



## **Physical Therapist Clinical Education Models — Overview**

*Debbie Ingram and Randy Roesch*

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The primary objective in our clinical education programs and all of education is to prepare our students to achieve the professional expectation of entry-level practice. With the National Physical Therapy Exam fixed-date testing model, there is a potential to delay employment for several months for some students. From an anecdotal perspective, we can tell you that a student who takes the exam a week after completing clinical education or immediately post-graduation is more likely to pass the exam than those who delay taking the exam for several months. Physical therapy students are typically in clinical experiences at the end of their education, and we know the licensing exam is given in some professions before students ever go into that clinical environment, while others incorporate exams while they are in clinic.

Of 213 accredited physical therapy programs, 208 offer the doctorate degree in physical therapy. Typical physical therapist clinical education programs range from 20 weeks to 55 weeks of full-time clinical experiences; the average is 35 weeks. The DPT clinical education program is 36 weeks or roughly 20 percent of the curriculum, and the length of the final clinical experience varies from four to 48 weeks, with the average at 19 weeks. The total physical therapist program is now at 120 weeks or eight semesters. And with this increase in the PT and PTA programs, there are some challenges to our clinical education model as it exists.

The first challenge is increased student population. We've had a 7,000 student increase from the 2003-2004 academic years, and just one percent of PT students were previously physical therapy assistants. The typical program graduates 32 students, but the range is up to more than 200 students per program. The second major challenge is significant changes in the payer challenges. With Medicare Part A, our students may have direct supervision while in acute care hospitals. The Skilled Nursing Facilities (SNF) rule was one of site supervision for our students while they were in SNF placements. Part A is based upon state law rather than one of site supervision while in the clinical setting. Part B states that student-provided services cannot be billed to Medicare; services provided by the licensed therapist are those that are actually billed. While that doesn't mean that our students cannot work with Medicare Part B patients, it does

mean that you cannot bill for services when the student is providing them.

Another challenge that we're facing in clinical education with the payer is that the economy has impacted our patients' delayed access to care because they may be making personal choices to seek services based on out-of-pocket expenses and the co-pay.

The next major challenge our clinical community faces is the significant productivity requirement. The significant productivity demands and expectations in regard to supervising our students are making acute care very challenging because hospitals are also facing significant shortages and they may have contract labor providing the care. There are also staffing challenges in the rural community.

All PT programs must be accredited at the doctoral level by 2015 which means that all graduates of 2017 must be at the doctoral level. They've also stipulated a minimum number of 30 weeks for full-time clinical experiences. Differential diagnosis, radiology/imaging, pharmacology evidence-based practice and autonomous practice are all components added to our DPT programs. So how is it that we in the academic programs make decisions about clinical education? An interesting finding in a systematic review of more than 3,000 articles on clinical education is that most of the quality is based just upon opinion or anecdotal evidence. There isn't really a model that stands out in regard to clinical education. That's disappointing.

There are four models that you typically see in regard to clinical education - the integrated or traditional model, the independent model, the self-contained model and the hybrid. Without a specific or uniform model of clinical education required in the United States, it is up to the academic institution to choose its model.

**Integrated Model** - The integrated model is one that most of us probably had for our education. Longer experiences are typically lighter in the curriculum, and multiple clinic sites are involved so that students have the opportunity to experience not only the depths of what physical therapy offers but also the different types of experiences and different patient populations. The goal is to bridge theory with practice. At the University of Tennessee at Chattanooga, this is a 36-week clinical education curriculum which again is the average for DPT programs. Our students have the musculoskeletal system in the first year of the program, and then have a seven-week outpatient orthopedic experience. The second year includes all of the other systems. Then students go into an acute care environment for six weeks and follow that with a neuro-rehab environment for eight weeks. (Eight weeks was chosen on the advice of our clinical instructors.) Our challenge right now is working our schedule around large hospital settings in order to make our acute care program work. The students finish the third year of the curriculum which culminates with a 15-week internship. They get to choose the setting. Students then graduate and seek licensure.

Clinicians prefer long-term clinical experiences and our testing of that model verified that a one-time, seven-week clinical at the end of the third semester achieved the same result as shorter clinicals at the end of the first, second and third semesters. So, we eliminated all short-term experiences. We then asked directors of clinical education throughout the United States what types of experiences they thought all students must have in order to enter this profession. The overwhelming response was that students need to have experiences in acute care, so we implemented that program.

**Independent Model** - The independent model is the extended internship. As soon as students graduate from PT programs they want to stay for an additional residency program where they will have continued mentorship from a skilled physical therapist who can guide them to making decisions. At MGH, students are interviewed and selected by a site, and that site contracts with the institution and with the students. The students are paid for their service for that year-long internship. The first four months are still under the supervision and monitoring of the academic institution. They're still students at MGH. At the completion of those first four months, the students take the national PT exam. If they pass the exam, they return to the clinical setting to continue in a mentorship program with that particular clinic site helping to guide them as they pursue their decision making in becoming this expert clinician.

**Self-Contained Model** - With the self-contained internship model, faculty serve as clinical instructors to their students. Faculty members from the academic program come into the patient's room with a group of students and provide the care. It's a model used in nursing and dentistry that is becoming more popular in PT programs. The University of Pittsburgh has a large healthcare and academic system and the students in this model participate in their clinical experiences within the university; faculty members within that system are the clinical instructors for students. There are contracts with Children's Hospital, so students are able to have pediatric opportunities outside the University of Pittsburgh.

**Hybrid Model** - The hybrid model is a combination of the other three; it is one of the newest alternatives. It helps engage our students with students in other professions and with professionals who work outside our discipline so that we can work together in coordinated care for the people that we are serving. This new model is being introduced to Western University of Pomona, California. Nine different health professions are represented at this academic institution and through 38 weeks of clinical education, students are going to work with different students and patients.

The task of clinical experience continues to change. The Clinical Education Special Interest Group for the American Physical Therapy Association has just implemented the requirement that students must work with the aging population. That has a lot to do with our work force need.

There are significant challenges working with that population. Are we prepared as a profession? Another issue is that some of our students work in only urban facilities for their clinical experiences. How do rural areas attract people to come to their small town? Another challenge is convincing students who already have \$100,000 in loan debt at a public university to go away to a clinical experience when they are trying to cut back on expenses. We need to be mindful of other options in clinical education. I send students to the Mayo Clinic which has an interesting model in that all the students start and stop at about the same time. They work in groups. The clinical instructor goes with them and as they develop their independence, that clinical instructor is still there and on the floor. Our students were pleased with that model and I think Mayo is happy with that model, too.

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The Private Practice Section (PPS) had a strategic planning meeting in August of 2009 and we talked about the need to have more private practices involved in clinical education. We're constantly hearing from the education community that it doesn't have enough sites for students and that it's disappointed that private practice wouldn't take the students. We really want to expose students to private practice and obviously, if they're not going to the settings, they're not learning about private practice. We saw a recruitment opportunity for private practice, which always has a challenge finding enough physical therapists. To that end, we developed a task force in January 2010.

We talked about a formal way to develop and promote this model of clinical education where students would be a licensed intern and therefore be able to carry a case load and provide a revenue stream to defer the cost of clinical education. The clinics derive the benefit of having a licensed clinician and that person becomes more skilled as the internship goes on. The student or intern is paid a reduced salary so there's also some cost savings on the side of the private practice.

Many people said, "I really miss being a clinical instructor but we can't do it anymore in our private practice," and certainly there are many advantages to being a clinical instructor. We also looked at it as a way for some private practices to have career ladders for their staff and satisfy interest in wanting to be involved as mentors and clinical instructors. We decided that this was the model that we really wanted to promote. With changes to the doctoring profession, we need to look at our competency levels, especially at entry level. We expect a doctor of physical therapy to leave the educational program and be able to hit the ground running. We also believe that having a year-long internship, a year of supervised, mentored clinical education is extremely beneficial to developing these competent entry-level clinicians. We also know that our healthcare system is becoming more demanding. In many states, these folks need to be able to step into direct access situations. For those reasons, the year-long internship was appropriate

and it's a cost-effective way to get clinicians up to that level. One lofty goal is to look at this problem considering the variation of clinical practice. One reason there is so much variation in clinical practice is that there are variations in clinical education. We really believe that we can help reduce this variability in clinical education and some day help reduce variability in practice.

We wanted to move forward as quickly as we could because of so many frustrations with clinical education, lack of sites, designing effective methods and standardization. Also at issue are the increasing cost of physical therapy education and huge debts that students are incurring. Our model, by the way, cuts out almost a year of tuition. We obviously couldn't do this on our own, so brought non-PPS members onboard. At our first meeting in early 2010, we developed our goal to produce a standardized model. We wanted at least 15 programs across the United States to transform into the internship model. We want to help find an adequate number of clinical sites. While we are trying to get more private practice involved and promote private practice as a clinical site, we are in no way advocating that they'd be the only site for clinical education. We also wanted to develop a framework for delivery of this model so that every program is not reinventing the wheel.

The internship model is a 12-month clinical internship and a terminal portion of the educational process. During that first phase, the intern is really still a student. However, the student is also an employee of the practice and gets a salary for the entire year. The supervision of the student is consistent with your jurisdiction. At the end of that time, students become graduate interns so they graduate from the PT program and they sit for the NPT exam as quickly as possible.

We're a little bit challenged now with this fixed date situation; if you have temporary or restrictive licensure in your state, it's going to make a big difference. If neither of those exists, it's going to be a little more difficult for an internship program in that state. Once students have their license, they have full professional responsibilities; by the end of that nine-month period, they're carrying a full case load even though they still have a supervisor. In rural settings, we're looking at contracting two sites; a private practice and a hospital might split the intern because neither may be able to afford to give up a full time slot or have enough work.

These interns are paid a lower salary. We're recommending about 66 percent of a full-time salary. Once they become licensed, we're recommending that they spend about 75 percent of their time in patient care with at least 50 percent of that time with minimal supervision and 25 percent one-on-one. These are just guidelines, of course. We are developing some performance modules and benchmarks. There will be a contractual arrangement between the student or the intern and the facility and benefits such as health insurance would be provided by the facility just like they do for any other employee.

We currently have 15 entities - 6 universities and 9 private programs - across the country that

are willing to go to the internship model. Another 10 are contemplating it. Seventy clinical sites are interested in being a site for interns. We have worked closely with the residency group because it sees the natural flow of the medical model from intern right into the program.

How do we move forward? How do we standardize this model? We've developed six project teams who are going to look at economic liability and economic examples in the settings. We're setting up performance standards and measures. We're looking at developing a pre-internship competency exam which will go beyond the CPI. The concept of a restricted or provisional licensure for the internship is very encouraging. We want to be able to say, "When you finish your internship, bring us a certificate and it turns into a full license." That would be ideal. Once interns get a full license, they're contracted to stay in the setting although theoretically, they could leave, even if it rarely occurs. However, a restrictive license concept would eradicate that problem.

Lastly, we have a project team that's going to work on CI credentialing, CI qualifications and all the different concepts of mentoring. We've worked with CAPTE and APTA. APTA, of course, can't take a stand and say that it believes one model is better than another but it's very supportive and very interested in what we're doing as we move forward.

*Debbie Ingram has been the director of Clinical Education for the University of Tennessee at Chattanooga for 22 years and the former national chair for clinical education for the American Physical Therapy Association Special Interest Group on Clinical Education. Randy Roesch is a member of the Private Practice Section Board of Directors.*