

FAQ: BEST PRACTICES FOR PHYSICAL THERAPIST CLINICAL EDUCATION TASK FORCE REPORT

What is the planned timeline for achieving the recommendations of the report?

Much of the response to this question is dependent on what the APTA Board of Directors chooses to do in November (ie, adopt a recommendation, modify a recommendation, reject a recommendation, or seek a new report). Regardless, all recommendations will have the intent of moving physical therapist education forward. Some components of those recommendations may develop or evolve quickly (eg, 1-5 years), while others more slowly (eg, 5-10+ years). Similar to the professions adoption of Vision 2020 in 2000, we had no clue how long it might take us to achieve each of the elements identified, but set a 20-year goal.

I think there is a lack of evidence in clinical education to support any significant changes. We need to gather more information. The "task force believes" was stated multiple times in this town hall. If we are teaching EBP to our students, how do we model this by changing our clinical education system without evidence?

In the case of clinical education, there is no clear evidence supporting any single model. The task force report was a consensus-based report resulting in a charge from the profession through the House of Delegates. Multiple sources of information were considered by the task force, including review of previous clinical education conferences (eg, ACAPT's Clinical Education Summit), relevant literature, interviews with a broad representative sample of stakeholders in PT clinical education, and information from other professions including nursing, pharmacy, and physician assistant education.

Similar to the concept of evidence-based practice, any decision should not only rely on the best available evidence, but on the expertise and experience of the profession and the perspective and input from all stakeholders. It is important to recognize the interrelated nature of the recommendations of the task force. Recommendations 3 (academic-clinical partnership), 4 (data), and 5 (education research) are integral as we seek to develop a standard model of physical therapist education. The information gathered as this "research-as-you-go" process would inform our decision making as the process moves forward.

The proliferation of physical therapist education programs seems to be causing the problem for clinical education. Will APTA or CAPTE create policies that limit/control the development of new programs?

APTA cannot create policies that limit CAPTE's ability to do its work. To do so would jeopardize CAPTE's standing with the US Department of Education (USDE) and the Council for Higher Education Accreditation (CHEA). If CAPTE decided it would not accredit more than a certain number of programs, **that decision undoubtedly would be a restraint of trade in violation of the federal antitrust laws.** The law prohibits competitors from banding together to prevent new competitors from entering the marketplace. Although APTA itself is not an institution of higher learning that operates an entry-level education program, most of CAPTE's members work for such institutions. Allowing CAPTE to limit the number of programs would be akin to letting Kellogg's, General Mills, and Post band together to prevent new companies from producing breakfast cereals.

How did the task force determine that current clinical education models are not designed to produce practitioners of the future?

The Task Force believed that current models of clinical education are unsustainable. The Task Force considered literature describing entry-level graduates as novices who require additional support, education, or training to achieve the desired level of physical therapist competence.¹⁻⁶ According to the Excellence in Education Task Force Report (2015), "There are widespread concerns that students are not optimally prepared for clinical education, practice, and the evolving health care environment."⁷ Additionally, reports from new professional and employers suggest that graduates need to be more able to "hit the ground running" when they enter the workforce.

What does the health care system of the future look like?

The health care system in the United States is evolving to include elements such as health informatics, interprofessional teams, outcomes and data-driven care, and value-based payment, to name a few.

As stated in the report, in his 2012 APTA McMillan Lecture, Alan M. Jette, PT, PhD, described 3 major societal storms: 1) lack of access to health care, 2) the age wave, and 3) costs of health care.⁸ Jette proposed that to meet societal needs, “physical therapists must possess and use critical systems skills” including “... universal standardized measurement and data collection, widespread quality improvement and implementation techniques, interprofessional coordination and care management, diffusion of practice innovations and standardized practice models, and health policy leadership for widespread change.”⁸ Physical therapist education must continue to evolve as physical therapists increasingly position themselves to function as points-of-entry in a complex and dynamic health care system focused on outcomes, value, and efficiency.

Who manages the learner during the clinical internship phase (after first exam)? If the student/graduate is no longer enrolled in a PT education program then there is no revenue or credit hours to the academic institution.

Adopting a framework that formal preparation for practice includes PT professional education followed by clinical internship and mandatory postprofessional residency would require clarification of the roles and responsibilities of the academic programs, clinical internship and residency sites, and the student/graduate. Economic factors were identified in the report as a primary consideration in future PT clinical education, with an emphasis on not increasing student debt. This would include consideration of economic factors in the academic institutions.

Currently, approximately 50% of accredited and developing residency programs are sponsored (in full or in part) by academic institutions. It is likely that many academic institutions currently providing professional (entry-level) education will participate in meeting residency education needs for the profession.

If students are going to be specialized so early on, what happens to goal of producing generalists? Is the feeling that there is no place in the profession for generalists?

The task force was unable to find any reference to an expectation of “producing generalists.” The term “generalist” in the context of physical therapy does not appear to be defined by the Commission on Accreditation in Physical Therapy Education (CAPTE), the *Normative Model of Physical Therapist Education* (APTA, 2004), or any other seminal APTA documents. The task force believes that removing the expectation that a new graduate can, as a “generalist,” treat patients and clients of all ages, with any condition, and in every setting, would allow these developing professionals to begin clinical practice under the expectation that they would continue their formal educational experience and begin a path toward specialization.

In the model example provided, students would specialize after broad exposure to multiple practice settings and patient/client conditions during their integrated clinical education experiences and clinical internship. The task force did have significant discussion regarding the possible need for a “generalist” to be a specialist similar to family practice in medicine. This would prepare specialists who have expertise in treating a general range of conditions, and in triaging patients who need more specialized care, which might be ideal for some rural and urban environments.

My concern is the ability of all of the students to get residencies, especially as the number of new schools is growing exponentially, and the limited number of residency programs currently available. Did the task force consider this?

Yes, the task force recognized that current residency program capacity would be a barrier to implementation of this model, and would expect significant efforts to expedite residency programs if these recommendations move forward.

Did the task force consider rural PT communities when making their recommendations? I think it may be difficult for rural practices to support this model. I worry that rural practices will suffer from poor service while students are in urban areas for their residency.

Yes, the task force considered rural communities in its recommendations. Innovative models of residency may include distance learning opportunities. Rural communities would likely benefit from PTs with a “generalist” specialty.

A large portion of the justification for changing to the medical model seems to be based on the belief that we are not producing quality clinicians.

The task force members did not suggest that education programs are not producing quality graduates, nor did they recommend changing to the medical model. As noted in the report, the board considered the need of “graduating a DPT with core knowledge and skills, followed by an intense, structured clinical internship and finally specializing in an area of practice through a skilled residency program,” which “aligns with other doctoring professions.”

If we move to a residency/specialist model for physical therapy are there any concerns about the payment structure for reimbursement?

Although not mandated, residency education has grown by 79% in the past 5 years. Similarly, growth in specialization has grown by 72% during that same period of time. Currently, more than 10% of all physical therapists have achieved board certification through ABPTS. Based on current trends, the number of residency programs, enrollment in residency education, and specialist certification applications are expected to increase in the future. One example of current payment structure tied to board certification is payment for electromyography (EMG) studies. While we do not know what the payment environment of the future will look like, these factors would need to be investigated more fully if these proposals move toward implementation.

Would the proposed process of professional education limit mid-career shifts in practice?

The current licensure process permits any licensed PT to practice in any setting or with any patient population. If the profession believes this flexibility is important in future models of professional education, processes would need to balance that priority with mechanisms to ensure competence in providing best practice to patients and clients.

How will staged licensure be implemented across the various jurisdictions?

Similar to legislative changes outside and within the profession, this action would need to be completed specific to each of the 53 licensing jurisdictions.

Who would be responsible for a clinical matching program?

Determining when matching would occur and who would be responsible for the matching program are details the profession would need to address if it chooses to go in that direction.

Was consideration given to the impact of change in educational model on PTA education?

The task force’s charge was specific to physical therapist education. However, there was recognition that changes made to physical therapist education, including the clinical components, could impact PTA education. If changes were adopted, PTA-specific education discussions may be needed.

Does the model that was used as an example in the report work against the discussion at ACAPT’s Clinical Education Summit on the value of integrated clinical education experiences?

Integrated clinical education experiences are valuable components of physical therapist education and are represented in the model example (eg, 18-24 weeks).

Why did the task force state that our graduates are not prepared to meet the needs of their patients at graduation?

The statement on page 5, line 10 of the report regarding a future graduate's ability to "manage the care of clients and patients of all diagnoses and conditions across the lifespan" was based on the task force's observation and support from the literature. There was no intent to suggest that academic and clinical partners are not educating students, or that graduates are not prepared to practice. Rather, the intent of this statement was specific to the future of the profession, the needs of society, and the evolution of physical therapist education.

References

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