

## ELEMENTS TO SATISFY CAPP CASE REFLECTION EXPECTATIONS

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### PURPOSE AND MISSION OF THE CAPP CASE REFLECTION

Similar to a “final exam,” the **purpose of the CAPP Case Reflection** is to serve as the comprehensive evaluation for obtaining the CAPP certificate, in which the author demonstrates a culmination of the acquired knowledge, skills and critical thinking processes obtained through the didactic course instruction and testing.

To achieve this purpose, the **mission for the author** of the CAPP Case Reflection is to describe a patient in the author's care from start to finish, while demonstrating:

1. The ability to integrate didactic coursework and current literature into the selection and provision of examination, evaluation, plan of care, functional outcome measures, interventions, and follow-up care for a patient requiring rehabilitation of a pelvic condition (CAPP-Pelvic) or a condition related specifically to pregnancy or postpartum (CAPP-OB).
2. Rationale and reasoning for selection and provision of these items.
3. Reflection on the case, particularly describing areas in the case that:
  - a. Differed from literature and why
  - b. The author has learned from and would alter with future patients.

### GENERAL RECOMMENDATIONS FOR WRITING THE CAPP CASE REFLECTION

1. Organize the paper in the same order and with the same section headings as in the **Case Reflection Rubric** ([Download Now](#)) which is posted with the CAPP information on the SoWH website. This allows reviewers to easily locate all required pieces of information.
  - The required sections are: Introduction, Examination (includes subsections History, Systems Review, Tests and Measures, and Outcome Tools), Evaluation/Diagnosis, Prognosis/Plan of Care, Intervention, Outcome, and Case Reflection.
  - Clearly label the required section headings on a separate line and in bold font.
  - You may include sub-headings to further clarify inclusion of required information.
  - Case Reviewers will score your case reflection by this rubric.
2. Write cases clearly at a professional/post-graduate level.
  - Use accepted English syntax, grammar, spelling, consistent tense, and punctuation.
  - Use full sentences and paragraphs to describe the case. It is unacceptable to use bullet point formatting, shorthand and abbreviations; the case should resemble a professional literature review, and not clinic notes.
  - The first time an acronym is used, it must be defined (e.g., DRA, PFM, SUI).
  - In all cases, and especially if English is not the first language of the author, ask a colleague familiar with English language to proofread and provide feedback on readability and professionalism before submission.

- **Cases that are judged to be difficult to read because of formatting, syntax, grammar, spelling, and punctuation will automatically be returned for revision.**
3. The case will be judged against the **Case Reflection Rubric** and will fail to pass if items on the rubric are not addressed. For instance, if no barriers to treatment existed, then the author must directly state that barriers did not exist and further explain as appropriate. Compare your case to the rubric and to the element descriptions to make sure each required item on the rubric is included in the case prior to submission. This assures that you have included the necessary information that reviewers will be seeking.
  4. Plagiarism is unacceptable. As in any professional writing, information used word for word from another source is to be placed in quotes and the source cited as a footnote. Background information is expected to be integrated from appropriate sources and re-written in your own words as it pertains to your subject, giving credit to the sources of ideas expressed. It is not acceptable to place large blocks of copied general information within your case, even if referenced. Please review the article on types of plagiarism at [www.plagiarism.org](http://www.plagiarism.org) for clarification. The plagiarism policies a student follows in an academic institution continue to be pertinent to the professional therapist.
  5. Use current standardized terminology to describe your examination and evaluation findings. If quoting a reference that uses outdated terminology, the author should provide explanation of updated terminology following the quote. (E.g.: use of “overactivity of pelvic floor muscles” rather than “muscle spasm.”)
  6. List references in the order in which they are cited in the case according to AMA (American Medical Association) or APA (American Psychological Association) styling. AMA and APA style formats are easily obtained through the internet.
  7. Select background information from recognized scientific, primarily peer-reviewed sources.
    - Required are primary references from peer-reviewed sources within the last 10 years. As a guide, most well written cases will contain 20 references or more in order to adequately support the author’s clinical choices and rationale for each section.
    - Other references, unless considered a seminal study, are expected to be less than 10 years old.
    - Use of internet references from reputable sources such as government or professional organizations (ACOG, AMA, CDC) is acceptable, as is locating a peer-reviewed journal article via the web. It is not acceptable to use sources such as Wikipedia for background information.
    - Quoting a course instructor is not considered appropriate evidence to support clinical reasoning or decisions. When referencing material from a course manual, the reference provided in the manual must be personally reviewed and then cited.
  8. Graphs, charts, tables, and graphics are encouraged to simplify the understanding and readability of data and may be included (within the body of the document or as an appendix) to enhance the written material.
  9. Each section must provide commentary clarifying the decision making process: cited references should support choices for examination, differential diagnoses, and interventions.
  10. Share your knowledge and insights with the reader so it is clear to the reader that you understand what you are writing. A reader should clearly understand the author’s thought process. Consider including boxed sections titled *Reflections*, to provide your opinion and explanation of thoughts/decisions if this helps to organize the paper.
  11. Provide details, particularly regarding chosen interventions and rationale as it relates to current practice/literature.
  12. Clearly explain medical terms and acronyms if used. Write as if your reader is not familiar with

- orthopedic or women's health terminology. For example, what is "force closure," a "R upslip," or "a short pelvic floor"? Clearly describe findings using current standardized terminology.
13. Clearly describe and/or define terminology pertaining specifically to obstetric or pelvic specialty practice, including terms related to the examination, diagnosis and any medical terminology. (E.g.: PFM MMT 2/5 or history of P2G2 is defined and described).
    - A therapist who is not in WH practice, or a physical therapy student, should be able to read the case and understand clearly the terminology and descriptions used.
  14. De-identify to safeguard a patient's identity.
  15. Focus the paper's attention on pelvic floor physical therapy if seeking CAPP-Pelvic and obstetric physical therapy if seeking CAPP-OB. For example, if the case reflection is for CAPP-OB, the paper's focus should be on the material learned (exam, special tests, intervention, evidence) in the CAPP-OB curriculum, and not on assessment and treatment of the pelvic floor.
  16. **Be aware that for the case to receive a passing score, all components of each section of the case needs to receive a passing score.**

### **CASE REVISIONS AND RESUBMISSIONS**

Authors should not be concerned if a case is returned for revisions. The CAPP Case Reflection is part of the overall learning process, and often performing revisions enhances the richness of the learning experience.

#### **Steps to follow for resubmission:**

1. Six months are allowed to complete revisions and resubmit a case. If an extension is needed, simply make a request to Karen Snowden, Chair of the CAPP Case Reflection Review Committee at: [ksnowden@rcn.com](mailto:ksnowden@rcn.com).
2. Use the two returned rubrics to determine specifically which sections need revision. Only these sections will be reviewed when the case is resubmitted.
3. Perform revisions within the original paper. Generally, there is no need to completely rewrite the paper. Be sure to address each point that did not pass for each section in both rubrics.
4. After your revisions are complete, resubmit your case to the Section on Women's Health office at: [aika.barzh@womenshealthapta.org](mailto:aika.barzh@womenshealthapta.org).
5. Your resubmitted case will be forwarded to the Lead CAPP Case Reviewer (Lead Reviewer), who will compare your previously scored rubrics to your new case. The Lead Reviewer will complete a new rubric, addressing only the items that did not previously pass.

### **SECTIONS OF THE CASE REFLECTION**

*The first section is the only one that is not defined using a heading within the case. If this section does not pass, the case will automatically be returned for revision prior to the review being completed, as the presence of these elements contribute to readability and overall completeness of the case.*

#### **CASE REFLECTION ORGANIZATION AND PRESENTATION**

- Proofread for errors in syntax, grammar, spelling, tense used, and/or punctuation.
- Use complete sentences and paragraphs.
- Label each section with the appropriate heading in the same order they appear in the scoring rubric.

- Include appropriate references in AMA or APA format as discussed in “General Recommendations,” listed in the order in which they are cited.
- De-identify to safeguard the patient’s identity.

### **CASE TITLE AND IDENTIFICATION**

- Create an appropriate, descriptive title for the case reflection. Highlight the topic, an unusual outcome, or give insight into what a case is about.
- Identify the case reflection as CAPP-Pelvic or CAPP-OB.
- Author name
- Date case submitted
- Date of PF3 or OB-Advanced course attendance

### **INTRODUCTION**

- Provide a general overview of what the case is about.
- Include background information such as definition of medical terms.
- Explain the case rationale and how it represents specialist practice (ie: diagnosis among those most seen by a women’s health practitioner, how this treatment differs from that for a man, co-morbidities, or presence of “red flags”).
- Describe and provide literature citations for current medical evaluation and treatment of the diagnosis/patient type presented. Describe any inconsistencies in the literature.
- Clearly delineate the medical from the musculoskeletal differential diagnoses.

*Note:* Avoid unclear passive tense “It is hypothesized that ...”: by whom? If the author, say so; if others, cite supportive references.

### **EXAMINATION**

#### ❖ **History**

- Provide relevant history, including demographic characteristics and pertinent psychological, social, and environmental factors.
- Discuss contributing factors, precautions or contraindications.
- Describe prior or current services as well as medical diagnostics and treatment related to the current episode of physical therapy. Manometry? Cystometry? MRI? Bed rest status?
- Include relevant medical diagnoses and medical/surgical history.
- Explain comorbidities that may affect the prognosis, anticipated goals, expected outcomes, and/or plan of care.
- Describe the patient’s desired outcomes.
- Include cultural considerations if pertinent.
- Describe functional status (past/present).

#### ❖ **Systems Review**

- Address any pertinent findings within neuromuscular, cardiopulmonary, and integumentary systems.
- Fully describe musculoskeletal system/orthopedic screen findings, even if unremarkable.

#### ❖ **Test and Measures** –

- Provide rationale for chosen tests (to confirm or reject hypothesis, support clinical judgments).
- Provide reasoning why testing positions were utilized if other than the standard position.
- Was pelvic exam consent received? Was it verbal, written?

- Provide commentary on reliability, specificity, validity, sensitivity, and likelihood ratios of tests and measures when appropriate.
- Explain findings in detail. What makes a test positive or negative? What do the results of special tests or other measures mean?
- If you modified a test, explain your rationale for the modification, and your rationale of what you interpret the results to mean.

*Notes:*

Avoid statements such as “PFMs with poor tone externally” without further explanation of what is meant by this.

“Patient had perineal decent.” What is this; is this a normal finding? How was this measured or determined?

“Patient demonstrated positive testing with anterior vaginal wall and apical testing with bearing down”. What test was used? What was the grade?

“Pelvic floor muscle strength was 2/5.” What does this mean; how was a 2/5 grade determined?

“Patient had (+) posterior pelvic pain provocation test on the right”. What does this indicate?

At this level of practice, it is expected that examination of pelvic floor disorders will include musculoskeletal screening. Describe these results, even if findings were unremarkable. Provide an explanation if screening was not performed.

❖ **Outcome Tools**

- Describe outcome tools used. Provide information on validity, specificity, sensitivity, and/or likelihood ratio of outcome tools when available. If not available, state this.
- Explain what outcome scores mean. (In other words is a blood pressure of 150/90 mm Hg WNLs? What does a questionnaire score of 33 mean?)
- If no outcome tool was used, discuss why and what was used instead as an outcome measure.

**EVALUATION/DIAGNOSIS**

- Provide a summary of findings.
- Consider dominant pain mechanism, symptoms consistent with a particular syndrome, extent of impairments, functional limitations, and associated tissue changes.
- Provide explanation of decision making and rationale of examination findings from history, systems review, and test and measures.
- Provide hypothesis of suspected cause of symptoms/diagnosis. Describe your thought process with differential diagnosis.
- Provide physical therapy diagnoses (ie: “pelvic floor muscle strength deficit” verses medical diagnosis of “urinary incontinence”) as supported by current literature.
- Include description of differential diagnosis.

**PROGNOSIS/PLAN of CARE**

- Provide a list of patient-centered, objectively measured, **functional** goals in a specific time period.
- Provide prognosis for patient to achieve established goals.
- Describe plan of care and explain what guided your decisions for PT interventions, referral to other practitioners, and frequency / duration of treatment.

*Notes:*

Prognosis is based on literature and understanding the nature of the disorder, for instance whether or not it is inflammatory, degrees of irritability, and course of recovery to date (whether worsening or

improving). Prognosis is also based on precautions, patho-biological mechanisms, patient perceptions (ie: cognitive/affective status), and contributing factors.

Examples of poor vs. appropriate goals:

Poor: Strength will improve to 4/5. (Whose strength, strength of what, how is strength measured, what is the timeframe to meet the goal, how does this relate to function?)

Appropriate: Within 8 weeks, patient will demonstrate levator ani muscle strength improved to 4/5 on Laycock scale in order to improve urinary continence. (This is patient-centered, specific to strength of pelvic floor, objectively measurable, and related to function of continence within a specified time period of reaching the goal.)

Poor: Patient will report decrease in pain. (What is the timeframe for meeting the goal, where is the pain, how is the pain reduction measured, how will the pain reduction relate to function?)

Appropriate: Within 12 weeks, patient will report right-sided pelvic girdle pain reduced to 2/10 or less on a numeric rating scale while lifting her baby into a stroller. (Patient centered, specific to pelvic girdle pain, objectively measurable, and related to the daily function of placing baby in stroller within a specified timeframe of reaching the goal.)

## **INTERVENTION**

- Describe interventions in sufficient detail such that another clinician could replicate them.
- Provide the purpose for each chosen intervention and why you chose it. Link to hypothesis and support your choices with available evidence.
- Was the treatment or home exercise program progressed? If so, how and why? Relate to evidence.
- What topics were the patient/family educated in and why? Relate to evidence.
- Include communication with other health care providers.
- Were modifications necessary throughout the course of treatment? If so, why and were modifications effective?
- Provide parameters of modalities and why these parameters were chosen.
- Describing each treatment session may be a way to capture the necessary details.
- Describe how risk factors and overall health promotion were addressed.

*Notes:*

“Treatment intervention included general and gynecological manual therapy, electrical therapy, NM Re-Ed, PF relaxation, as well as PF and core strengthening” is too vague and needs to be explained in detail.

“Internal myofascial releases” is too vague.

“Pelvic floor and core strength was increased” or “exercises were progressed” needs to be explained.

“Gentle stretching of the walls of the vagina was performed.” Specifically how was this done?

“The patient contracted her multifidus and transverse abdominus muscles.” Explain how the patient was instructed to do this.

What exercises were provided, targeting which muscles, and why?

How many repetitions, sets, frequency of clinic and home exercises? Why were these parameters chosen?

## **OUTCOME**

- What was the outcome of PT treatment? Compare measured outcomes with patient’s pre-treatment status.

- Were goals met, or was progress made towards patient's desired outcomes?
- Provide results of outcome tools and describe in your words what the results mean. **You should have already provided the validity and specificity of your tools in the Examination section.**
- Describe patient adherence, and how this impacted the outcome.
- Provide number of treatments provided in a specific time frame.
- If goals, frequency, or duration were adjusted during the course of treatment, explain why.

*Note:*

"PFM tone reduced upon discharge from PT." Objective data in case study must support this statement.

**POST-CASE REFLECTION**

- Provide a reflection of your case.
- Describe barriers encountered during treatment, and how they may have impacted the patient's outcome.
- Was there a better outcomes tool you would use in the future? Support your choice.
- Describe clues that were missed, under- or over- weighted.
- What did you learn from this case, and what might you do differently?
- Explain how understanding the patient's problem changed your management in subsequent visits.
- How was the outcome managed if less than 100% resolved?
- Include relevant administrative or financial implications.
- How were the patient's needs met or not met?
- How did this case relate to other cases or reports in the literature, if applicable? Reflect on differences between your case and others.

**REFERENCES**

- Provide in AMA and APA format as described above.
- Follows criteria as listed in general recommendations above.