2019 WOMEN’S HEALTH SPECIALIST CERTIFICATION CANDIDATE GUIDE
Dear Fellow Physical Therapist:

Congratulations! By acquiring this Candidate Guide, you have been proactive in your interest in and pursuit of specialist certification. The specialist certification program has been designed to identify and define physical therapy specialty areas and to formally recognize physical therapists who have attained advanced knowledge and skills in those areas.

Certification also assists the public and health care community in identifying therapists with acknowledged expertise in a particular field of practice and demonstrates that physical therapists are devoted to addressing the unique needs of the people with whom we work.

Certification is achieved through successful completion of a standardized online application and examination process. Coordination of this program is provided by the American Board of Physical Therapy Specialties (ABPTS), the governing body for approval of new specialty areas and certification of clinical specialists. Specialty councils representing the 9 recognized specialty areas have been appointed to delineate and describe the advanced knowledge, skills, and abilities of clinical specialists; determine specific requirements for certification; and develop the certification examinations.

The dedicated volunteers currently giving their time and service to the development of this process are listed in the rosters in the beginning of this booklet. APTA established this program in 1978 to provide formal recognition for physical therapists with advanced clinical knowledge, competence, and skills in a special area of practice. The program evolved from the membership of special interest sections of APTA as a way to encourage and facilitate the professional growth of individual members and thereby facilitate growth of the entire profession.

Certified specialists have clearly demonstrated their commitment to service by the variety, depth, and consistency of their professional involvement. Their desire to attain formal recognition of their advanced clinical knowledge, competence, and skills reflects their devotion to their profession and their patients. In these times of dramatic health care reform, dedication to public service by providing high quality physical therapy services is paramount.

If you share these personal and professional principles, then you are in the right place! Please join the growing number of physical therapists who have chosen this pathway of professional development.

Thank you for your interest and I wish you success in this endeavor.

Sincerely,

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Chair, American Board of Physical Therapy Specialties
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1. GENERAL DEFINITIONS

1.1. American Physical Therapy Association
The American Physical Therapy Association (APTA) is a national professional organization representing more than 100,000 physical therapists, physical therapist assistants, and physical therapy students throughout the United States. Its goals are to serve its members and to serve the public by increasing the understanding of the physical therapist’s role in the health care system, and by fostering improvements in physical therapy education, practice, research, and professional development.

APTA established the specialist certification program in 1978 to provide formal recognition for physical therapists with advanced clinical knowledge, experience, and skills in a special area of practice, and to assist consumers and the health care community to identify physical therapy specialists.

1.2. American Board of Physical Therapy Specialties
Coordination and oversight of the specialist certification process is provided by the American Board of Physical Therapy Specialties (ABPTS), which is the governing body for approval of new specialty areas and certification of clinical specialists. ABPTS comprises board-certified physical therapists from different specialty areas; a physical therapist member of the APTA Board of Directors; an individual with expertise in test development, evaluation, and education; and a nonphysical therapist member representing the public.

The American Physical Therapy Association (APTA) prohibits preferential treatment or adverse discrimination on the basis of race, creed, color, gender, age, national or ethnic origin, sexual orientation, disability or health status in all areas including, but not limited to, its qualifications for membership, rights of members, policies, programs, activities, and employment practices.

1.3. Specialty Council
The Specialty Council, representing the area of clinical electrophysiologic physical therapy, has been appointed to delineate the advanced knowledge, skills, and abilities for their specialty area; to determine the academic and clinical requirements for certification; and to develop the certification examinations and oversee the maintenance of specialist certification. The Council comprises 4 board-certified specialists in the practice area.

1.4. Additional Physical Therapy Examinations
Individuals interested in Cardiovascular & Pulmonary, Clinical Electrophysiology, Geriatric, Neurologic, Oncologic, Orthopaedic, Pediatric, and Sports certifications must complete a separate online application, accessible through APTA’s Specialist Certification Program website (www.abpts.org).

1.5. National Board of Medical Examiners
The National Board of Medical Examiners® (NBME®) is a nonprofit organization that strives to provide the highest quality testing and research services to organizations involved in the licensure and certification of medical and health science professionals. NBME provides test development, test administration, editorial production, and psychometric services to ABPTS and the specialty councils.

1.6. Prometric
NBME currently delivers the specialist certification examinations by computer through Prometric. Prometric administers testing programs for educational institutions, professional associations, corporations, and other organizations. Examinations are delivered in test centers that have secure rooms dedicated to test delivery.

Note: Prometric test center locations are subject to change, and there is no guarantee that a center listed on the Prometric website at the time of application will be available for a future ABPTS administration. The most efficient way for candidates to check for test center locations is to log on to www.prometric.com/ABPTS and select “locate a test center.” This provides the most up-to-date information.

1.7. Restriction of the Term Board-Certified Specialist
APTA’s House of Delegates adopted a policy that no physical therapist shall purport to be a “Board-Certified Clinical Specialist” unless (s)he has successfully completed the certification process as developed by the American Board of Physical Therapy Specialties (HOD 06- 94-23-39). In addition, ABPTS does not permit applicants for certification to state that they are “board eligible.”

2. CERTIFICATION REQUIREMENTS

2.1. General Requirements
Applicants must hold a current permanent/unrestricted license to practice physical therapy in the United States or any of its possessions or territories. In addition, applicants are required to pay the application review fee.

Applicants must meet the minimum eligibility requirements for the 2019 examination by the application deadline of July 1, 2018.

Applicants must submit a complete application and review fee for each specialist certification examination.

ABPTS does not permit applicants to use the same direct patient care hours for different specialty areas.

2.2. Other Requirements
Applicants must meet requirements for Option A or Option B.

Option A
Applicants must submit evidence of 2,000 hours of direct patient care as a licensed United States physical therapist (temporary license excluded) in the specialty area within the last ten (10) years, 25% (500) of which must have occurred within the last three (3) years. Direct patient care must include activities in each of the elements of patient/client management applicable to the specialty area and included in the Description of Specialty Practice (DSP). These elements, as defined by the Guide to Physical Therapist Practice, are examination, evaluation, diagnosis, prognosis, and intervention.

Applicants must also submit 1 case reflection demonstrating specialty practice in women’s health. This case reflection must be based on a patient/client seen within the last 3 years.

Note: (See 12.1 thru 12.4 beginning on page 11 for other requirements.)
Option B
Applicants must submit evidence of successful completion of an APTA-accredited postprofessional clinical residency completed within the last 10 years that has a curriculum plan reflective of the *Description of Specialty Practice: Women’s Health Physical Therapy* (DSP). Experience from residencies in which the curriculum plan reflects only a portion of the DSP will not be considered.

Applicants applying under Option B also must submit one (1) case reflection demonstrating specialty practice in women’s health. This case reflection must be based on a patient/client seen within the last three (3) years.

Applicants must submit evidence of successful completion of an APTA-accredited post professional Women’s Health clinical residency. Applicants who are currently enrolled in an ABPTRFE-accredited clinical residency, or enrolled in a residency program that has been granted candidacy status, may apply for the specialist certification examination in the appropriate specialty area prior to completion of the residency. These applicants will be conditionally approved to sit for the examination, as long as they meet all other eligibility requirements, pending submission of evidence of successful completion of the ABPTRFE-accredited clinical residency to ABPTS’s Specialist Certification Program no later than 1 month before the examination window opens. To verify your residency program’s accreditation status, please visit www.abptrfe.org.

2.3. Steps to Complete Certification
Certification as a Physical Therapy Clinical Specialist consists of 2 major steps:

**STEP 1.** You must submit evidence that you have fulfilled the minimum eligibility requirements as defined by the specialty council. This includes completion of all required application forms, fees, documentation of the required practice hours, and other requirements specified by the specialty council.

You must meet all requirements by the application deadline, July 1, 2018. The specialty council will not consider experience toward the minimum eligibility requirements that was not acquired by the application deadline.

**STEP 2.** Following completion of Step 1 and approval of the application, the candidate must sit for and receive a passing score on the computer-based certification exam.

Certification is awarded for a period of 10 years. ABPTS has adopted a model of continued competency throughout the years of certification rather than a one-time recertification process as the certification period lapses. This model is titled the “Maintenance of Specialist Certification (MOSC).” Please review details of the MOSC program in Section 2.4.

2.4. Maintenance of Specialist Certification (MOSC)
ABPTS has developed a model for maintaining certification that focuses on continuing competence of the physical therapist specialist. This new model has been titled the “Maintenance of Specialist Certification” and includes the following elements:

- Professional Standing and Direct Patient Care Hours
- Commitment to Lifelong Learning Through Professional Development
- Practice Performance Through Examples of Patient Care and Clinical Reasoning
- Cognitive Expertise Through a Test of Knowledge in the Profession

**Requirement 1: Professional Standing and Direct Patient Care Hours**
- In years 3, 6, and 9, a specialist must submit evidence of current licensure as a physical therapist in the United States or any of its possessions or territories.
- In years 3, 6, and 9, a specialist must submit evidence of 200 hours of direct patient care acquired in the specialty area within the last 3 years. Direct patient care hours accrued in year 10 may be applied to the year 3 requirements for the next MOSC cycle.

**Requirement 2: Commitment to Lifelong Learning Through Professional Development**
- Each board-certified specialist is obligated to participate in ongoing professional development, within his or her designated specialty area, which leads to a level of practice consistent with acceptable standards. Each specialist may choose to pursue professional development that leads to a level of practice beyond prevailing standards.
- A web-based system to track continuing competence in a specialty area will be developed. This system will provide an individual account tracking mechanism for each specialist to record professional development activities during years 3, 6, and 9 of his or her certification cycle. There is not an hour requirement in this area, but the specialist must show evidence of professional development activities (equivalent to 10 MOSC credits) within 2 of the 3 designated activity categories in years 3, 6, and 9. By year 9, a specialist must have accrued a minimum of 30 MOSC credits and demonstrated professional development in each of the 3 designated activity categories. These activities include professional services, continuing education coursework, publications, presentations, clinical supervision and consultation, research, clinical instruction, and teaching.

**Requirement 3: Practice Performance Through Examples of Clinical Care and Reasoning**
- The purpose of this requirement is to document continuing competency in patient/client management in the specialty area.
- The specialist will use an online system to complete 1 reflective portfolio submission in years 3, 6, and 9 of his or her certification cycle. These reflective portfolio submissions will be used to demonstrate the specialist’s use of clinical care and reasoning. Each submission must have a reflective component and must have documentation that reflects clinical reasoning.
- These reflective portfolio submissions will not be scored but will be screened for completion of required information and reflection.

**Requirement 4: Cognitive Expertise Through a Test of Knowledge in the Profession**
- During year 10 of the certification cycle, the specialist will be required to sit for a recertification examination, comprising approximately 100 items. The exam will be specialty specific, assess an individual’s cognitive expertise in the specialty area, and reflect contemporary specialist practice.
- The exam blueprint breakdown for this exam will mirror that of the initial certification exam, as noted in the various *Descriptions of Specialty Practice*. Items will be coded and pulled from existing specialty item banks.
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• Successful completion of requirements 1-3 are prerequisites for sitting for the recertification exam. If a specialist fails to receive a passing score after the first attempt, he or she will be permitted to sit for the exam 1 additional time and will maintain his or her certification during this 1-year grace period.

Any additional questions/concerns should be addressed to staff at spec-recert@apta.org or 800/999-APTA (2782), ext 3390.

2.5. Ineligibility for Certification
Item writers and reviewers are not eligible to sit for the specialist certification examination in their specialty area for 2 years from the date of involvement in the process.

Specialty council members, ABPTS members, and cut-score study participants are prohibited from sitting for the specialist certification exam for a period of 2 years from the date of participation in the certification process.

3. APPLICATION PROCESS

3.1. Application Deadline
Completed applications and application review fees for the 2019 specialist certification examinations must be submitted online to the APTA Specialist Certification Program on or before July 1, 2018. Applications submitted after the deadline may not be reviewed.

3.2. Procedures for Application Review
The Specialist Certification Program staff will conduct the initial review of all submitted documents within approximately 6 weeks. Then your application will be forwarded to the Specialty Council for their expert review. This final review process will take approximately 10 business days from the time the Council receives the documents, and should the council have questions or need clarification about documents submitted the Specialist Certification staff will contact you via email. The applicant must resubmit requested documentation within 10 business days after email notification is received. Only one resubmission is permitted for an exam cycle.

If the applicant does not resubmit by the specified deadline, the record will indicate that he or she has not met the minimum eligibility requirements and is not approved to sit for the 2019 exam.

3.3. Services for Persons With Disabilities
The American Board of Physical Therapy Specialties (ABPTS) provides reasonable and appropriate accommodations in accordance with the Americans with Disabilities Act for individuals with documented disabilities who demonstrate a need for accommodations.

It is the responsibility of the person with a disability to provide advance notice and appropriate documentation of the disability with a request for test accommodations. If an applicant identifies functional limitations or special needs that would prevent him or her from taking the certification exam under standard testing conditions, ABPTS in consultation with its testing agency, will evaluate and respond to that applicant’s needs for special arrangements.

Any requests must be submitted to ABPTS, accompanied by the appropriate forms and uploaded at the time of the online application submission for the exam (by July 1, 2018). The request for testing accommodations must include verification of the disabling condition from a professional specializing in the relevant area and a description of the requested accommodation. Applicants will be notified in the fall of the decision regarding the request and the accommodations that will be provided. If accommodation is not requested in advance, availability of accommodation cannot be guaranteed.

Note: Certain testing accommodations may require shared cost with candidate.

3.4. Certification in More Than 1 Specialty Area
Applicants must submit a complete set of online application materials and fees for each specialist certification exam. A certified specialist who applies for certification in a second specialty area is not permitted to submit the same direct patient care hours that he or she submitted for certification in the first specialty area. The Specialist Certification Program staff will review previously submitted applications for duplication of hours.

3.5. Submission of Application
It is the applicant’s responsibility to ensure that the application is completed according to instructions.

In addition, it is imperative that you enter your name on the application exactly as it appears on the identification form you intend to present at the testing center. Please note that the way your name is entered on the application is also the way your name will appear in the APTA membership database.

Applicants who opt to pay the review fee by check should send the application fee with the appropriate payment form described in Section 3.6 below in a single mailing to:

APTA
Specialist Certification Application
P.O. Box 75701
Baltimore, MD 21275

If applicable, verification of current physical therapy license must be sent separately by your state licensing agency.

3.6. Application Review Fee
The nonrefundable application review fee must be submitted with your online application to the APTA Specialist Certification Program on or before July 1, 2018.

Payment of the review fee may be made by check (payable to APTA) or by credit card (MasterCard, VISA, Discover, or American Express). The Payment Form must accompany your fee. The applicant review fees are listed below:

APTA Member: $525
Non-APTA Member: $870
Member/Non-APTA Member Reapplication: $170

Note: Reapplication fee is due by August 31, 2018
3.7. Time Limit for Active Application/Reapplication
Applicant files will remain active for only 2 consecutive exam administrations. However, eligibility for the second exam administration requires an online reapplication submission by August 31, along with a $170 reapplication fee, as well as the current examination fee by November 30. This policy applies to those who choose to defer sitting for the exam, those who are not approved to sit for the examination, and those who do not pass the exam. Eligible reapplicants will receive reapplication information by email directly from the Specialist Certification Program. To reapply, you must submit an online reapplication, verification of current licensure to practice physical therapy, updated direct patient care hours, and any other requested documentation. The APTA Specialist Certification Program must receive this documentation by the reapplication deadline for the next scheduled exam. Reapplicants must meet the current practice requirements to be eligible to sit for the exam.

After 2 consecutive exam administrations, you must submit an entirely new application and initial applicant review fee to apply for specialist certification.

3.8. Address Changes
Should your mailing address, email address, or phone number change, please notify the APTA Specialist Certification Program immediately. The Specialist Certification Program maintains separate records from APTA’s membership database, so candidates must email (spec-cert@apta.org) or phone (800/999-2782, ext 8520) the department.

4. SCHEDULING THE EXAM

4.1. Examination Fee and Scheduling Permit
The examination fee is submitted after you have been notified that you are eligible to sit for the exam. The fee must be received by the APTA Specialist Certification Program on or before November 30, 2018.

You may pay the examination fee by check (payable to APTA) or by credit card (MasterCard, VISA, DISCOVER or AMEX), by mail or online. Please note that both first-time and repeat test takers must pay the following examination fees:

- APTA Member: $810
- Non-APTA Member: $1,535

If you are planning to sit for the examination in an international location, please make sure that you enter that in your online application.

Before the end of December, after your examination fee has been received, APTA’s Specialist Certification Program will send you an email with instructions on how to access and download your electronic scheduling permit online. You must print your scheduling permit before you contact Prometric to schedule a test date. Check to make sure that the information on your permit is correct, and that your name (first name, middle initials, last name) exactly matches your name on the identification you will use on the day of the examination. If the name on your permit does not match the name on your identification, you must contact APTA immediately. Name changes or corrections cannot be made within 7 business days of your scheduled testing date. You will be denied admission to the test if the name on the permit does not match the name on your identification.

4.2. Test Dates
The examination will be administered at testing centers worldwide between the dates of March 2 and March 16, 2019.

4.3. How to Schedule an Appointment at a Testing Center
The Specialist Certification Program will notify approved candidates when they may begin to schedule a date to sit for the examination. Candidates are not eligible to schedule a session until they have paid their exam fee and have their scheduling permit.

You must print or download your scheduling permit before you contact Prometric to schedule a testing appointment. To schedule a testing appointment, you will need to provide Prometric with the scheduling number that is included on your scheduling permit. Appointments are assigned on a first-come, first-served basis; therefore, you should Schedule an appointment as soon as possible after you have accessed your scheduling permit. If you defer scheduling you may not be able to make an appointment at your preferred test site or for your preferred test date. You should report any problems in scheduling a testing appointment to the Specialist Certification Program at least 4 weeks before the first day of the testing window to give ABPTS an opportunity to resolve the problem.

Prior to your testing appointment, you can log in at the URL provided by the Specialist Certification Program to access and reprint your permit if necessary.

4.4. Refunds and Cancellations
The Applicant Review Fee is not refundable. You must notify the specialist certification program staff through the on-line application system deferment process if you decide, for any reason, not to sit for the 2019 exam. Upon receipt of written notification, your examination fee will be refunded minus 20% of the fee. Please allow 6-8 weeks for processing.

4.5. Rescheduling an Exam
If you are unable to keep a testing appointment and would like to reschedule, you must contact Prometric by 12:00 pm local time of the second business day prior to your appointment. The rescheduled test date must fall within the testing window. Fees from your previously scheduled test will be transferred to the rescheduled exam as follows:

a. If you contact Prometric by 12:00 pm local time of the second business day prior to your test date, you will be permitted to reschedule without penalty. If you provide less than 2 business days’ notice, Prometric will charge a $101 fee to reschedule your examination (rescheduling fees vary for international sites).

b. If you cancel your appointment within 2 business days or do not appear on your test date, you must contact Prometric Candidate Cares at the phone number listed in the permit and pay a $101 fee to reinstate your eligibility record in order to reschedule your appointment within the testing window (rescheduling fees vary for international sites).

5. PREPARING FOR THE EXAM

5.1. Description of Specialty Practice (DSP)
The Descriptions of Specialty Practice (DSP) are documents developed for each specialty area that outline the knowledge, skills, and abilities related to clinical practice in the specialty area. The DSP content is based on a detailed practice analysis conducted by the specialty council. A
practice analysis involves extensive research, including survey data and judgments of subject matter experts, of the knowledge, tasks, and roles that describe advanced specialty practice. The specialty council develops the written exam from the DSP and includes a percentage of questions from each of the major content areas identified in the practice analysis. Because applicants will find the DSP for their specialty area helpful in organizing exam preparation, a copy is made available electronically to each new applicant upon submission of their application and payment of the application review fee. If you wish to purchase an advance copy of the DSP, please contact APTA's Member Services at 800-999-2782.

5.2. Exam Content Outline
The content outline for the exam that specifies the percentage of questions in each major content area is found on page 9. The content outline is presented as an approximation of the test construction and should not be interpreted as an exact distribution of test items.

5.3. Preparation for the Exam
You declare your intent to sit for the specialist certification exam at the time of application and are expected to begin preparation for the exam at that time. You are responsible for determining the method and amount of preparation necessary for the exam. Results from candidate surveys suggest that helpful methods of examination preparation include, but are not limited to, advanced level texts, *Physical Therapy*, and other journals containing current physical therapy research. You may also want to review the *Description of Specialty Practice* and the content outline to determine what content will be covered on the exam and to direct your study efforts.

5.4. Review Materials and Courses
A resource guide listing prepared by APTA's Women's Health Section can be found on page 21. Some sections hold review courses related to advanced practice in their specialty area. Applicants should contact their section directly to receive information. Neither ABPTS nor the specialty councils review or endorse the content of review materials and courses.

5.5. Study Groups
The APTA Specialist Certification Program maintains a list of candidates who are interested in participating in study groups. To be included in study group listings, select “participate in study group” and answer “yes” on the online application. Study group lists will be generated and emailed by November 17, 2018, to candidates who have indicated their interest in participating in study groups. Study group lists are emailed by request only.

5.6. Exam Development
The specialty certification examinations are developed by specialty councils of ABPTS. APTA has contracted with the NBME to assist in the development, administration, scoring, and reporting of results for the certification examinations. Using the DSP as a basis, the specialty councils make the final determinations regarding the exam content and the number of items in each area.

Questions (items) for the exam are solicited from content area experts currently practicing in the specialty area representing the full range of practice settings and focus in all regions of the country. Item writers attend workshops and receive instruction to enable them to write high-quality, practice-related test items. Test items undergo extensive editing and review by subject matter experts and professional test editors before specialty councils approve them to be placed on the examinations.

5.7. Exam Question Format
Questions (items) are designed to test synthesis and analysis levels of cognitive skills, as well as content knowledge. The exam is composed of objective multiple-choice questions with 4 or 5 answer choices. The questions either stand alone or are part of a series that relates to a presented case study. Beginning on page 9 are sample questions that are representative of the format of questions for each exam, but may not necessarily reflect the ability level or content of the items. There are 200 items on the exam, consisting of 50 questions in each 1½-hour time block.

5.8. Answer Strategy
You should consider answers to each question carefully and eliminate the least likely ones instead of randomly selecting an answer. Please keep in mind that there is no penalty for incorrect responses. Since test scores are based on the actual number of questions answered correctly, it is to the candidate's advantage to select an answer for each question rather than leaving any blank. There is only one best answer for each question.

5.9. Tutorial
After you are approved to sit for the examination, the Specialist Certification Program will make available a tutorial so that you may practice using the testing software prior to your test day. The tutorial can be accessed on the APTA Specialist Certification website (www.abpts.org/SpecCertExamTutorial/). You should acquaint yourself with the testing software well before your test date. Test center staff are not authorized to provide instruction on use of the software.

The tutorial will also be available at the beginning of the examination session. You may use up to 10 minutes before beginning the examination. The test driver is easy to understand and requires little or no prior computer experience.

6. SITTING FOR THE EXAM

6.1. Computer Testing
The specialist certification examinations are administered by computer. The examination questions are presented on computers, and candidates provide their responses using a mouse or keyboard. NBME works with Prometric to deliver these examinations worldwide at more than 300 test centers. Approved candidates should contact Prometric as soon as possible once they have their scheduling permit to schedule a testing appointment. Candidates may take the test on any day that it is offered during the testing window, provided that there is space at the Prometric test center of choice.

6.2. Test Centers and Testing Conditions
Prometric provides computer-based testing services for academic assessment, professional licensure, and certification. Please be aware that there may be test takers from other professions taking examinations during your test administration. Their exam schedule may differ from your schedule, and they may arrive and depart at different times.

These test centers provide the resources necessary for secure administration of the examination, including video and audio monitoring and recording, and use of digital cameras to record the identity of candidates.

6.3. Exam Time
You should arrive 30 minutes before your scheduled testing appointment.

The official exam time begins the moment that you enter your Candidate identification number. There are 200 questions on the exam. The exam is administered during a seven (7) hour testing session, which consists of a
brief tutorial (up to 10 minutes), four 1½-hour test-blocks, and 50 minutes of optional break time to be used after any block. Please note that if you finish a section early, you may not use the extra time for a different section of the exam, however, this time will be available as additional break time.

If you have unused time after you complete the examination, you will be given the opportunity to complete an online survey about the test administration. The purpose of the survey is to evaluate the test scheduling and delivery procedures. Your responses will be kept confidential, and the time you take to complete this survey will not detract from your allotted examination time.

6.4. Admission to the Test

You should arrive at the test center at least 30 minutes before your scheduled testing time on your testing day. If you arrive late, the test center administrator may refuse you admission. If you arrive more than 30 minutes after your scheduled testing time, you will not be admitted. In that event, you must pay a $101 fee to Prometric to reinstate your eligibility record in order to reschedule your appointment within the testing window (rescheduling fees vary for international sites).

Upon arrival at the test center, you must present a printed copy of your scheduling permit or present it electronically (e.g. via Smartphone) and an unexpired, government-issued form of identification (such as a current driver’s license, valid passport, or military ID) that includes both your photograph and signature. If your identification contains your photograph but not your signature, you may use another form of unexpired identification that contains your signature, such as student/employee identification card or a credit card, to supplement your photo-bearing, government-issued identification.

As a security procedure, you will be photographed before you begin taking the examination. You will also sign a test center log, and store your personal belongings in your assigned locker. You will be scanned with a handheld metal detector and be asked to empty and turn out your pockets prior to entry into the testing room to confirm that you have no prohibited items. You will be required to remove eyeglasses for visual inspection by the test center administrators. Jewelry, except for wedding and engagement rings, is prohibited and hair accessories are subject to inspection. You should not wear ornate clips, combs, barrettes, headbands, and other hair accessories. Any examinee wearing any of these items may be prohibited from wearing them in the testing room, and asked to store such items in their locker. These inspections will take a few seconds, and will be done at check-in and upon return from breaks.

If you brought a printed copy of your scheduling permit, the Test Center Staff will collect it. You will be provided with laminated writing surfaces and markers. You will be instructed to write your name and Candidate Information Number (CIN) on one of the laminated writing surfaces provided. Your scheduling permit will be retained by the Test Center Administrator. You may request access to the permit during the examination if it becomes necessary for you to rewrite the CIN on the laminated writing surface. Test Center Staff will escort you to your assigned testing station and provide brief instructions on use of the computer equipment. Laminated writing surfaces and markers issued are to be used for making notes and/or calculations during the testing session. They should only be used at your assigned testing station, and only after you have begun your examination by entering your CIN. You must enter your CIN to start the examination, which will begin with a brief tutorial prior to the first test block. If you have filled the laminated writing surfaces and need additional space for making notes, you will need to notify test center staff and a replacement will be provided. Laminated writing surfaces must be returned to test center staff at the end of the testing session.

Important Note: You will not be admitted to the testing room without presenting either a printed or electronic copy of your permit and an unexpired, government-issued form of identification (such as a driver’s license or passport) that includes both your photograph and signature. The name on your scheduling permit must exactly match the name on your identification form. The only acceptable difference would be the presence of middle name or middle initial, or suffix on one document and its absence on the other. If you do not present your permit and required identification on the exam day, you will be denied admission to test. In that event, you must pay a fee to Prometric to reschedule your test (see section 4.5 for additional instructions).

6.5. Testing Regulations and Rules of Conduct

Test center staff monitor all testing sessions. Candidates must follow instructions of test center staff throughout the examination. Test center staff are not authorized to answer questions from candidates regarding examination content, testing software, or scoring. If staff observes a candidate violating test administration rules or engaging in other forms of irregular behavior during an examination, the test center staff will not necessarily tell the candidate of the observation at the time of the examination. Test center administrators are required to report such incidents to NBME; each is fully investigated.

Candidates may not bring any personal belongings into the testing area, including but not limited to the following:

- Mechanical or electronic devices, such as cellular telephones, calculators, watches of any type, electronic paging devices, recording or filming devices, radios
- Outerwear such as coats, jackets, head wear, gloves
- Book bags, backpacks, handbags, briefcases, wallets
- Books, notes, study materials, or scratch paper
- Food, candy, gum, or beverages

If you bring any personal belongings to the test center, you must store them in a designated locker outside the testing room. You should keep in mind that the lockers are small and that mechanical or electronic devices stored in lockers must be turned off. Making notes of any kind during an examination, except on the laminated writing surface provided at the test center, is not permitted and removal of those materials from the secure testing area during a testing session or break is prohibited.

Note: Although the site provides noise-reducing headphones, you are encouraged to bring your own cordless soft-foam earplugs (subject to inspection).

6.6. Irregular Behavior During the Examination Process

Irregular behavior includes any action by candidates or others when solicited by a candidate that subverts or attempts to subvert the examination process. Test center administrators are required to report any irregular behavior by a candidate during the examination. Irregular behavior may include, but is not limited to, the following:

- Seeking and/or obtaining access to examination materials
- Impersonating a candidate or engaging another individual to take the examination by proxy
- Giving, receiving, or obtaining unauthorized assistance during the examination or attempting to do so
- Making notes of any kind during an examination except on the erasable writing surface provided at the test center...
Women’s Health Specialist Certification Candidate Guide

6.7. Canceled or Delayed Exam Administration or Problems at the Testing Center

Every effort is made to administer an examination at the scheduled test time and location. On occasion, however, exam administrations may be delayed or cancelled in emergencies such as severe weather, a natural disaster that renders a Prometric Testing Center (PTC) inaccessible or unsafe, or extreme technical difficulties. If Prometric closes a testing center where you have already scheduled a testing appointment, it will reschedule the examination appointment at no additional charge. In that event, Prometric will attempt to notify you in advance of your testing appointment to schedule a different time and/or center. Rescheduling an appointment for a different time or center may occur at the last minute due to limited availability of seats in a PTC.

One week prior to testing, you are advised to reconfirm your appointment with Prometric and maintain flexibility in any travel arrangements you may make.

If you experience an emergency situation on the day of your examination that you feel may jeopardize your ability to perform effectively on the examination, you may be eligible to postpone sitting for the examination until 2020. However, please note that if you opt to still sit for the examination and are not successful, this is not a basis for appealing examination results and your ability to sit again in 2020 at no additional cost may be in jeopardy.

Any candidate, once checked in and seated at a test station, who is delayed to take the examination by more than 30 minutes because of technical difficulties, is responsible for reporting the delay to the Specialist Certification Program at 800/999-2782, ext 8520, as soon as possible. For such cases, the candidate may be eligible to choose to reschedule his or her examination at no additional charge. Before deciding to reschedule, you should be sure that there is another appointment available during the testing-block. The test administration will not be considered “irregular” if you choose to remain and test despite the delay. You will receive the maximum number of hours available to candidates to complete the exam even if the test is delayed.

Any candidate, once checked in and seated at a test station, who has a concern or complaint about the test center environment, should immediately report the problem to the test center administrator. If you feel that the problem was not resolved to your satisfaction, you should contact the Specialist Certification Program at 800/999-2782, ext 8520, as soon as possible.

6.8. Exam Deferral

Candidates may defer their examinations through the ABPTS online application system located at www.abpts.org. To access your application click on “Online Application” from the Quick Links menu. Find your current application and click “History.” On the left-hand side of the screen, click on “Applicant Admin.” At the top of the Applicant Admin page is “Submit Deferral.” It is recommended that you review the deferral guidelines before selecting “Yes” from the drop-down menu. Last, scroll to the bottom of the page, and click “Save” to complete the deferral request. Please note you will not receive an email confirming the deferral, but once you click save that will finalize the process.

6.9. Equipment Malfunction

Should you experience any difficulty with the computer, please notify the test center administrator immediately. Do not wait until you have completed the exam to bring equipment malfunctions to the attention of the test center administrator. Once again, if you feel that the problem was not resolved to your satisfaction, you should contact the Specialist Certification Program at 800/999-2782, ext 8520, as soon as possible.

Please note that, occasionally, a computer at the test center may need to be restarted. Prometric has appropriate safeguards in place to ensure the integrity of candidate examination data. As soon as a candidate answers a test item, the response is immediately copied and saved on the candidate’s directory on the server at a center. If there is a computer restart, the driver locates the results from the directory and picks up where the examinee left off. The system does not change or delete any responses. Thus, examination data are captured at the instant a candidate responds to a question; the computer can be restarted, if necessary, without losing or corrupting examination data.

6.10. Incomplete Examinations

After you start taking an examination, you cannot cancel or reschedule that examination unless a technical problem prevents you from completing your examination. As noted in section 6.9, if you experience a computer problem during the test, notify test center staff immediately. The testing software is designed to allow the test to restart at the point it was interrupted. In most cases, your test can be restarted at the point of interruption with no loss of testing time. If you do not finish the exam for any reason you are not permitted to resume the incomplete sections of the test. You must reapply for the next regularly scheduled administration (see section on “Reapplication” 3.7). The examination fee is nonrefundable for incomplete examinations.

7. EXAM RESULTS

7.1. Exam Results and Notification

After ABPTS meets in May 2019 to make certification decisions, score reports will be prepared for online distribution in mid-June 2019. The score report specifies your examination score, the passing score on the examination, and feedback on your performance in the major competency areas tested. In mid-June 2019, the Specialist Certification Program staff will send you an email notification announcing that score reports are available online, including instructions on how to access and download your score report.
Although there is a time lapse between the close of the examination window and the availability of examination results, much is happening during this period of time. Key validation takes place after the exam window closes in March. Key validation is a process of preliminary scoring and item analysis of the exam data, followed by careful evaluation of the item-level data, to identify potentially flawed or incorrect items prior to final scoring. During April and early May, standard setting committees are convened at the NBME to participate in content-based standard setting studies. The outcome of each committee’s standard setting meeting is the recommendation of a passing standard of each of the specialty examinations during their May meeting. NBME then scores the specialist certification examinations and candidates are notified of their exam results as soon as this information is received by the Specialist Certification Program.

8. CONFIDENTIALITY

8.1. Confidentiality of Applicant Identity

Applicant names, application documents, and test scores are considered confidential. Only Specialist Certification Program staff, members of the American Board of Physical Therapy Specialties, members of the Specialty Council, and designated staff at the NBME and its subcontractors shall have access to this information. Applicant identity can be released for study group purposes only, with the consent of each applicant. Copies of test scores will be released only at the written request of the candidate.

8.2. Confidentiality of Examination Content

All candidates must sign/acknowledge the Affidavit & Pledge of Confidentiality in their online application for certification. Candidates must not disclose examination content to others or reproduce any portion of the examination in any manner. The examination of any candidate who violates these security rules will not be scored.

9. GROUNDS FOR DISCIPLINARY ACTION

Applicants or candidates who are determined to have engaged in fraud, misrepresentation, or irregular behavior in the application or examination process, to have disclosed examination content to others or reproduced any portion of the examination in any manner, or to have violated the Affidavit & Pledge of Confidentiality will be subject to disciplinary action, to be determined by ABPTS, which may include, without limitation, withdrawal of any certification granted and permanent or temporary exclusion from the certification process. Before taking disciplinary action, ABPTS will give the individual written notice of the evidence against the candidate and an opportunity to respond.

10. PROCEDURES FOR REVIEW OF DECISIONS

10.1. Reconsideration of Decision Regarding Eligibility to Sit for the Exam

An applicant whom the Specialty Council has determined to be ineligible may request the Council to reconsider its denial of eligibility. The request for reconsideration must specify the grounds on which it is based. An applicant may submit new information in support of his or her request for reconsideration. An applicant may challenge the Specialty Council’s application of the eligibility requirements to his or her case, but not the requirements themselves. An applicant may not appeal to ABPTS unless he or she has first submitted a request for reconsideration to the Council. An applicant must submit his or her request for reconsideration no later than 2 weeks from the date of the denial letter. For purposes of determining compliance with the foregoing deadline, a request for reconsideration will be deemed submitted on the postmark date. The Specialty Council will notify the applicant in writing of its decision on reconsideration.

10.2. Appeal to ABPTS of Specialty Council’s Decision Regarding Eligibility to Sit for the Exam

An applicant who wishes to submit an appeal must contact the Specialist Certification Program for a complete copy of the procedures. An applicant whom the Council has determined upon reconsideration to be ineligible may appeal the decision to ABPTS. An applicant may challenge the Council’s application of the eligibility requirements to his or her case, but not the requirements themselves. The applicant must submit his or her appeal no later than 2 weeks from the date of the Council’s decision on reconsideration. The appeal must be in writing and must be addressed to the Chair of ABPTS at the APTA Specialist Certification Program. For purposes of determining compliance with the foregoing deadline, a request for reconsideration will be deemed submitted on the postmark date. The appeal must specify the grounds on which it is based.
The Appeal Committee, a committee of ABPTS, will be responsible for the review and disposition of requests from applicants for appeal of a Specialty Council decision. The Appeal Committee will make its decision no later than 30 days from the date of receipt of the request for appeal. The Appeal Committee will send written notification of its decision to the Chair of the Specialty Council and the applicant by certified mail, return receipt requested, no later than 7 days from the date of its decision.

10.3. Procedures for Review of Certification Actions
A candidate who wishes to request that ABPTS reconsider its decision to deny certification must request a complete copy of procedures from the Specialist Certification Program.

The purpose of the ABPTS reconsideration procedure is to enable a candidate to challenge an ABPTS decision denying certification and to seek relief from untoward circumstances associated with the onsite administration of the examination and errors in the transmission of examination responses due to technical malfunction. To be considered, the request must include supporting evidence of technical malfunction.

Candidates must submit a request for reconsideration in writing and address the request to the Chair of ABPTS at the APTA Specialist Certification Program. To request reconsideration, the candidate must submit a written request no later than 2 weeks after the date of the letter notifying the candidate of exam results. For purposes of determining compliance with the foregoing deadline, a request for reconsideration will be deemed submitted on the postmark date. The request for reconsideration must specify the grounds on which it is based and the corrective action sought. Within 7 days of the receipt of a request for consideration ABPTS will acknowledge in writing the receipt of the request, including the date on which the request was received.

10.4. Appeal to APTA Board of Directors of ABPTS Decision to Deny Certification
A person may not appeal to the APTA Board of Directors unless he or she has submitted a request for reconsideration to ABPTS. A candidate who wishes to submit an appeal must request a complete copy of procedures from the Specialist Certification Program. Any candidate adversely affected by the ABPTS decision on reconsideration may appeal to the APTA Board of Directors within 14 days of receipt of the ABPTS notification of the Appeal Committee’s decision. A candidate must submit this appeal in writing, and the candidate must address it to the President of the APTA at the APTA Governance Department. The candidate must also send a copy of the written appeal to the Chair of ABPTS at the APTA Specialist Certification Program. The appeal must set forth arguments in support of the candidate’s position. ABPTS will send written acknowledgment of receipt of the appeal to the candidate within 7 days after ABPTS receives the candidate’s written appeal request.

11. EXAM CONTENT OUTLINE & SAMPLE QUESTIONS

11.1. Exam Content Outline
The questions on the exam will be distributed approximately according to the following percentages of content areas. This is an approximation only and may not represent the exact distribution of questions on the examination. All questions on the examination relate to competencies as outlined in the book Description of Specialty Practice: Women’s Health Physical Therapy.

<table>
<thead>
<tr>
<th>Content Area</th>
<th>% of Exam Questions</th>
</tr>
</thead>
<tbody>
<tr>
<td>I. Knowledge Areas:</td>
<td>15%</td>
</tr>
<tr>
<td>a. Foundation Sciences (3%)</td>
<td></td>
</tr>
<tr>
<td>b. Behavioral Sciences (3%)</td>
<td></td>
</tr>
<tr>
<td>c. Clinical Sciences (3%)</td>
<td></td>
</tr>
<tr>
<td>d. Ancillary Tests (1%)</td>
<td></td>
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<tr>
<td>e. Medical Interventions (3%)</td>
<td></td>
</tr>
<tr>
<td>f. Critical Inquiry (2%)</td>
<td></td>
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<tr>
<td>II. Practice Expectations:</td>
<td>85%</td>
</tr>
<tr>
<td>a. Professional Roles and Responsibilities</td>
<td></td>
</tr>
<tr>
<td>1. Professional Responsibilities (2%)</td>
<td></td>
</tr>
<tr>
<td>2. Risk Management (2%)</td>
<td></td>
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<tr>
<td>3. Professional Development (2%)</td>
<td></td>
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<tr>
<td>4. Education (2%)</td>
<td></td>
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<tr>
<td>5. Evidence-Based Practice (2%)</td>
<td></td>
</tr>
<tr>
<td>6. Consultation (2%)</td>
<td></td>
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<tr>
<td>7. Social Responsibility (2%)</td>
<td></td>
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<tr>
<td>8. Prevention/Wellness/Health Promotion (2%)</td>
<td></td>
</tr>
<tr>
<td>b. Patient/Client Management</td>
<td></td>
</tr>
<tr>
<td>1. Examination (23%)</td>
<td></td>
</tr>
<tr>
<td>2. Evaluation/Diagnosis/Prognosis (14%)</td>
<td></td>
</tr>
<tr>
<td>3. Intervention (27%)</td>
<td></td>
</tr>
<tr>
<td>4. Outcomes (5%)</td>
<td></td>
</tr>
<tr>
<td>TOTAL:</td>
<td>100%</td>
</tr>
</tbody>
</table>

11.2. Sample Questions
Candidates for the specialist certification examination in women’s health are encouraged to review the following sample questions to familiarize themselves with the examination format. Please note that the questions listed below reflect the format but not necessarily the complexity of the actual examination questions.

Case Scenario 1
A 54-year-old white woman who reports moderate urine loss associated with physical exertion for 8 years and a “falling out feeling” in her perineal area is referred for outpatient physical therapy. She reports anywhere from 1 to 4 leakage episodes per day associated with coughing, sneezing, laughing, position changes such as moving from sit to stand, and lifting objects. She feels that when she has the urge to go to the bathroom she had better get there quickly for fear that she will wet herself. Although she is generally able to get to the bathroom on time, she feels that she is “going all of the time” and knows where every bathroom in the city is located. She requires the use of 2 absorbent pads (Serenity®) daily. She lives with her husband and 2 daughters, who are supportive of her condition. The patient was referred to you by her gynecologist following her annual visit in which she finally decided that she needed to address this problem.
Questions

1. Which of the following tests is the most reliable method to assess the ability of the pelvic floor musculature to generate power?
   A. Visual inspection
   B. sEMG biofeedback
   C. Diagnostic ultrasound
   D. Intravaginal palpation

2. Examination of the patient’s pelvic floor musculature reveals significant weakness; the patient is able to perform a full contraction of the pelvic floor musculature, including a posterior lift, but she is unable to maintain this contraction for more than 5 seconds. She also presents with a Grade II (50% to the level of the vaginal introitus) anterior prolapse while performing the valsalva maneuver. Intravaginal sensation is intact. Anal wink and clitoral/sacral reflexes are intact. Based on the best available outcome evidence for this particular population, which of the following is the most appropriate intervention strategy for this patient?
   A. Pelvic floor muscle exercises augmented with use of electrical stimulation
   B. Pelvic floor muscle exercises and diet/fluid modification instruction
   C. Pelvic floor muscle exercises augmented with use of vaginal cones
   D. Refer for surgical consult

3. Prior to referral for physical therapy, this patient underwent urodynamic testing in which she demonstrated detrusor instability. If the patient fails to achieve her goals through physical therapy intervention, she will be referred for surgical consult. Which of the following surgical procedures is most appropriate for this patient?
   A. Retropubic suspension
   B. Sacral nerve stimulation
   C. Pubovaginal sling
   D. Peri-urethral collagen injections

Case Scenario 2

The patient is a 39-year-old Hispanic woman who arrives with complaints of right-side low back pain that began about 2 months ago and is getting progressively worse. She is a medical resident in her final year of her residency program. Her pain worsens with prolonged standing or walking and is especially painful during work hours. She also complains of pain and numbness that extend down into her right posterior thigh. She awakens some nights while turning in bed and experiences interrupted sleep that is affecting her ability to concentrate during the day. She had been taking fitness classes 3 times each week at a local health club but has had to discontinue due to this discomfort. She is 6 months pregnant and would like to work until her delivery if possible. She was referred to physical therapy by her obstetrician. This is her second pregnancy. She has a 2-year-old son. She reports she had mild low back pain during her first pregnancy that did not limit her function. She had a prolonged labor and delivery ultimately resulting in a cesarean section delivery following 3 hours of pushing. She has had no other complications during this pregnancy except for some mild vaginal bleeding during the first trimester which has since ceased.

Questions

4. The screening examination reveals the ability to heel-and-toe walk. She demonstrates full lumbar range of motion with pain at end of range lumbar flexion and extension. Straight-leg raise test is limited to 80 degrees bilaterally with a firm muscular end-feel. Manual muscle tests reveal 5/5 strength in all musculature of the lower extremities. Sensation was impaired to light touch over the dorsal surface of the right foot, including the first web space. Muscle stretch reflexes were 2+ at the knees and ankles bilaterally. From the information provided in the scenario above, the patient’s neurologic symptoms are most likely associated with which of the following?
   A. L4 radiculopathy
   B. Sciatic nerve compression
   C. Femoral nerve compression
   D. Obturator nerve compression

5. Physical therapists specializing in women’s health should have knowledge of medical conditions affecting the pregnant patient’s/client’s ability to participate in an exercise program. Women showing signs and symptoms of various conditions should be referred to appropriate health care providers for necessary medical evaluation and intervention. As this patient progresses, she expresses a desire to return to participation in regular fitness classes. She is now 29 weeks pregnant and has been diagnosed with placenta previa. Which of the following is the most appropriate action by the women’s health clinical specialist?
   A. Continue exercise; monitor vitals closely
   B. Continue exercise; avoid positions in which the hips are above the head
   C. Discontinue resistive exercise but continue aerobic conditioning
   D. Discontinue all exercise until after delivery

6. The patient asks the women’s health clinical specialist about the difference in outcomes when performing stabilization activities alone or in combination with the use of a lumbar corset. Which of the following levels of evidence should the women’s health clinical specialist offer as the greatest strength regarding the value of the use of a lumbar corset on outcome?
   A. Clinical experience
   B. Randomized clinical trials
   C. Observational studies
   D. Case studies

Case Scenario 3

A 42-year-old African American woman was diagnosed 6 months ago with Stage IIIA invasive ductal breast cancer of the left breast. Due to extensive family history of breast cancer and evidence of ipsilateral axillary lymph node involvement following a sentinel lymph node biopsy, the patient elected to have a bilateral radical mastectomy with oophorectomy and a Level III axillary lymph node dissection on the left 4 months ago. The pathology report revealed that the tumor was positive for the estrogen and progesterone receptors but was negative for the HER-2/neu proto-oncogene receptor. She tested positive for mutation in the BRCA-1 gene. She just completed her first course of chemotherapy.
(8 treatments), which had been delivered every 2 weeks for 4 months. She is scheduled to start tamoxifen treatment in a few weeks. She did not receive radiation treatment.

She is referred to outpatient physical therapy due to recent onset of significant swelling in the left upper extremity and complaints of left shoulder pain, left upper extremity heaviness, and discomfort when wearing her rings or her watch on her left side.

Prior to her diagnosis of breast cancer, her medical history was unremarkable except for delivery of 2 children, now ages 4 and 7, and her strong family history of breast cancer. She is currently self-employed as an interior designer and lives with her husband and their children. She has recently attempted to return to work but has been limited by fatigue, pain, and limited function in her left UE. She is right-handed but uses her left UE extensively when sewing, carrying fabric, hanging draperies, measuring windows, etc.

**Questions**

7. During the course of treatment, the patient reports new onset of low back pain. She denies any particular incident or injury. She describes the pain as coming on mostly at night. It wakes her from a deep sleep, and she is unable to find a position of comfort to relieve it. She describes it as a dull ache. Physical examination reveals a normal lordotic curve, full pain-free lumbar range of motion, mild hamstring restriction, 2+ muscle stretch reflexes at the knee and ankle, 5/5 strength, and intact sensation in the lower extremities. She denies tenderness to palpation in the lumbar musculature but does have some mild tenderness over the spinous processes at L3 and L4. What should the physical therapist’s next step be?
   - A. Add hamstring stretching exercises to the current intervention plan
   - B. Instruct the patient in use of heat and ice for pain relief
   - C. Instruct the patient in modification of sleeping position
   - D. Refer the patient to a physician for further evaluation

8. This patient has completed a 6-week program of physical therapy and has achieved all of the functional goals established. Prior to discharge, the physical therapist would like to provide the patient education regarding general wellness/health promotion. Of the following, which is the most important consideration for this patient?
   - A. Maintenance of healthy weight (BMI 18.5-24.9)
   - B. General flexibility exercises
   - C. Risk factors for cardiac disease
   - D. Lifestyle modifications to manage fatigue

**Key:** 1-D, 2-B, 3-B, 4-B, 5-D, 6-B, 7-D, 8-D

12. **PREPARING A CASE REFLECTION**

12.1. **Instructions**

**Purpose:** The purpose of the clinical case reflection is to document competency in patient/client management in the specialty area. Patient management in a clinical case reveals clinical reasoning skills that are essential to demonstrating competency in the women’s health physical therapy specialty area.

**Guidelines for case selection:** Patient/client management has five elements — examination, evaluation, diagnosis, prognosis, and intervention — which lead to optimal outcomes of care. Please select a typical case in your practice where you can provide evidence that demonstrates your competency in all five elements. The case should provide a clear picture of how the applicant provided care that is beyond that of an entry level practitioner. ABPTS may audit your submitted case reflection to verify its authenticity.

**Material/information to include** (see attached sample case reflection):

- The document you submit should be able to be read in no more than 10 minutes.
- You should begin the document with your rationale for selecting the case.
- Each case must include relevant clinical information, which may be presented using tables, graphs, bullet-points, etc.
- The information presented can be descriptive or actual documentation with identifying information removed.
- Provide a written description of your clinical reasoning based on a synthesis of information and what is known in the literature, i.e. discuss why certain tests/measures or interventions were selected based on the literature and appropriateness for the patient.
- Provide relevant citations from the literature to support your clinical decision making. The case reviewer will consider the relevance of these references when evaluating the case reflection.

The case should indicate contemporary, specialist practice as depicted in the Description of Specialty Practice for Women’s Health Physical Therapy. An individual evaluating your competency should be able to rate your performance from reading your case using the scoring rubric described below.

**Scoring Rubric:** After review of the case reflection, the rater will decide if it has met competency as specified by the scoring rubric. Your submitted case must meet competency for approval at this step of initial certification. Competency is defined as obtaining a score of “Pass” for the screening criteria.

**Process for Submission of a Clinical Case Reflection:**

1. A case must be submitted along with the application to sit for the Women’s Health Specialty Examination.
2. The candidate must sign a notarized attestation indicating that the report reflects what actually was done for the patient and does not represent an embellishment of the case. (Note: this can be done through notarization of the exam application itself. A separate notarization of the case reflection is not required).
3. A case will be evaluated within 3 months of submission.
4. A case that does not meet the screening criteria will be returned with an explanation.
5. A case not rated as competent will be returned with the rater’s comments.
6. If this case is rated as not meeting the screening criteria or competent, it can be resubmitted after corrections are made or replaced with another case, but only once.
7. Each case will be reviewed by a trained rater in the specialty area. Any case that is not rated as competent by the initial reviewer will be reviewed by a second reviewer. Any discrepancy between the raters will be referred to a third, trained rater.

8. A candidate whose case is not rated as competent may submit a written request to the American Board of Physical Therapy Specialties (ABPTS) for reconsideration per existing ABPTS policy and procedures for reconsideration requests.

**Compliance With HIPAA Privacy Rule:**

Please note that, in order to be in compliance with the HIPAA Privacy Rule, the case reflection and any documentation you submit must conform to either Option 1 or Option 2 below:

Option 1. De-identify the patient information in the case reflection and documentation per the HIPAA Privacy Rule, which defines 18 specific items that must be removed to release patient information without patient authorization. The list of these 18 items can be found under Option 2 below.

Option 2. Obtain written authorization from the patient. A template of a form to be used for this purpose is attached. This written authorization does NOT need to be obtained if patient information in the case reflection and documentation is de-identified per the instructions in Option 1 above.

HIPAA Privacy Rule defines 18 specific items that must be removed to release patient information without patient authorization or approval from the Research Privacy Board. These 18 items are:

1. Names.
2. All geographic subdivisions smaller than a state, including street address, city, county, precinct, ZIP Code, and their equivalent geographical codes, except for the initial three digits of a ZIP Code if, according to the current publicly available data from the Bureau of the Census:
   a. The geographic unit formed by combining all ZIP Codes with the same three initial digits contains more than 20,000 people.
   b. The initial three digits of a ZIP Code for all such geographic units containing 20,000 or fewer people are changed to 000.
3. All elements of dates (except year) for dates directly related to an individual, including birth date, admission date, discharge date, date of death; and all ages over 89 and all elements of dates (including year) indicative of such age, except that such ages and elements may be aggregated into a single category of age 90 or older.
4. Telephone numbers.
5. Facsimile numbers.
6. Electronic mail addresses.
7. Social security numbers.
8. Medical record numbers.
9. Health plan beneficiary numbers.
10. Account numbers.
12. Vehicle identifiers and serial numbers, including license plate numbers.
15. Internet protocol (IP) address numbers.
16. Biometric identifiers, including fingerprints and voiceprints.
17. Full-face photographic images and any comparable images.
18. Any other unique identifying number, characteristic, or code, unless otherwise permitted by the Privacy Rule for re-identification.
12.2. Authorization to Disclose Protected Health Information Template

Authorization to Disclose Protected Health Information

Patient Name: ___________________________________________________________

Description of information to be used or disclosed: ___________________________________________________________

Purpose or purposes of disclosure: ___________________________________________________________

Persons authorized to use or disclose information: ___________________________________________________________

Persons to whom information may be disclosed: ___________________________________________________________

Expiration date or expiration event: ___________________________________________________________

**Right to Terminate or Revoke Authorization**
This authorization may be revoked or terminated by submitting a written revocation to (name) at (clinic name).

**Potential for Redisclosure**
Information disclosed pursuant to this authorization is subject to redisclosure by the recipient, and may no longer be protected.

**Your Rights**
You have the right to receive a copy of this authorization and to be told the purpose and to whom the protected health information is being disclosed.

**Refusing Authorization**
If you refuse to sign this authorization, you may not be denied appropriate treatment by this facility.

____________________________________________________________                      _________________
Printed name of patient

____________________________________________________________
Signature of patient or patient representative  Date
12.3. Case Reflection Checklist

PURPOSE:
The purpose of the patient case reflection is to demonstrate the advanced clinical reasoning and decision making process reflective of that of a women’s health clinical specialist. Clinical specialists are set apart from non-board certified therapists with entry level proficiency by their ability to synthesize information from a variety of sources including, but not limited to, the patient/client, examination, differential diagnosis, intervention, and the incorporation of literature into clinical practice.

Clinical specialists are able to incorporate what is learned from each patient case, positive or negative, into future patient management. The case reflection should demonstrate these learning experiences by providing rationale for decision making throughout the plan of care. Relevant citations of the literature should be included in the case reflection.

Cases reflections will be accepted on both male and female cases that are representative of women’s health clinical practice.

REFERENCES:
All documented citations should be <10 years since publication unless the article is considered a seminal study. References are to be provided throughout ALL sections of the case reflection. The applicant should provide reference citations supporting all clinical decision making and intervention techniques. Course manuals are not accepted as supporting references.

AREAS OF REFLECTION:
The applicant is to provide reflection within each section of the case reflection document. These reflections should highlight the specialist’s clinical thought processes and rationale. This is the opportunity for the applicant to clearly demonstrate their ability to understand and practice as a clinical specialist. This may include discussion on decisions that were made correctly or decisions that would be made differently in the future. The applicant may also highlight items that would be focused on in more detail next time or methods on which they would change their practice with future patients.

SCORING:
Case reflections which are poorly assembled, which rely on outdated literature (>10 years since publication unless a seminal study), or do not adequately demonstrate the clinical decision making process throughout the document in the reflections will not receive a passing score. Applicants will be provided one opportunity for revision if a non-passing score is received.

Refer to the case reflection scoring rubric for specific points of content which should be included in the case reflection to achieve a passing score. The applicant must include all points within each section of the case reflection (as clearly outlined on the scoring rubric) to receive a passing score.

MISTAKES TO AVOID:
- These are the most common mistakes applicants make in the case reflection. Take care to avoid these mistakes which result in a non-passing score.
- Failure to provide the required reflection within each section of the case document
- Failure to address each point on the scoring rubric
- Incomplete post case reflection or failure to include this section
- Failure to cite supporting literature throughout the case document to support clinical decisions and treatment interventions
- Submission of a case report in format for publication; the case reflection is NOT a case report. The case reflection is a document that shows the applicants learning and critical thinking skills based on the patient experience.

12.4. Case Reflection Scoring Rubric

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Pass</th>
</tr>
</thead>
<tbody>
<tr>
<td>Case Rationale</td>
<td></td>
</tr>
<tr>
<td>The case represents specialist practice, is professional in appearance,</td>
<td></td>
</tr>
<tr>
<td>using correct grammar, spelling and punctuation, and adheres to the</td>
<td></td>
</tr>
<tr>
<td>word count of 2,000 or less words.</td>
<td></td>
</tr>
<tr>
<td>The applicant presented a rationale for the case, e.g., diagnosis</td>
<td></td>
</tr>
<tr>
<td>within those seen most often by a women’s health practitioner or</td>
<td></td>
</tr>
<tr>
<td>whose treatment is different than that for a man, co-morbidities,</td>
<td></td>
</tr>
<tr>
<td>presence of “red flags.”</td>
<td></td>
</tr>
<tr>
<td>The applicant provided insight regarding his/her perspective of</td>
<td></td>
</tr>
<tr>
<td>specialist practice.</td>
<td></td>
</tr>
</tbody>
</table>

For each element noted below, the specialist must provide commentary clarifying the decision making process.

Explain the basis on which the case was approached. How was the case handled? What decisions were made? Why? How did information, change, and/or progress inform decisions? A reader should have a clear idea about the specialist’s thinking process.
### Examination

<table>
<thead>
<tr>
<th>Applicant must describe decision making and rationale for the following:</th>
</tr>
</thead>
<tbody>
<tr>
<td>The history, systems review (risk factor assessment), and tests and measures demonstrate appropriate rationale supported by current practice/literature allowing for measurement of outcomes, diagnostic classification, and/or, as appropriate, a referral to or collaboration with another practitioner(s).</td>
</tr>
<tr>
<td>The applicant’s clinical reasoning reflects an organizational approach that considers development of hypotheses in the categories of activity capability/restriction, patient's perspective on their experience, patho-biological mechanisms, impairments, and source of the symptoms, contributing factors, precautions and contraindications.</td>
</tr>
<tr>
<td>The applicant provided rationale for decisions including relevant citations.</td>
</tr>
<tr>
<td>Tests and Measures: The applicant provides a rationale for the tests/measures that describes the necessity to (1) confirm or reject a hypothesis about the factors that contribute to making the current level of patient/client function less than optimal and (2) support the physical therapist’s clinical judgments about appropriate interventions, anticipated goals, and expected outcomes.</td>
</tr>
<tr>
<td>• Provides commentary on reliability, validity, specificity, sensitivity, likelihood ratios as available of tests and measures when appropriate.</td>
</tr>
<tr>
<td>With the information from the three elements of the examination (history, systems review, test and measures) the applicant provided his/her reasoning for decisions regarding patient management. The applicant shared what s/he was thinking, what guided his/her decisions and how s/he made plans for the patient's management at this point.</td>
</tr>
</tbody>
</table>

### Evaluation/Diagnosis

<table>
<thead>
<tr>
<th>Applicant must describe decision making and rationale for the following:</th>
</tr>
</thead>
<tbody>
<tr>
<td>The evaluation/diagnosis demonstrates the synthesis of all the examination findings from the history, systems review, and tests and measures and applies a differential diagnosis process to establish the diagnosis, prognosis, and plan of care as supported by current practice/literature.</td>
</tr>
<tr>
<td>Reflection is provided including supporting evidence regarding the principal hypothesis of the nature of the onset or diagnosis (e.g., is it consistent with a particular syndrome, practice pattern per the Guide, structures at fault or suggest a dominant pain mechanism?), extent of impairment, functional limitations and associated tissue damage/change. The applicant provides insight into how the diagnosis directs treatment planning.</td>
</tr>
</tbody>
</table>

### Prognosis/Plan of Care

<table>
<thead>
<tr>
<th>Applicant must describe decision making and rationale for the following:</th>
</tr>
</thead>
<tbody>
<tr>
<td>The prognosis includes a predicted optimal level of improvement in function and the amount of time needed to reach that level.</td>
</tr>
<tr>
<td>The applicant reflects on favorable and unfavorable prognostic indicators and identifies appropriate prognosis for this patient. The prognosis is based on the literature, understanding of the nature of the disorder (e.g. inflammatory, degree of irritability, worsening, and other indicators of the need for caution), the patho-biological mechanisms, the patient’s perceptions (i.e. cognitive/affective status) and possible contributing factors.</td>
</tr>
<tr>
<td>The plan of care demonstrates the use of interventions to produce changes in the condition that are consistent with the diagnosis/prognosis.</td>
</tr>
</tbody>
</table>

### Intervention

<table>
<thead>
<tr>
<th>Applicant must describe decision making and rationale for the following:</th>
</tr>
</thead>
<tbody>
<tr>
<td>The timing and progression of interventions were designed to maximize the patient's/client's recovery.</td>
</tr>
<tr>
<td>The interventions were relevant to functional outcomes as supported by current practice/literature.</td>
</tr>
<tr>
<td>Monitoring or reexamination of the patient's/client's responses/progress toward achieving the anticipated goals and expected outcomes was adequately documented.</td>
</tr>
<tr>
<td>Evidence is presented demonstrating that risk factors and health promotion were addressed.</td>
</tr>
</tbody>
</table>
**Formatting the Case Reflection:**
The following questions can be used to help form your case reflection. Please also use the scoring rubric to ensure all points are included in your case reflection. **NOTE:** the points below are to provide a guide for developing the case reflection; additional information is likely indicated and should be included.

**Case Rationale:**
- Is the case representative of women’s health specialty practice?
- Does the specialist provide rationale for the case clearly outlining the indicators that make it reflective of women’s health specialty practice?
- Does the specialist provide insight regarding his/her perspective of specialist practice?

**Examination:**
The history, systems review (risk factor assessment), and tests and measures demonstrate appropriate **rationale** supported by current practice/literature allowing for measurement of outcomes, diagnostic classification, and/or, as appropriate, a referral to or collaboration with another practitioner(s)

The specialist’s clinical reasoning reflects an organizational approach that considers development of hypotheses in the categories of activity capability/restriction, patient’s perspective on their experience, patho-biological mechanisms, impairments, and source of the symptoms, contributing factors, precautions and contraindications.

**Tests/Measures:**
- How do the physical signs fit with the symptoms? If they do not, how might this influence the prognosis, plan of care and intervention?
- What element of the specialist’s physical examination findings would indicate the need for caution in the intervention?
- What did the specialist consider about referring the client to another health provider?

**Evaluation/Diagnosis:**
- What is the assessment of the patient’s understanding of his/her problem?
- What is the specialist assessment of the patient’s feeling about his/her problem, its affect on his/her life and how it has been managed to date?
- What does the patient expect/want from the specialist management (i.e., patient goals)?
- How did the specialist determine that the patient’s goals were appropriate?
- What effect does the specialist anticipate the patient’s understanding and feeling regarding his/her problem may have on the prognosis, plan of care and intervention?
- Have impairments that may require management/reassessment (e.g. posture, movement patterns, motor control, soft tissue/muscle/joint/neural mobility/sensitivity, etc.) been identified?
- Has supporting and negating evidence from the examination for diagnosis, faulty structure or patho-biological mechanism been adequately presented and considered (comment on reliability/validity/specificity/sensitivity/likelihood ratios of test and measures)?
- Would there be a perceived need to refer the client to another health provider?

**Prognosis/Plan of Care:**
- How do the physical signs fit with the symptoms and if not, how would this influence the prognosis, plan of care, and intervention?
- What about the examination findings would indicate the need for caution in the prognosis, plan of care, and intervention for the patient?
- What is the management of the patient for day 1 (e.g., advice, exercise, passive mobilization, referral for further investigation, etc.)? Why was this chosen over the other options?
- If passive treatment was used, what are the principle treatment techniques (rationale provided)?

**Post-Case Reflections**

<table>
<thead>
<tr>
<th><strong>Yes</strong></th>
<th><strong>No</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Applicant must document:</strong></td>
<td></td>
</tr>
<tr>
<td>How similar cases were managed based on what was learned from this case.</td>
<td></td>
</tr>
<tr>
<td>How applicant or patient understanding of the patient’s problem and management changed in subsequent visits.</td>
<td></td>
</tr>
<tr>
<td>How the patient’s needs are being met.</td>
<td></td>
</tr>
<tr>
<td>Clues that were missed, misinterpreted, under- or overweighted.</td>
<td></td>
</tr>
<tr>
<td>What to do differently next time.</td>
<td></td>
</tr>
<tr>
<td>Decision about management if the outcome will be less than a 100% resolution of the problem(s)</td>
<td></td>
</tr>
<tr>
<td>Interventions to improve the overall health status of the patient.</td>
<td></td>
</tr>
</tbody>
</table>
• What physical examination findings (comment on reliability/validity/specificity/sensitivity/likelihood ratios of test and measures) support your choice for management?
• What is the specialist's expectation of the patient's response over the next 24 hours?

Intervention:
• How would the specialist progress this patient?
• What kind of outcomes to expect for this patient?
• What would the specialist justify referring the patient to another health provider?
• After subsequent visits, how has the specialist or patient understanding of the patient's problem and management changed since first session?
• How are the patient's needs being met?
• What interventions were introduced to improve the overall health status of the patient?
• If the outcome will be less than a 100% resolution of the problem(s), at what point would the specialist cease management and why?

Post-Case Reflections:
• On reflection, what clues can be recognized by the specialist that were missed, misinterpreted, under- or over weighted?
• What would the specialist do differently next time?
• Discuss how similar cases were managed based on learning experience from this case?

12.5. Sample Case Reflection
Submitted to Demonstrate Competence as a Women's Health Clinical Specialist

Case Rationale
The case below is representative of women's health specialty practice. Approximately 69% of all pregnant women complain of low back pain (LBP) and about 57% of those complain of LBP that impairs daily living.1 There are many sources of LBP during pregnancy, including postural factors, joint laxity related to hormonal changes, and non-musculoskeletal causes such as vascular congestion.2,3 A consideration of the normal postural, physiologic, and metabolic changes that occur during pregnancy and their relationship to physical and psychosocial function and disability was necessary to plan an examination of this patient.4,5

Based on the results of the examination, I designed a physical therapy intervention plan. Interventions must be selected with caution, considering the potential effects of interventions applied over the pregnant uterus and the general health of the mother and fetus. For example, caution should be taken when considering the use of modalities for pain relief. There is limited evidence to describe the specific effects of ultrasound or electrical stimulation applied over the pregnant uterus on the fetus.6 The therapist must also be aware of any special conditions such as pre-eclampsia, gestational diabetes, placenta previa, or multiple gestation and their impact on exercise prescription.7 The specialist also has an important role in the prevention of low back pain and other musculoskeletal dysfunction associated with pregnancy and the post-partum period.

Most often the specialist will encounter this patient in an outpatient setting. The physical therapist may encounter this patient without a physician referral. Therefore, it is critical that the physical therapist examine the patient holistically throughout the course of care and note any changes that might indicate the need for other health care professionals to be involved.

EXAMINATION (History, Systems Review, Test & Measures):

Reflection: The Guide to Physical Therapist Practice® offers a documentation template for physical therapist patient/client management. This patient’s history was taken in an interview session, using the template provided by the Guide for organization of the history. The patient referral indicates the woman is complaining of lower back pain during pregnancy. Women with a history of LBP prior to pregnancy are twice as likely to experience LBP during pregnancy as compared to women without a history of LBP. Therefore, the history included a detailed description of her prior pregnancy and delivery.

Patient History:
A 39-year-old Hispanic female, 6 months pregnant, was referred to physical therapy by her obstetrician with complaints of right-sided lower back pain of 2 months duration. She also complained of pain and numbness that extended distally into the posterior aspect of her right lower extremity. The right lower back pain was described as an intermittent dull ache and the right lower leg pain was described as a burning numbness/tingling pain (similar to the feeling of the leg “falling asleep”).

Current Condition/Chief Complaint:
The patient reported right-sided lower back and right lower extremity pain. She also complained of pain and numbness that extended distally into the posterior aspect of her right lower extremity. The right lower back pain was described as an intermittent dull ache and the right leg pain was described as a burning numbness/tingling pain (similar to the feeling of the leg “falling asleep”).

She reported that the symptoms were getting progressively worse over the 2-month period. Her pain was worse with prolonged standing or walking and was especially painful during work hours. She awakened some nights while turning in bed and experienced interrupted sleep that was affecting her ability to concentrate during the day. She reported symptom relief while sitting with her feet elevated and when resting on her side. She reported her pain level between 0-6/10 using the Verbal Rating Scale.9

Medications:
She stated that she had not taken any medications for this condition and denied taking medications for any other medical conditions at the time of the examination. She did report taking a pre-natal vitamin as prescribed by her physician since her positive pregnancy test at 4 weeks gestation.

Reflection: Pregnancy limits the ability to prescribe medications for pain management. The use of NSAIDS is contraindicated during pregnancy.10 The therapist needs to make sure that the patient is aware of the risk of the use of NSAIDS during pregnancy and potentially refer the patient back to their physician to review appropriate medications to provide the patient adequate pain relief. Appropriate medications may include Tylenol (acetaminophen) and/or limited use of an analgesic as appropriate.10
**Medical/Surgical History:**
This was her second pregnancy. She had a 2-year-old son. She reported experiencing mild lower back pain during her first pregnancy that did not limit her function and did not require medical intervention. She had a prolonged labor and delivery, ultimately resulting in a cesarean section delivery following 3 hours of pushing. She had no other complications during this pregnancy except for some mild vaginal bleeding during the first trimester, which ceased.

**Social History/Employment/Work:**
The patient was a medical resident in the final year of a family medicine residency program and wanted to work until her delivery if possible. She had a supportive spouse who was a stay-at-home dad. She reported that they lived in a single-story home with 2 steps to get into the home. She reported no difficulty negotiating the steps, however reported regular use of the handrail for support with ascent and descent due to the lower back and leg pain. There were no other medical complications and she reported that she had always been healthy and active.

**Systems Review:**
She denied any history of heart or lung problems, diabetes, or cancer. She reported a healthy diet and regular exercise. She had been taking fitness classes 3x/week at a local health club but had to discontinue due to this discomfort.

**Pain:**

0-6/10 (0-10 scale).8

**Postural Assessment:**
The patient presented with moderate forward head and shoulder posture and an anterior pelvic tilt in the standing and sitting positions. Patient's abdominal size was consistent with her 24 weeks gestation.

**Reflex Integrity:**
Intact and equal bilaterally, 2+ LE

**Circulation:**
No observational presence of swelling or circulatory abnormalities was noted. Distal pedal pulses were present.

**Cervical Range of Motion:**
Within normal limits.13

**Trunk Range of Motion:**
Patient was able to achieve full mobility. Pain was present at the end range of flexion, extension, and right lateral flexion.14 The patient reported an “achey” type pain over the R sacroiliac region with movement. Application of overpressure during flexion and R lateral flexion caused mild radiation of pain into the R buttock. The patient demonstrated a “juttering” type motion with the return to neutral from a flexed position.

**Upper Extremity Range of Motion:**
Within normal limits.13

**Lower Extremity Range of Motion:**
The patient reported pain into the right lower lumbosacral region with hamstring length testing (straight leg raise test) at 80°, total motion to 92°. Pain, tingling and numbness into the right posterior thigh with hamstring length testing at 80°. Straight
leg raise testing on the left reveals 95° total hip motion. Symptoms were relieved when hip flexion was combined with knee flexion. Sidelying muscle length testing revealed tightness of the bilateral quadriceps.5

**Muscle Performance (Manual Muscle Testing):** 5/5 UE/LE.15 Patient is able to complete an isolated abdominal hollowing exercise indicating a 3/5 of the transversus abdominis.16 Pain present with quadricep and hamstring manual muscle testing. Note: the hamstring manual muscle test was modified to performed in sitting due to the inability of the patient to assume the prone position. Pain decreases with pre-contraction of the transversus abdominus muscle.

**Spinal Mobility:** Pain and hypermobility of the sacroiliac joint were noted during superoinferior translation of the innominate/sacrum in sitting and in the sidelying positions.17 Patient was not tested in the supine position due to her 24 weeks gestation.4 Pain was present into the lumbosacral region on the right with provocation testing of the R SI joint with a transverse anterior distraction.19

**Palpation:** Pt c/o tenderness surrounding the right PSIS region and distal lumbar paraspinals on the right.

**Special Tests:**

- **Diastasis recti:** 2 finger width separation at the level of the umbilicus.18
- **Active Straight Leg Raise Test:** + increase in ability to perform straight leg raise on the R with form and force closure.19
- **Modified Prone Instability Test:**14, 20 The patient was placed in sidelying. A P-A force was applied over the L4-5 and L5-S1 spinal segments. The patient was then asked to actively contract her spinal extensors. The patient was instructed in activation of the extensors by performing an anterior pelvic tilt prior to the onset of the test. The patient had minimal c/o pain and no hypermobility with the P-A glide which did not change with activation of the spinal extensors. Therefore the test was considered negative.

**Ambulation:** Patient ambulates with a wide base of support, antalgic gait with slight limp during stance phase on the right.

**Transfers:** Transfers to/from the treatment plinth are independent, movements in lumbosacral region are guarded with rotational movements secondary to increase in symptoms.

**Ergonomic/Body Mechanics:** Patient presents with faulty body positioning as observed with picking up the diaper bag and when lifting/carrying and interacting with her 2-year-old son. Faulty movements include: excessive trunk forward flexion and rotation with reaching and carrying, with minimal squatting and use of the lower extremities observed. Patient was able to correct with verbal cuing to use her legs, keep the load close, avoid bending and twisting.

**Oswestry Disability Questionnaire:**23 20% disability

**Fear Avoidance Belief Questionnaire:**22

- **Work subscale – 12**
- **Physical Activity subscale – 6**

**Reflection:** The Oswestry Disability Questionnaire (ODQ) is a condition-specific disability scale for patients with LBP, consisting of 10 items addressing different aspect of function, each scored from 0-5 with higher values representing greater disability. It has been found to have high levels of reliability, validity, and responsiveness.24 Fritz and Irrgang report minimum clinical important difference at 6 points (sensitivity=91% [95 CI=82%-99%], specificity=83% [95 CI=67%-98%] and a test-retest reliability of the OSW as being high (ICC = 0.90).23 Patients with acute LBP will have generally have minimum ODQ scores of 20% to 25%.24 A successful outcome of physical therapy treatment has been defined in some studies as at least 50% reduction in the ODQ score.25

**Fear-Avoidance Beliefs Questionnaire (FABQ)** is an additional self-report measure that contains two subscales, one related to work activity (FABOW) and the other to general physical activity (FABOPA). Previous studies have reported that scores greater than 34 on the FABOW among subjects with work-related LBP may be at risk for prolonged disability and may indicate a need for a multidisciplinary approach. Those subjects with a FABOPA score above 13 to 14 may benefit from a cognitive-behavioral approach to classification-based therapy, including a reduced emphasis on subjective reports of pain and establishing specific exercise goals agreed upon by the patient and therapist.26,27 Scores above 18 on the FABOW have been associated with decreased likelihood of success with a manipulative treatment approach.25

The therapist also notes that the test positions for various tests/measures were modified based on the inability of the pregnant patient/client to assume the prone position or maintain the supine position for > 5 minutes once in the second trimester of pregnancy.

The assessment of diastasis recti is important as anything less than or equal to 2 fingers-breadth in width is considered normal.19 However, this patient is only 24 weeks pregnant (second trimester). The largest growth in the fetus and the size of the mother is during the third trimester.5 The patient is at risk of developing a clinically significant diastasis. It will be important to address abdominal strengthening and body mechanics during the intervention to minimize the risk of further diastasis of the rectus abdominus.

The faulty body mechanics noted during the examination are also important to note. There are many stresses placed on the pregnant woman during the care of other children that are often significant precipitating or aggravating factors. Proper body mechanics during lifting, carrying, and bending will be important to address during the intervention.

**Evaluation/Physical Therapy Diagnosis**

The patient presents with pain, postural dysfunction, impaired sensation, impaired abdominal muscle function and hypermobility of the sacroiliac joint. Using the treatment based classification system for LBP as described by DeLitto et al,11,12 this patient would fall into the stabilization category. According to the Guide to Physical Therapist Practice the patient would fall under Musculoskeletal Practice Pattern 4D – Impaired joint mobility, motor function, muscle performance, and range of motion associated with connective tissue dysfunction. In addition, this patient has an elevated resting blood pressure and is at risk for developing pre-eclampsia.

**Reflection:** Due to the hormonal and physical changes associated with pregnancy, pregnant clients are likely to experience laxity in the pelvic joints. This occasionally leads to hypermobility of the joints and impaired function as noted. Often, the body is more efficient at producing these hormones in multiparous patients vs. primiparas. Therefore, multiparas may be at greater risk for physical dysfunction vs. primiparas.

As stated previously, due to the elevated resting blood pressure, this patient will be referred back to their physician for further evaluation.
Prognosis

Physical therapy is appropriate to attain patient goals. The frequency of treatment was established at 2 times per week for 4 weeks with goals of independent home program, independent donning and doffing of an SI belt, and reduction of pain to allow continued work as a medical intern until delivery.

Reflection: Prognosis for attaining goals is considered to be good given the client’s motivation and according to a clinical prediction rule developed by Hicks et al., to predict patients most likely to benefit from a lumbopelvic stabilization program. This patient meets 3 of the 4 criteria established (age < 40 years old, + aberrant movement, average SLR > 91°). The study demonstrated a positive likelihood ratio of 4.0 when 3 of the 4 criteria were met thus increasing the likelihood of a successful treatment.

Intervention

Coordination, Communication, Documentation:

In addition to initiating the physical therapy plan of care, the therapist consults the physician regarding the patient’s elevated resting blood pressure. The physician encourages frequent monitoring of BP especially during exercise. Therefore, the patient is instructed in signs/symptoms of elevated blood pressure to be aware of such as headache, fatigue, flushed face, etc. Blood pressure will be monitored at the beginning, during, and following all physical therapy treatment sessions.

Manual Therapy:

- Week 1 the therapist applied joint mobilization/manipulation techniques to the R SI joint which resulted in an immediate reduction in pain and a reduction in ODQ score by 50%.

Therapeutic Exercise:

- Week 1: basic instruction in activation of the transversus abdominis, multifidus, and pelvic floor musculature.
- Week 2: progression of stabilization activities to include upper extremity and lower extremity motion in semi-supine with a wedge cushion and quadraped positions while maintaining the core contraction.
- Week 3: progression of stabilization activities in sitting and standing and on therapeutic exercise ball.
- Week 4: progression of stabilization activities to include functional activities such as squatting, sit to stand, reaching, etc.

Other:

- Week 1: the patient was fitted with a SI belt which she was instructed to wear as needed during the day at work and during bending/lifting activities outside of work.
- Week 2 and beyond: The patient was instructed in the body mechanics of sitting, standing, lifting, bending, etc. to minimize stress on the pelvic region.

Outcomes:

- Patient reports pain level is 0/10 with use of SI belt.
- ODQ score is 0% disability.
- Patient demonstrates independence in home exercise and management program.

The patient was discharged from physical therapy care and was encouraged to continue her home exercise program and use of the SI strap as needed during her pregnancy. She was also instructed in the normal progression of symptoms following delivery. She was encouraged to return to physical therapy for further consultation if her low back pain had not completely subsided at 6 weeks following delivery. The patient indicated that she was interested in breast feeding and therefore the patient was given preliminary instruction in positioning during breast feeding to minimize stress. She was also given other information related to proper body mechanics during care of her child, C-section scar management (because of her prior C-section she was to have a scheduled C-section delivery of this child), and pelvic floor and abdominal strengthening exercises following delivery.

Reflection: The patient received a manual therapeutic intervention at the initial treatment session which resulted in the reduction of pain and disability. There are potential risks of manual therapeutic interventions in the pregnant client, however, I felt that the potential benefits outweighed the risks. However, it was my opinion that the patient needed to be brought to a balanced (neutral) position prior to initiating the stabilization activities whether through use of an SI belt or through the use of stabilization exercises.

The therapeutic exercises were selected based on the patient’s needs and were progressed while monitoring the patient’s response to exercise throughout. The exercise position was modified from a supine position to semi-supine with a wedge as to prevent supine hypotension syndrome.

Women are also at risk for LBP and pelvic girdle dysfunction during the postpartum period. Hormonal levels generally return to normal within a few weeks following delivery. But the return to normal ligamentous laxity is often delayed especially if the woman is breastfeeding. Care of a newborn can place stress on the musculoskeletal system. The abdominal and pelvic floor musculature, important in stability of the lumbopelvic region, have been compromised and are limited in their ability to provide adequate stability to the region. Therefore, the patient was instructed in posture and body mechanics specific to the postpartum period and other activities that will facilitate recovery from the delivery (C-section scar management, pelvic floor/abdominal exercises) and prevent future disability.

The outcomes of this intervention were good (0/10 pain and 0% disability on the ODQ) and were met within the time estimated initially (4 weeks).

I would expect that with continued exercise beyond delivery and into the postpartum period that the patient will not experience further difficulty. However, this patient is at significantly increased risk for LBP with future pregnancies and should be counseled appropriately.

References


13. GLOSSARY

Description of Specialty Practice (DSP). This document is based on a practice analysis, which is a systematic study of professional practice behaviors and content knowledge of specialty practice. The purpose of the practice analysis is to collect data that will describe what specialist practitioners do, and what skills and knowledge bases enable them to perform specialty practice. These data are used to describe specialty practice. The DSP defines the content area for the clinical specialist certification examination in the specialty area.

Guide to Physical Therapist Practice. This reference describes physical therapist practice in general, using the disablement model as the basis; describes the various roles of physical therapists and the setting in which they practice; standardizes physical therapy terminology; delineates tests and measures and the interventions that are used in physical therapist practice; and provides preferred practice patterns to assist in (a) improving quality of care, (b) enhancing positive outcomes of physical therapy services, (c) enhancing patient/client satisfaction, (d) promoting appropriate utilization of health care services, (e) increasing efficiency and reduce unwarranted variation in the provision of services, and (f) diminishing economic burden of disablement through prevention and the promotion of health, wellness, and fitness initiatives.

Part 1 of the Guide, “A Description of Patient/Client Management” describes the process of patient/client management including the following 5 elements:

• Examination. A comprehensive screening and specific testing process leading to diagnostic classification or, as appropriate, to referral to another practitioner. The examination has three components: the patient/client history, the systems review, and tests and measures.

• Evaluation. A dynamic process in which the physical therapist makes clinical judgment based on data gathered during the examination
• **Diagnosis.** Diagnosis is both a process and a label. The diagnostic process includes integrating and evaluating the data that are obtained during the examination to describe the patient/client condition in terms that will guide the prognosis, the plan of care, and intervention strategies. Physical therapists use diagnostic labels that identify the impact of a condition on function at the level of the system (especially the movement system) and at the level of the whole person.

• **Prognosis.** The determination of the predicted optimal level of improvement in function and the amount of time needed to reach that level.

• **Intervention.** The purposeful interaction of the physical therapist with the patient/client and, when appropriate, with other individuals involved in patient/client care, using various physical therapy procedures and techniques to produce changes in the condition.

14. RESOURCE GUIDE INFORMATION

Resource guides are compiled by APTA sections and board-certified specialists to reflect current literature in the specialty area. They are provided for your information only. Neither the ABPTS nor the specialty councils has reviewed or endorsed the content of these lists. In addition, reviewing these resources does not guarantee that a candidate will receive a passing score on the specialist certification examination.

Women’s Health Physical Therapy Resource Information

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