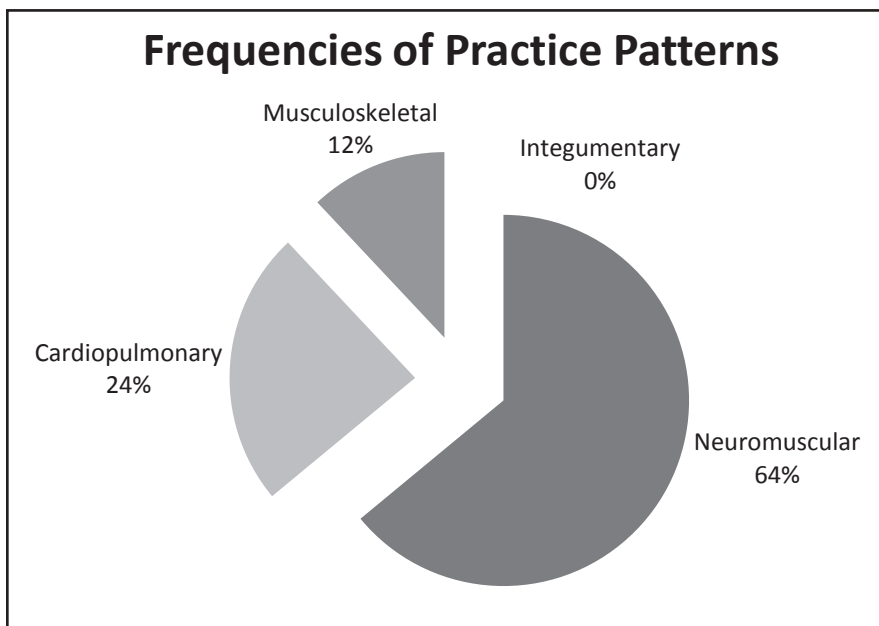


Figure 1. Reasons for referral for a PT consult in the Outpatient Geriatric Clinic according to the APTA's Practice Patterns Categories.

trast, the reasons for consult for the 25 geriatric patients in this study were categorized as neuromuscular (64%), cardiopulmonary (24%), and musculoskeletal (12%). One possible explanation for this difference is that Miller⁵ surveyed physical therapists in all settings. Additionally, the majority of the patients were female (66.7%) and younger than the average age of the patient seen for a consultation in the outpatient geriatric clinic.

POTENTIAL MODEL OF CARE

As a managed care system, the VAMC is an ideal setting to implement a PT consult service, in part because individual services such as physical therapy and physician appointments are not individually billed. However, we think that reimbursement issues are not insurmountable, and PT consult services could be implemented in settings outside of the VA, with the net result of helping patients who otherwise may have been missed. Another potential model of care, similar to that implemented in long-term care facilities, would consist of the PT screening all new patients seen in the clinic.

In addition to their traditional roles, physical therapists now have an opportunity to engage directly in primary care. The model described here serves as one example of autonomous practice. The PT in this model is practicing according to the core values of the profession of PT and the net effect is increased quality of care, and improved patient satisfaction. The referring clinicians are also gaining increased knowledge about the profession of PT. We think that attempts to replicate this model in other settings outside the VAMC setting can only serve to positively impact patients.

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Rania Karim, PT, DPT, GCS, obtained a doctor of physical therapy from Washington University in St. Louis in 2008. Following graduation, she participated in a geriatric residency program at St. Catherine's Villa Maria in Miami, Florida. She is currently finishing a two year geriatric post-doctoral fellowship at the Cleveland Louis Stokes VA. In addition to her research on dementia and procedural learning, Dr. Karim consults on patients seen in the VA's Geriatric Outpatient Clinic and works PRN for University Hospitals Home Care.

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